Sukhvinder Marjara

Sycamore Lodge Care Home

Inspection report

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Ratings

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

Overall summary

An unannounced inspection was carried out at the service on 2 and 3 October 2014 by an adult social care inspector.

Sycamore Lodge provides personal and nursing care to a maximum of 45 people. It is situated in the town of Ashby on the outskirts of Scunthorpe. There are bedrooms and bathrooms on two floors, which can accessed by a passenger lift or stairs. There is a range of communal areas including a conservatory and a number of lounges.

At our last inspection on 24 September 2013 the service met the regulations inspected.

There was a registered manager at the service at the time of our inspection who had been in post for over 10 years. 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.

Summary of findings

During our inspection we looked at six care files. Each file contained a pre admission assessment that was used to develop an individual plan of care. Risk assessments were in place to reduce the risks to the people who lived at the home.

Care staff had been trained to recognise the signs of abuse and were aware of what action to take if they suspected abuse had occurred. A care worker we spoke with said, "I would report anything I saw straight away, but all the staff are really caring and I've never seen anything that has concerned me."

Staff we spoke with confirmed that they had completed training in relation to the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection two people who lived at the home were subject to such safeguards. We saw that people were not deprived of their liberty unlawfully.

A care plan we reviewed stated a person who lived at the home was at risk of developing pressure sores. Plans had been developed to minimise the possibility of this occurring. However, the records we saw showed that the plans had not been followed and person had not received the amount of fluids required to reduce the risk them developing pressure sores.

We spent time observing how care workers and other staff interacted with people who lived at the home. We saw that people were treated respectfully and that care workers asked personal questions in a discreet way. When care workers supported people it was done at their own pace and was not task orientated.

Reasonable adjustments had been made to the home to enable people to remain as independent as possible. Grab rails, a passenger lift and other aids were available within the home. One person had a communication book that had been specifically designed to enable them to communicate with care workers.

We saw evidence to confirm that a range of health care professionals were involved in the care and support of people who lived at the home. For example doctors, district nurses, dieticians and social workers.

Team meetings were held regularly and used as a forum to discuss changes to policies and procedures, paperwork and staff training. We saw that handover meetings were held daily to ensure staff were aware of any changes in the needs of people who lived at the home.

Staff confirmed that the registered manager was a visible presence within the home and that they could discuss any issues or concerns they had openly and honestly.

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. People who lived at the home were protected from abuse and avoidable harm by care workers who had been trained to recognise signs of possible abuse.

Assessments of people needs were completed and risk assessments were produced to reduce the risk to people who lived at the home. Accidents and incidents were reviewed and action was taken to improve the service as required.

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

Is the service effective?

Requires Improvement

The service was not always effective. People who lived at the home were not always supported effectively to ensure they did not develop pressure sores.

Care workers completed training deemed as mandatory by the registered provider. We saw evidence to show staff training was kept under review and updated as required.

We saw evidence confirming that staff had undertaken training in relation to The Mental Capacity Act (2005), Deprivation of Liberty Safeguards (DoLS). When people no longer had the capacity to make decisions for themselves best interest meetings were held with relevant health care professionals.

Is the service caring?

Good

The service was caring. People who lived at the home were treated with dignity and respect by care workers.

The service had a dementia champion and a dignity champion to promote a high level of care for people who lived at the home. A care worker told us, “The dignity champion makes sure people are treated with dignity and respect at all times.”

People who lived at the home were involved in decisions about their care and treatment.

Is the service responsive?

Good

The service was responsive. Activities within the service were planned after consultation with people who lived at the home.

People were encouraged to express their views about the service through resident meetings and service user questionnaires.

Summary of findings

People's care and welfare needs were kept under review. Referrals to other health care professionals such as the dietician and the falls team were made when required.

Is the service well-led?

Good 

The service was well led. There was a registered manager in place. Staff we spoke with told us that the registered manager and the residential manager were visible within the service and available to discuss any concerns they had.

An audit schedule was in place that covered a range of topics including health and safety, care planning, the laundry, the kitchen, pressure sores and accidents and incidents.

Sycamore Lodge Care Home

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, and to provide a rating for the service under the Care Act 2014.

An unannounced inspection was carried out at the service on 2 and 3 October 2014 by an adult social care inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection the PIR for the service was reviewed and evaluated. We also spoke to a number of health care professionals involved with the service before the inspection took place. For example, community nurses, district nurses and social workers.

During the inspection we spoke with the registered manager, a registered nurse, eight care workers, five relatives and six people who lived at the home. We also spoke to the residential manager who was responsible for the care workers on the residential side of the home. We spent time observing how care workers and other staff interacted with the people who lived at the home. We completed two short observational framework for inspections (SOFI), one in the lounge and the second over lunchtime. SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We reviewed a range of paperwork including eight people's care plans and risk assessments, the registered providers policies and procedures, staff meeting minutes and minutes from 'resident and relative' meetings, audits, accident and incident records and complaints.

