Sycamore Cottage Rest Home Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Sycamore Cottage Rest Home Limited on 2 and 3 March 2017. This was an unannounced inspection.

Sycamore Cottage Rest Home Limited provides care for up to 20 people living with differing stages of dementia. There were 19 people living at the home on the days of our inspection. Accommodation was provided over two floors of a converted residential dwelling, with a stair lift that provided access to the second floor.

The registered manager had left the home in November 2016 and Sycamore Cottage Rest Home Limited did not have a registered manager in place on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. Following the inspection the registered provider informed us that a new manager had been recruited and they would be starting in April 2017 to ensure the registered provider would meet their registration requirement to have a registered manager in place. The deputy manager had fulfilled the role of interim home manager since November 2016.

We found an effective governance system to monitor the quality of the service and identify the risks to the health and safety of people was not in place. A regular programme of audits had not been completed in relation to the management of people's medicines, infection control practices, health and safety and quality of care records. The interim home manager and the registered provider had not identified the areas of concern we had found. As a result, action had not been taken to improve the quality of care and ensure the safety of people.

We found people's safety was being compromised in a number of areas. Risks to people in relation to the use of medicines, equipment, malnutrition, behaviour and the environment had not always been assessed and risk management plans in place were not sufficient to enable staff to keep people safe.

People's care records did not include all the information staff would need to provide people's care and when people received care this was not always recorded. Staff and the interim home manager could therefore not judge from people's records whether people had received their care as planned and their medicines as prescribed.

Medicines were not managed safely or administered and recorded appropriately to ensure people received their medicines as prescribed.

Staff had not received the support, induction, guidance and training to develop their skills and knowledge to ensure they could meet people's needs and keep them safe. We found the support provided to people living

with dementia did not always meet their needs and preferences.

Recruitment arrangements were not safe. All the information required to inform safe recruitment decisions was not available at the time the provider had determined applicants were suitable for their role.

Improvement was needed to ensure staff would always identify potential abuse, including neglect, so that action could be taken to report and investigate these concerns to protect people from potential harm.

Where people lacked the mental capacity to make informed decision, or give consent to their care, the registered provider did not always act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice to ensure people's right were upheld.

People's privacy and dignity were respected and they were complementary about the caring relationships they had built with staff.

Opportunities were available for people and their relatives to provide feedback about the service and this was taken into consideration when making improvements to the service.

People were supported to access the GP and offered a balanced diet.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

Following this inspection we wrote to the provider to request a plan of action setting out how they would address the immediate and urgent concerns identified at our inspection. We received an action plan from the provider that indicated that they had already started to take action to address the identified concerns.

We identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The home was not safe.

People were not protected from risks to their health and safety. Staff did not always follow best practice when supporting people, which put them at risk of harm.

Medicines were not managed safely and administered appropriately to ensure people received their medicines as prescribed.

Pre-recruitment checks had not been satisfactorily completed investigated and documented. There was a risk that unsuitable staff could be employed.

People's care plans did not always include all the information staff would need to support people safely.

Is the service effective?

Requires Improvement

The home was not effective.

Staff had not received sufficient training and support to understand the needs of people and remain up to date with best practice.

Improvement was needed to ensure the rights of people who could not consent to their care were protected in accordance with legislation.

People were supported to access the GP.

Is the service caring?

Good

The home was caring.

People received kind and compassionate care from staff.

People were given choices and staff respected their wishes.

Staff upheld people's privacy and dignity when delivering their care.

Is the service responsive?

Requires Improvement

The home was not always responsive.

People living with dementia were not always given the opportunity to retain their skills, remain involved in day to day tasks and live a stimulating life.

People and relatives feedback was listened to and taken into account when improvements were made to the home.

Complaints were investigated but not used as an opportunity to improve the service provided for people.

Is the service well-led?

Inadequate

The home was not well led.

Management awareness of risks in the service was limited and action had not been taken to address safety and quality concerns.

Governance systems were not in place to effectively monitor the quality of service people received and this had placed people at risk of not receiving safe and effective care.

Communication with staff and guidance was not always sufficient to support them to understand their roles and responsibilities in providing quality care.

Sycamore Cottage Rest Home Limited

Detailed findings

Background to this inspection

This inspection took place on 2 and 3 March 2017 and was unannounced. The inspection was carried out by one adult social care inspector.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection. Before the inspection, we did not ask the registered provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information during our inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

During our inspection we spoke with five people using the service, two relatives and two friends of a person living in the home. We also spoke with the interim home manager, the cook, the housekeeper and five care staff. We spoke with two community occupational therapists that were visiting the home during our inspection.

