Viridian Housing

Sycamore Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 15 and 16 June 2016. The visit on 15 June was unannounced and we told the provider we would return on 16 June to complete the inspection. We last inspected the service in June 2015 when we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and awarded a quality rating of Requires Improvement. The provider sent us an action plan and said they would make the required improvements by the end of September 2015. At this inspection we found the provider had taken action to address the issues we raised at our last inspection but further improvements were needed.

Sycamore Lodge provides accommodation, care and nursing for up to 77 older people, some of whom were living with the experience of dementia. The home is divided into five separate units according to people's needs. When we inspected, 76 people were using the service.
The service's registered manager had not worked at the home for some time, after taking up another post with the provider. The provider had appointed a manager in March 2016 and they told us they were applying to register with the Care Quality Commission. 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 found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not always take action to address issues identified in audits and checks they carried out to monitor quality in the service and make improvements. You can see what action we told the provider to take at the back of the full version of the report.

The provider had not always taken action after they had identified risks although we also found evidence of the provider reviewing and updating risk assessments and care plans when people's needs changed

There were enough staff on duty to support people and the provider carried out pre-employment checks to make sure staff were suitable to work in the service.

The provider had assessed people's capacity to make decisions and taken appropriate action where restrictions were in place. They worked with the local authority to make sure any restrictions were agreed.

People using the service were supported and cared for by staff who were appropriately trained and supported.

People's nutritional needs were met and most told us they enjoyed the choice of food provided in the service. Staff supported people living with the experience of dementia to have a positive experience at meal times.

Staff supported people to stay healthy and arranged for them to see other healthcare professionals as needed.

People using the service and their relatives and visitors told us staff were caring and that they always treated people with respect. Throughout the inspection we saw interactions between staff and people using the service that were caring and kind. Staff made sure people were comfortable and responded promptly when they asked for support.

Staff supported people to take part in meaningful activities to meet their social and emotional needs.

Managers and staff assessed people's care needs and recorded these in care plans which they reviewed and updated regularly.

People knew how to make a complaint and felt confident that these would be responded to.

The provider, managers and staff carried out other audits and checks to monitor quality in the service and we saw these were up to date.

The service had a new manager and Head of Nursing and together with the Head of Care, this meant the service had a permanent management team in place. Staff told us they felt well supported by their managers.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The provider did not operate systems to make sure people received their medicines safely.

The provider assessed risks to people using the service and took action to mitigate these.

There were enough staff on duty to support people and the provider carried out pre-employment checks to make sure staff were suitable to work in the service.

Is the service effective?

Good

The service was effective.

The provider had assessed people's capacity to make decisions and taken appropriate action where restrictions were in place. They worked with the local authority to make sure any restrictions were agreed.

People using the service were supported and cared for by staff who were appropriately trained and supported.

People's nutritional needs were met and most told us they enjoyed the choice of food provided in the service.

Staff supported people to stay healthy and arranged for them to see other healthcare professionals as needed.

Is the service caring?

Good

The service was caring.

People using the service and their relatives and visitors told us staff were caring and that they always treated people with respect.

Throughout the inspection we saw interactions between staff and people using the service that were caring and kind.

Staff made sure people were comfortable and responded promptly when people asked for support.

Is the service responsive?

Good

The service was responsive.

Staff supported people to take part in meaningful activities to meet their social and emotional needs.

Managers and staff assessed people's care needs and recorded these in care plans which they reviewed and updated regularly.

People knew how to make a complaint and felt confident that these would be responded to.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

The provider had not always taken action after they identified risks to people's safety and wellbeing.

The provider, managers and staff carried out other audits and checks to monitor quality in the service and we saw these were up to date.

The service had a new manager and Head of Nursing and together with the Head of Care, this meant the service had a permanent management team in place. Staff told us they felt well supported by their managers.

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 15 and 16 June 2016. The visit on 15 June was unannounced and we told the provider we would return on 16 June to complete the inspection.

The inspection team consisted of one inspector, a specialist professional advisor who was a qualified nurse and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection had experience of caring for someone living with dementia.

Before the inspection we reviewed the information we held about the service. This included the last inspection report, the action plan the provider sent to us following the last inspection and notifications of significant events and incidents affecting people using the service. We contacted the local authority's safeguarding adults and contract monitoring teams for their views on the service. We also contacted 12 community professionals who worked with people using the service, including GP's, local authority care managers and health care professionals.