Is the service safe?

Our findings

People who lived at the home told us they felt safe. One person we spoke with told us, "I'm safe and well looked after." Another person said, "I feel safe, there is always someone here if I need them. I used to be scared on a night time but I'm not anymore." A visiting relative told us, "I know my Dad is safe here and that is a great feeling."

Care workers and nursing staff had undertaken training in relation to safeguarding of vulnerable adults. We spoke to eight care workers who were aware of the different types of abuse that may occur and could independently describe what action they would take if they suspected abuse had occurred. A care worker we spoke with said, "I would report anything I saw straight away, but all the staff are really caring and I've never seen anything that has concerned me." We saw evidence to confirm that referrals to the local authority safeguarding team had been made and appropriate action had been taken after investigations had concluded. The registered manager worked with relevant healthcare professional to ensure that people who lived at the home were safe and protected from harm.

Risk assessments had been completed in a range of areas such as wheelchair requirements, bed rails, falls, pressure sores and moving abilities. Ways of reducing the risks to people had been documented. Advice and guidance from other professionals such as the falls team had been incorporated.

Due to a recent issue with the ceiling in one of the downstairs bathrooms the bathroom had become unsafe. During our tour of the home we noted that the bathroom was not in use, however it was still accessible to people who lived at the home; posing a risk to their health and safety. We mentioned this to the residential manager who immediately locked the bathroom so it could not be entered.

People's needs were assessed and staffing levels were reviewed and increased as required. The residential manager told us, "We change the staffing levels depending on they type of people we have in the home, if we have more than 12 nursing clients we increase the nursing staff." During the inspection care workers answered call bells promptly and people who lived at the home had their care needs met by sufficient numbers of staff. A care worker we spoke with told us, "Sometimes it can be busy, sometimes less so, it just depends on the day really but people don't ever have to wait too long."

Appropriate arrangements were in place for the safe ordering, storage, dispensing and destruction of medication. There was a management of medicines policy in place that outlined how to manage medicines effectively, which included controlled drugs and self medication.

The service had a dedicated medicines room for the safe storage of medication. This included a second lockable cupboard for the storage of controlled drugs, two medication trollies that were secured to the wall as per best practice guidance and a medicines fridge. We saw that fridge and room temperatures were recorded on a daily basis to ensure storage recommendations were adhered to. A nurse we spoke with told us, "We ask people if they want to continue to manage their own medicines when they come in to the home but no one is doing that at the moment."

We looked at five staff files and saw that care workers and other staff were employed after appropriate checks had been completed. The registered manager told us that before people commenced working within the service disclosure and barring service (DBS) checks were completed, references were received and gaps in employment were explored. A member of staff we spoke with told us, "Before I started I had to wait for my DBS check to be sent back but it didn't take a long time."

Is the service effective?

Our findings

One person who lived at the home had been assessed as being at high risk of developing pressure sores. Their care plan stated that they must drink two litres of fluid everyday as part of a plan to reduce the possibility of pressure sores occurring. We checked their fluid intake chart and saw that care workers had not recorded that the person had achieved this in August or September (2014). We discussed this with the nurse on shift who told us, "I'm sure that is a recording issue because the charts (fluid intake charts) are not kept in people's rooms because they [the person who lived at the home] drink really well, they get through a lot of fluids." We saw evidence to confirm that no pressure sores had developed due to a lack of fluid intake.

People who lived at the home had their health and social care needs met by staff who understood their responsibilities within the multi disciplinary team. Care workers had the knowledge and skills to carry out their roles effectively. A visiting relative we spoke with said, "I think all the staff are brilliant from the manager to the carers to the cleaners" and "It's not like some of the stories you hear, whenever we need a staff member they are easy to find."

Staff supervisions and team meetings were conducted regularly. We saw from the meeting minutes that staffing levels, equipment, training and working as a team were discussed. A care worker we spoke with told us, "I think it's a very supportive place to work, all the staff get on well. We have one to one meetings with the manager and team meetings where we talk about everything to do with the home and the residents."

We saw evidence confirming that staff had undertaken training in relation to The Mental Capacity Act (2005), Deprivation of Liberty Safeguards (DoLS), safeguarding vulnerable adults, moving and handling, infection control and fire safety. A care worker told us, "We do lots of training mandatory, I'm also doing dementia training at the moment."

Stair gates were in place at the entrance of two of the stairwells. The registered manager told us, "We have them in place because one person likes to use the stairs but tries to carry their walking frame down which is really dangerous." We saw that the stair gates had been risk assessed and had been taken into account when personal emergency evacuation plans (PEEPs) had been written. Following the inspection we spoke with registered manager and asked if the gates were the least restrictive intervention, they agreed that it wasn't. They asked the person if they would consider moving to a room downstairs which they agreed to. The gates have now been removed.