We reviewed records relating to six people's care and support, such as their care plans and risk assessments and the medicines administration records for 15 people. We also reviewed training records for all staff and personnel files for three staff, and other records relevant to the management of the service.

This home was newly registered in September 2016 and we had not previously inspected this service.

Inadequate

Is the service safe?

Our findings

People and their relatives told us people were safe living at Sycamore Cottage Rest Home Limited. One person said, "I like it here, staff always come when I need them and make sure I am safe." Relatives told us ''I know my mum is safe here'' and ''They will always let me know and discuss with me if they feel there are any new risks''. Staff told us they did not have any concerns about people's safety in general but were concerned that one person could not safely mobilise anymore. Although people told us they felt safe, we found there were shortfalls which compromised people's safety and placed people at risk from receiving unsafe care.

Medicines were not managed safely and administered appropriately to ensure people received their medicines as prescribed. Controlled drugs (CDs) are medicines with an increased potential for misuse and by law required additional safety controls. The home did not store their CDs in accordance with the requirements of the Misuse of drugs (safe custody) regulations 1975 which increased the risk of unauthorised people accessing the CDs. The home did not record their CD's as required. One person's pain patches had not been recorded in the CD register. We were therefore not able to determine whether the required stock and supervised administration checks had always been completed in relation to this CD. The CD stock had been calculated inaccurately for another CD and the name, form and strength of the CDs had not always been specified at the top of each page in the CD book. These errors and omissions in the recording of CDs had increased the risk of misuse occurring. The provider did not operate safe controlled drugs practices and there was a risks people might not receive their CDs as prescribed or their medicines might be misused.

The medicine trolley was stored close to a radiator. Arrangements were not in place to monitor the temperature of the medicine trolley to ensure medicines were kept at the required temperature to ensure they would remain effective. Three medicines had a specific time scale within which they must be used after they had been opened; however, there was no system in place to ensure they were not used beyond this time. This meant it was not possible to establish whether the medicine were still safe and sufficiently effective to be administered.

We identified multiple medicine errors during our inspection. One person required a new pain patch to be administered every seven days and we found they had not received a pain patch as prescribed. A summary received from their GP on their admission noted that this person could not indicate when they were in pain and were to be supported to remain pain free. This medicine error had increased the likelihood of the person experiencing pain. Staff ensured this person received their pain patch when we brought this to their attention. Another person had exceeded their prescribed dosage of a sedative on more than one occasion as staff had not followed the prescribing instructions. They were at risk of experiencing side-effects from the additional dosage including an increased risk of falling. These medicine errors had not been identified and action had not been taken to identify the risks to people of not receiving their medicine as prescribed.

Medicine recording practices did not support the safe administration of medicines. People's medicine administration records (MAR) were not always completed when medicine was administered. We found multiple gaps in MARs where one would have expected to see a signature to evidence people had received

their medicine or an explanation of why medicine had not been administered. Stock calculations did not tally with the total medicines in stock and it was therefore not possible to determine whether the gap in people's MAR was a recording error or an indication that people had not received their medicine as prescribed. A second staff member had not always signed to show they had supervised the administration of people's CDs. Poor medicine record keeping had increased the risk of medicine errors occurring.

Senior staff were responsible for the administration of people's medicines. Records showed they had received medicine training. However, the interim home manager and staff told us the medicine training had not covered the areas we found concerns in. Staff's medicine training had not been sufficient to support staff to develop the knowledge and competencies required to manage people's medicines safely.

People were not consistently protected from harm through the effective assessment, identification and management of risks to their health and safety. For example, one person was prescribed anti-coagulant medicine which thins the blood and can have significant side effects including, prolonged and intense bleeding and bruising. We saw they had profound bruising on both arms and a scab on their head. We found one incident report that explained the bruising on their left arm; however, staff could not explain the scab on their head or the other bruising. Staff understood bruising could be a side-effect of their anti-coagulant medicine or an indication that the person's dosage was not correct. However, their care records and medicine MAR did not identify the risks associated with this medicine and how staff should monitor risk and address any concerns they may have. This person was prescribed a variable dosage of their anti-coagulant and required monthly blood tests, to monitor the safe use of this medicine. They had not been supported to receive their test results at the time required and there was a risk the dosage they received, would not be sufficient and put them at an increased risk of clotting or bleeding. People administered anti-coagulant medicine were not always protected from the risk associated with this medicine.