During the inspection we spoke with 27 people who used the service, four visiting relatives and friends and the staff on duty who included the registered manager, nurses, care workers, senior care workers, domestic and catering staff. We observed how people were being cared for, we looked at the environment and records relating to the care of people, the support, recruitment and training of staff and other records used to manage the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in June 2015 we found the provider did not assess or do all that was reasonably practicable to mitigate risks to the health and safety of people using the service. In their action plan the provider told us they would review risk assessments for people using the service who smoked. At this inspection we found that the provider had taken action and staff had reviewed the risk assessment for one person who smoked in their bedroom regularly, the last time in May 2016. The risk management plan included practical measures to reduce the risks caused by the person smoking, including the use of a metal bin and regular checks by staff to make sure the person was safe. Staff had assessed that the person had the capacity to make a decision about smoking and we saw they were involved in developing and agreeing their care plan and risk management plan.

Other people's risk assessments were up to date and staff reviewed them regularly. Risk assessments covered people's mobility, skin care, falls and nutrition. Staff used the risk assessments to develop risk management plans that included guidance on how to mitigate the risks they had identified for each person.

The provider had systems in place to manage people's prescribed medicines but needed to make some improvements. For example, staff recorded the daily temperature in each of the five rooms used to store prescribed medicines. We found that, in four of the service's five units, the daily recorded temperature was regularly above 25 degrees Centigrade, the recommended maximum storage temperature for some medicines. Storage temperatures above 25 degrees may affect the efficacy of some medicines. Although the provider recognised this was a concern, they had not taken action to provide storage at a safe temperature. Following the inspection, the provider told us they planned to construct new medicines storage areas within the service and they had ordered portable air conditioning units to lower the temperature in the storage rooms. However, they had not taken action at the time they identified the problem and people using the service may have been at risk of unsafe care.

We also noted that, on one unit, five of the Medication Administration Record (MAR) sheets nursing staff used to record people's medicines did not include a photograph of the person, although they had lived in the service for several weeks and in one case, three months. This meant new nursing staff or agency nurses could not be sure they were giving medicines to the correct person and this may have led to the risk of unsafe care, especially if people were living with the experience of dementia. We discussed this with the manager who confirmed after the inspection that they had taken photographs and added these to people's MAR sheets.

Other medicines records we checked were accurate and we saw that medicines protocol sheets were in place that described for nurses the purpose of the medicine, the dosage, frequency and possible side effects. We looked at 23 MAR charts and found no gaps in the recording of medicines administered, which indicated people were receiving their medicines safely, consistently and as prescribed. Controlled drugs were appropriately stored in accordance with legal requirements, with weekly audits of quantities done by two members of staff.

The provider had policies and procedures to safeguard people using the service and staff received the training they needed to understand and follow these.

People using the service and their relatives told us they felt safe in the service. Their comments included, "I feel very safe here. It wasn't safe for me to stay at home so my [family member] is much happier I'm living here," "Yes, I feel safe, the staff are here if I need them," "My [family member] is very safe here, I have no concerns at all" and "I had a fall at home and I'm better off being here where I would be found more quickly if I had another fall."

Staff told us, "I would tell [the Head of Care] or [the manager] if I thought someone was being abused," "I would tell someone straight away if I thought abuse was happening, it is never acceptable" and "We are taught to report any concerns and if I thought nothing was being done, I would go to the council or the Care Quality Commission."

The provider had systems in place to ensure staff were suitable to work with people using the service. The staff records we reviewed all included an application form, references from previous employers, proof of identity and leave to remain and work in the UK and Disclosure and Barring Service (DBS) criminal records checks. Staff told us they were not allowed to start work in the service until the provider had completed all of their checks.

The manager told us they deployed staff according to people's care needs. Nursing care units had more staff than those providing residential care. Although staff on all units were busy, we saw they worked well together as a team to make sure people did not wait for care and support. Staff were able to spend time with individual people, chatting and making sure they had everything they needed. During the inspection we did not see people having to wait for support and at the meal time we observed, staff supported people in a caring and patient way. A member of staff told us, "Yes sometimes it is hard but we have good team work. We can usually get through the demands of the day and staffing has been better over the last year. If I had to improve anything maybe the décor could be upgraded. But I am very happy working here."