A number of people who lived at the home had do not attempt resuscitation (DNACPRs) in place. We saw that they were reviewed appropriately and where possible discussed with the person who used the service or a relative. The registered manager told us, "They (The DNACPRs) are always reviewed when someone comes out of hospital and back in to the home."

The residential manager told us, "I have worked my way up from being a carer [care worker] to the residential manager. The owners and registered manager have always supported me" and went on to say, "I have completed level two, three and four of my NVQ (National Vocational Qualification) in health and social care and am now doing a QCF (Qualifications and Credit Framework) level five in leadership and management."

We saw that people's dietary requirements were recorded and displayed in the kitchen. The cook told us, "I know who is diabetic, who needs a special diet, who needs a pureed diet and to what consistency." Pureed meals were plated in a way that made them look visually appealing.

When people's needs changed, the registered manager made referrals to relevant health services. For example the falls team had been contacted for their advice and guidance to reduce the risks to people who used the service after accidents and incidents had taken place. A district nurse we spoke with said, "They (the registered provider) have run a pilot with us to reduce hospital admissions. We have done training with their staff about nutrition, signs of infection, pressure care and some other things. I feel it has made an already good service even better, they work really well with us."

A social worker we spoke with said, "In my experience they always communicate well and we have always worked in collaboration with one another. They were very proactive undertaking the initial assessment, they took their time to understand the person's needs and did a thorough job"

Is the service effective?

and went on to say, “We have held some reviews with the service and we have occasionally had teething problems but they have been discussed and they have listened and done what they could to alleviate the concerns.”

We saw that rooms were decorated to meet people’s personal tastes. The residential manager explained, “The people who are in the new rooms (in the extension) were given choices about what colour their room would be and if they wanted wall paper.” A person who lived at the home told us, “I love my room, the colours are lovely.”

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). We found the location was meeting the requirements. The registered manager was aware of the recent changes to the DoLS. At the time of our inspection two people were subject to such safeguards and checks on their records showed appropriate assessments of their capacity and mental health needs had been made prior to the authorisation being granted.

Is the service caring?

Our findings

A person who lived at the home told us, “It feels like I am at home, its very comfortable, clean and all the girls [care workers and nursing staff] are so kind; they all do the little things to make me happy and relaxed.” A second person said, “They [the care workers] do everything they can to make me as comfortable as possible.” A visiting relative we spoke with said, “The staff have always looked after her [relative] so well, I couldn’t ask for her to be in a better place.” Another relative told us, “I would recommend this place [the home] to anyone.”

We spent time observing interactions between people who lived at the home and staff. Staff showed patience and gave encouragement to people. It was apparent that staff knew people’s personal histories and individual needs. The registered manager told us about the life history of one person who lived at the home, “They [the person who lived at the home] always loved Scunthorpe United, when they were younger they would always go and watch them.” We saw that a trip to the ground had been arranged for the person.

During the inspection we used the SOFI (Short Observational Framework for Inspection) tool. SOFI allows us to spend time observing what is happening in a service and helps us to record how people spend their time, the type of support they received and if they had positive experiences. We spent time in a communal lounge and saw that staff interacted well with people who lived at the home. It was evident that positive relationships had been built and staff were aware of people’s personal needs.

We completed a second SOFI observing the lunch time experience and saw that support was provided in a compassionate way and people were assisted at a suitable pace to meet their needs. However, we noted that five people spent a period of over 25 minutes sitting in the dining room before any food was brought from the kitchen; these people were not prioritised to be given their lunch first and waited for a further 20 minutes whilst other people were brought their meals. We discussed this with the registered manager who assured us they would address this so people would not have to wait as long to be served their meal in future.

We saw advocacy posters were displayed on a prominent noticeboard, providing details of who to contact when a person lacked the capacity to make an informed decision for themselves. Independent mental capacity advocates (IMCAs) were available on request to support people who lived in the home to make decisions about the heath care needs. The residential manager explained, “We are lucky that we have not had to use this service for some time because everyone who lives here has families to support them.”

We observed care workers treating people with dignity and respect throughout the inspection. The service had a dementia champion and a dignity champion to promote a high level of care for people who lived at the home. A care worker told us, “The dignity champion makes sure people are treated with dignity and respect at all times.” Another care worker described how they would promote people’s independence and uphold their dignity, “I always offer people choices even if it’s only little things like where they want to sit or if they want to do activities” and “I knock on doors before I go in to rooms and cover people when I give personal care.” A person who lived at the home said, “The staff are really polite and treat me well.”

The registered provider had taken steps to support people with dementia including appointing a dignity champion and installing memory boxes. Memory boxes can be put outside people’s room and include pictures of themselves or family members in an attempt to help people orientate themselves.

Is the service responsive?

Our findings

A person who lived at the home told us, “I make choices about what I want to do, if I want to participate in the activities or if I want to stay in my room. I decide what meals I want, what to wear, I make all the decisions in my life.” Another person said, “I choose to go in to the town or to the seaside, I can’t choose what the weather does though so it always depends on that” and “Sometimes we go on the mini bus to the other home for lunch, that’s nice.”

A person we spoke with said, “I know I have a care plan but my daughter gets more involved with that than I do.” A relative we spoke with said, “We are involved with all the reviews about my relative’s care, they (the registered provider) really listen when we make suggestions” and “They always keep me updated, so if my relative is ill or needs to go to hospital I am informed immediately.”

People who lived at the home told us they were involved in making decisions about their care and developing their care plans. The care plans we saw had been signed by the person indicating they were in agreement with its content. When people lacked the capacity appointed people such as those with power of attorney had signed for them.

We saw that care plans were reviewed periodically. The registered manager told us, “Whenever people’s needs change we update their care plan.” A nurse we spoke with said, “When pressure sores occur we will produce a care plan straight away so that it is managed properly and heals quickly.”

Reasonable adjustments were made to support people who lived at the home. The residential manager told us, “One lady had a stroke so we have got her a communication book; it allows her to let us know what she wants.” The communication book contained a wide range of pictures of everyday items or activities such as a cup of tea, a sandwich, a toilet or a bath.

The registered provider had a complaints policy in place that was displayed on a notice board within the home. People who lived at the home and others had their comments and complaints listened to and acted on. We saw that a recent complaint had been responded to appropriately, investigated and resolved to the satisfaction of the complainant. This indicated that complaints were taken seriously by the registered provider and used as a way to improve the service.

One person who lived at the home explained, “If I was unhappy I would just tell someone.” Another person said, “We see the manager everyday so if I had any problems I would just tell her.”

A member of care staff told us, “The activities are different every week, we ask people what they want to do and then plan things that as many people as possible can get involved with.” A person who lived at the home told us, “We do different things (activities), we are having a tasting day today, I participate if I want to but not if I don’t.” The activities co-ordinator told us that people were encouraged to take part in movie nights, quizzes, trips out of the home to garden centres and for meals in a sister home. We saw evidence in people’s care plans when they had participated in activities and on various photo collages around the home.

A community support worker told us, “I’ve always thought the staff are very professional, they work with us to produce and update care plans for people and listen to our advice” and “I was involved in a best interest meeting with other professionals including the lead nurse (from the service) when a service user lost capacity; the outcome was great for the service user.” Responding to the changes in people’s needs in timely way helps to ensure that they receive the most appropriate care to meet their needs.

Is the service well-led?

Our findings

A registered manager was in place at the time of the inspection. 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.

We saw evidence that 'service user meetings' were held on a monthly basis. This provided people who lived at the home with a forum to discuss any changes to the running of the service, future outing and activities. We also saw that building work completed on the home and redecoration was discussed with people who lived at the home.

Staff we spoke with told us the registered manager and the residential manager were visible within the service and available to discuss any concerns they had. A care worker told us, "You can speak to the managers anytime, they are really supportive. I have worked here for years and know that I can talk to them about anything; even if it's not work related."

Effective systems were in place to drive continuous improvement with the service. An audit schedule was in place that covered a range of topics including health and safety, care planning, the laundry, the kitchen, pressure sores and accidents and incidents. We saw that action had been taken from the findings of recent audits including care plans being signed by people who lived at the home or relatives and the removal and replacement of some older furniture.

The service's supplying pharmacy completed periodic medication audits within the home. Following a recent audit they highlighted various issues such as clearer recording when people had taken variable doses of medication, recording the date that creams and lotions were opened and ensuring the 'new client' information was sent to the pharmacy in a timely manner. We saw this had been actioned appropriately.

The registered manager told us, "We work well with other professionals. We are currently involved with the district nursing team project to reduce hospital admissions and we have had some really good feedback and things have improved." The healthcare professionals we spoke with confirmed that the management and staff responded well to advice and guidance.

We saw evidence that team meetings were held regularly and used as a forum to discuss any changes to people's needs or best practice. A nurse we spoke with said, "We have lots of different meetings, team meetings, trained staff meetings and handover meetings. It's important that we can pass information to each other quickly so people on the next shift know what needs to be done."

The registered provider told us, "Some of the key challenges we have as a business is finding quality staff and retaining them" and "We are actively recruiting and will only employ good staff who can do a good job." The registered manager told us, "We have had some staff, including myself that have worked here for years and I think that's really good for providing a consistent level of care to people."

We saw evidence the registered manager worked with product representatives to ensure people who lived at the home were treated with new and innovative wound management products. The registered manager explained, "We work closely with reps (product representatives) and the tissue viability nurses to make sure we are using the best products available."