Throughout the inspection staff demonstrated safe moving and handling techniques when they transferred people. They used hoists, communicated with residents clearly and worked in twos as required. A nurse from the night shift had stayed behind to support an agency nurse until she had a full understanding of the needs for the day. With that support, the agency nurse assumed the nurse in charge role for the unit with ease and confidence. They knew what was expected, worked methodically and prioritised as required. They coordinated efficiently and was seen as a source of support to other staff. The nurse said their training was comprehensive and up to date, and the agency insisted on this prior to allocating work. This included continuing care; lifting and handling; fire safety; mental capacity and best interest assessments; dementia and challenging behaviour. They gave a good account of safeguarding, the types of abuse possible and how to deal with it appropriately.

Corridors were clear of obstacles, doorways were wide and clear and handrails were fitted on both sides of all corridors. Some hoists and wheelchairs were parked in corridor recesses but did not obstruct people moving around the unit. Equipment was clean, in good working order and accessible. Staff told us there was adequate equipment to meet the needs of people using the service in the working day. People on bedrest were on pressure mattresses, bedrails were padded and clean and care files held risk assessments for these. Floor areas were generally uncluttered with space for manoeuvring chairs and hoists.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The law requires the Care Quality Commission (CQC) to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them.

At our last inspection in June 2015 we found the provider did not seek lawful authority before people were deprived of their liberty for the purpose of receiving care and treatment. For example, the exit doors on each unit were locked with a key pad. The code for the key pad was displayed and the manager told us some people knew this and could leave the units when they chose. Other people, including people living with dementia, were not able to leave the units without staff support. The provider had recognised this was a restriction but had not applied to the local authority for authorisation of these restrictions. At this inspection we found that the manager understood their responsibilities under the MCA and DoLS and they had applied to the local authority for authorisation to deprive people of their liberty, where this was required to keep them safe. The manager told us they had applied to the local authority for 21 authorisations to deprive people of their liberty. The manager understood the legal requirement to notify CQC of the outcome of each application.

At our last inspection in June 2015 we found some staff employed in the service did not always receive appropriate training to enable them to carry out the duties they were employed to perform.
For example, the provider's training matrix showed a number of staff had not completed training in areas the provider considered mandatory. This included fire safety, infection control, moving and handling and safeguarding adults. At this inspection the provider's care training and quality assurance manager provided evidence that mandatory training was up to date or planned for nurses and care staff working in the service. They told us, "We have a one week manual handling train the trainer course booked for July that [the service] has five staff booked on to. This will enable them to deliver this training in house and quickly update staff. Currently staff are loaded on to programmes in the interim at other homes. Infection Control is being delivered on Wednesday 22 June 2916. We are also using the Care Certificate Workbooks and SFH Clinical Infection Control e-learning for refresher training."

We saw the provider advertised planned training sessions around the service and staff were clear about the training they needed to attend.

Nurses and care staff told us they were well trained and could access the training they needed to care for people who used the service. Their comments included, "We get good training on lifting and handling. The team works well together and you are never left with a difficult situation on your own," "The training is very

good, it helps me to do my job and managers make sure we attend the training we need" and "I had a good induction of 2 weeks when I started and the training has been good ever since. I get an annual appraisal."

Staff also told us they felt well supported by managers in the service and had access to the provider's supervision and appraisal systems. We saw the manager had arranged a group supervision session for care staff in May 2016 and for domestic staff in April 2016. The last staff meeting was in April 2015 and a senior care meeting was held in June 2016. Staff files included records of individual supervision sessions with the Heads of Care or Nursing and the manager had completed 40 annual appraisals of staff in May 2016.

People received the support they needed to maintain a healthy and nutritious diet. People had enough to eat and drink and the provider monitored nutritional risk to make sure people's needs were met. Where people needed support with nutrition, staff recorded this in their care plans. Care plans included information about foods people liked or disliked and staff were able to tell us about people's preferences. We saw staff made sure people had drinks throughout the day and they offered a choice of drinks at meal times. The SOFI observation we carried out at lunchtime showed that people had a positive experience. They did not wait for support, staff offered them choices and where people needed support to eat or drink, staff provided this in a patient and caring way.

We saw that people on bedrest were comfortable, warm, clean and tidy. Meals and drinks were served to these people either to manage independently or on a one to one basis. The service was unhurried and staff interacted encouragingly with the residents.

People's comments about the food provided in the service included, "The food is very good" and "The food is quite good" When we asked one person about the food, they said they looked at the menu for the week and if there was anything they didn't like, they could order an alternative the day before. For example, this person knew the main course on the day we inspected was going to be spicy food so they had already requested something different.

Staff supported people to stay healthy. Everyone was registered with a local GP practice and the GP visited the service twice a week. Staff had assessed people's health needs and included these in their care plans. People's care plans included clear guidance for nurses and care staff about how to meet each person's identified health care needs. Where there was a change in a person's health, staff recorded this and took action. For example, where staff had noticed one person was losing weight, they referred them to the dietician who advised on the person's diet. Weight charts staff completed showed that, as a result, the person's weight had stabilised.

People told us they could see their doctor or other healthcare professionals whenever they needed and their care records provided evidence of this. They told us the staff looked after their health and monitored their wellbeing, organising for them to see a doctor when needed. Their comments included, "The doctor comes round and if I want to see him I tell the staff" and "The staff can arrange for me to see the doctor and they always remind me when I have a hospital appointment."

Good

Is the service caring?

Our findings

People told us staff in the service were caring and that they always treated people with respect.

One person told us their family members were happy that she lived in the service because it was so good, and she was from the local area. They said, "My [family members] are happy because they see I am happy." They also told us their family members visited regularly and were involved in their care and progress. Another person told us, "I've lived in several homes and this is one of the good places. I like going downstairs for breakfast and when the weather is good I love the garden and fresh air. I have a shower once a week and get help to wash the other days." When we asked one person if they thought the staff were kind and caring, they replied "Oh, absolutely." Another person had lived in the service for five years. They said they felt safe and described the staff as, "kind and caring." Another person said of a member of staff, "He's wonderful, I can always rely on him to sort something out if I have a problem." One relative told us, "I find the staff very good and caring. Can't think of anything bad about them."

One person living with the experience of dementia could not speak English but staff still sat and listened to her and were able to communicate by simple gestures and instruction. Staff told us, "We do have a member of staff who understands Arabic but the rest of us can still care for [person's name] because we know her well and we can work out what she wants." We saw that staff demonstrated that language was not a barrier to their caring and effective relationship and interaction. The person also had within reach a doll, used in a positive and comforting way; a common supportive and calming intervention for people living with the experience of advanced dementia.

We saw staff took time to sit beside people and chatted when they had time. Staff referred to people by their preferred names and there was no use of unnecessary terms of endearment. Preferred names were documented in Care Files under 'What I like to be called'. On notice boards around the service there were simple but effective tips on a range of Dos and Don'ts when supporting people living with the experience of dementia.

One person's relative told us, "It is marvellous here. My [family member] has been here for two years now and I am grateful for the help staff give us. She has a nice room and we go to the garden sometimes too. The food is also very good." A second relative said, "I visit regularly and always feel welcome. I know there is a care plan and staff talk to me when I should know about a change." A visitor told us, "I find the staff very good and caring. I can't think of anything bad about them."

Throughout the inspection we saw interactions between staff and people using the service that were caring and kind. For example, staff spoke with people by sitting or kneeling next to them to make sure they could have eye contact. Staff listened to what people said to them and responded patiently. If staff thought the person they spoke with did not understand what they were saying, they waited for a response and then repeated or rephrased what they had said until the person could follow. On one unit people had limited verbal communication skills but staff engaged with caring attitudes and addressed residents by their proper names.

Staff supported people with their personal care in a respectful way. They made sure people were comfortable and responded promptly when people asked for support. We saw staff provided support with personal care in people's rooms and they always closed the door to ensure privacy. Staff always knocked on bedroom doors before entering and waited to be invited in. A member of staff told us, "We can have a laugh and a joke with the residents, and that cheers us all up. We make sure we pay special attention to those in bed as they may feel lonely."

Good

Is the service responsive?

Our findings

Where possible, people using the service and/or their relatives were involved in the development of their care plan and other records relating to the person's life. Their comments included, "I'm involved if they change my [relative's] care plan" and "My [relative's] care plan is updated and I'm always involved." Another relative told us, "I visit regularly and always feel welcome. I know there is a care plan and staff talk to me when I should know about a change." One person using the service we spoke with was uncertain whether or not they had a care plan but they told us they were well cared for.

The provider ensured they assessed and recorded people's health and personal care needs and staff had access to guidance on how to meet these needs. Each person had a care plan that contained a comprehensive pre-admission assessment that outlined their health and social care needs. Assessments covered people's medical needs, mobility, personal care, communication, mental health, continence and skin integrity. Care records included a 'This Is Me' record that included person centred details with information on each person's routines and preferences. For example, there was a record of the person's food likes and dislikes, their usual time of going to bed / waking up, social interests and other activities they enjoyed. Staff recorded preferences that showed some people liked their bedroom doors open at night, while others liked the door closed and some people chose to lock their door.

Staff reviewed each area of people's care plans monthly or more regularly, if required. Where people's needs changed, staff updated the care plan to reflect this. For example, when one person became less mobile, staff reviewed the care plan and risk assessment to ensure they had the equipment and support they needed to move around the service.

We saw an example of an end of life care plan where staff had worked with the person to record their very specific wishes about their funeral. Staff had completed this in a very caring way and had contacted other organisations to make sure they were aware of and agreed with the person's wishes. One organisation replied, "It would be an honour for us to respect [person's name's] last wishes" and asked staff to contact them to make arrangements. This was an excellent example of person centred care planning that staff had completed with the full involvement of the person concerned.

Staff were able to tell us about people's individual needs and they were familiar with the different characteristics, routines and preferences of each person living in the service.

The daily care records staff completed mainly included information about people's health care needs, personal care and nutrition, although they also mentioned activities and visits by family members. These records showed that care was delivered in line with people's preferences and care plan.

People's care records included information about their life history, family members, previous employment, hobbies and interests. The provider's activities coordinator met with people to discuss the activities and outings they would enjoy and these were recorded. We saw the activities coordinator worked with individual people using the service and also with small groups, with support from the care staff. Planned activities were

advertised around the service, on notice boards in each unit. During the inspection we staff spent time chatting with people and supporting them to attend organised activities. We also saw the monthly activities plan for June and this included board games, bingo, Fathers' Day celebrations, reminiscence quizzes, music for health sessions, arts and crafts, chair exercise, music therapy and tea in the garden.

The provider had procedures for responding to complaints about the service. People told us they knew how to make a complaint and they felt confident they would be listened to. One person said, "I'd speak with the manager" and another person told us, "I've never had any complaints but I can always talk to the manager and I'm sure they would listen." A relative told us, "We were told about the complaints procedure but we've never needed it." Records showed there had been one complaint about the service's GP. The manager passed this to the GP practice who responded. This was evidence the provider had recorded and responded to complaints in line with their procedures.

Requires Improvement

Is the service well-led?

Our findings

The provider had systems in place to monitor quality in the service but these were not always effective at driving improvement. For example, senior staff, nursing and care staff completed regular audits of aspects of care and we saw they recorded these. However, where audits identified areas for improvement, the provider did not always take action. We saw senior staff had carried out audits of 12 people's care plans in 2016. Most of the audits identified areas of the person's care records that needed to be updated or completed but there was no evidence that recommended changes had been made by nurses and care staff. Senior staff in the service had also completed audits of Medication Administration Record (MAR) sheets that nurses used to record the medicines they gave to people using the service in May and June 2016. The audits had identified improvements that were needed but there was no evidence these had been checked to ensure they were completed. For example, an audit identified that some MAR sheets did not include photographs of the person using the service but these were still missing when we inspected the service.

These were breaches of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider, managers and staff carried out other audits and checks to monitor quality in the service and we saw these were up to date. For example, the provider's area manager completed monitoring visits to the service in January and April 2016. They produced a written report following each visit that included actions for the service to complete. Staff completed a monthly health and safety and maintenance inspection and we saw they followed up issues they identified. The provider also completed a health and safety audit in May 2015 and the record showed managers and staff had completed most of the required actions.

The service's registered manager had not worked at the home for some time, after taking up a more senior post with the provider. The provider had appointed a manager in 2015 but this person left the service before they registered with the Care Quality Commission (CQC). The provider appointed the current manager, a qualified nurse, in March 2016 and they told us they had applied to register with CQC. The service had a clear management structure and the provider had also appointed a new Head of Nursing since our last inspection. Together with the service's Head of Care, this meant the service had a permanent management team in place.

Staff told us they enjoyed their work and they liked working in the service. Their comments included, "The whole team is good. The Manager is approachable. I can talk to her. If I had a problem I feel I could go to her to discuss and get advice." Another member of staff told us they had worked in the service for a number of years and would not have stayed if it was bad. This person said they liked the new manager and that she was very approachable.

There was a welcoming and friendly atmosphere at the service. People who lived there, their visitors and staff reported feeling relaxed and happy there. Manager, nursing and care staff were supportive of one another and visitors told us they felt welcome when they visited the service. A visitor told us, "They never know when I'm going to drop in and I have never had any reason for concern. People look well and happy

whenever I visit and the staff always smile and say hello."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not assess, monitor and improve the quality and safety of the services provided. Regulation 17 (2) (a).