The provider had failed to provide people with proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person with limited mobility used the stair lift and two people's care plans indicated staff were to support them with the use of the electronic bath chair to get in and out of the bath. Risk assessments had not been completed to ensure staff would know how to support each person to use this equipment safely. An up to date service and maintenance record was not available for the stair lift and staff had also not been instructed to check all equipment before each use to ensure it remained safe to use. People using equipment to mobilise were not protected from the risk this equipment could pose to their safety.

The door to the kitchen and the fire door on the top floor posed risks to people's safety which had been identified by the interim home manager. Arrangements put in place to manage these risks were not always effective in protecting people from harm. For example, we saw the kitchen door was left open without staff in the kitchen numerous times and had to ask staff to assist a person who had become confused and wandered into the kitchen. The fire door upstairs was alarmed and would alert staff if someone was to open the door; it would, however, not give them enough time to reach the person and they might not be safe to manage the outside stairs unaided. Risks assessments had not been completed for people living upstairs for whom this might pose a risk due to their confusion. Environmental risks had not always been assed robustly to ensure people would be safe in the home.

Another person's mobility had declined significantly and they were at high risk of falling. Staff had made a referral to the community occupational therapist to assess their mobility needs. Staff were unclear of the support they needed to provide to ensure this person would be safe when getting in and out of bed, this was confirmed by the community occupational therapists we spoke with. Some staff told us they used a

handling belt to support the person to stand whilst others said they supported them by putting the person's hand on the wheelchair so they can support themselves. No risk assessment or care plan had been completed to inform staff how to support this person to safely mobilise when their needs had changed. Records showed not all staff had completed moving and handling training and there was a risk that people would be injured or bruised if they were supported to mobilise through unsafe practices. We saw this person had also not been supported to change their position in their wheelchair for six hours so that they could relieve the pressure on their skin. This placed them at risk of skin damage. Staff supported the person to move when we asked them to do so.

People were not supported to manage their behaviour safely. Two people could at times become anxious and agitated and their behaviour could then put themselves or others at risk of harm. They had been prescribed a sedative to be used 'when needed' when they were upset or unsettled. A positive behaviour plan was not available for these two people so that staff would know how to support them to manage their behaviour safely. For example, what might trigger their behaviour, strategies to prevent their behaviour from escalating and how to keep them safe if their behaviour was to escalate, including when the sedative needed to be administered. Where sedatives were prescribed for occasional use, guidance was not available to: inform staff when a second dose could be given; the maximum dose that could be administered; possible side-effects; risks associated with the medicine; and what action to take if the medicine was not effective to ensure people would remain safe. Staff did not follow a consistent approach when deciding when to administer the sedative and people did not always receive the support they needed to remain safe when they became anxious or agitated. .

Following MUST (Malnutrition Universal Screening Tool) screening in January 2017, four people had been identified at risk of malnutrition and it was noted on the home's 'Weight Summary' sheet that a food and drink chart needed to be completed for these four people to monitor their food and fluid intake. Staff could not tell us if these charts had been completed or provide these records. One person indicated at risk had lost 10kg in the past 12 months. A plan had not been put in place to address the risk of them becoming malnourished. We observed them during lunch time and saw they had their meal in the lounge and struggled to make a start. Staff were aware this person found it difficult to manage meal times but were not clear what support they needed. Plans were not in place to ensure people at risk of malnutrition would always receive the support they needed to manage this risk to their health.

Care and treatment was not provided to people in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the arrangements in place to ensure staff were recruited safely and people were protected from the employment of unsuitable staff. The provider's recruitment policy did not detail all the recruitment information that was required prior to making a recruitment decision to support the interim home manager to make safe recruitment decisions. Checks to ensure that staff were of suitable character and able to meet the requirements of the role for which they were employed had not been completed. Pre-recruitment checks, such as proof of applicants' identity, employment history, investigation of any criminal record, and declaration of fitness to work, had not been satisfactorily gathered, investigated and documented. The provider had not recorded the reasons why they considered an applicant to be suitable when information obtained through recruitment checks indicated possible risks to people. Risk assessments had not been completed when staff worked whilst waiting for their criminal checks to be completed. This would ensure a record would be available to evidence how the provider had considered and mitigated any potential recruitment risks.

The registered provider had failed to protect people by ensuring that staff were of good character and

suitable to work with the people they were supporting. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding policies and procedures were available and staff could describe the action they needed to take if they identified people were at risks of abuse or had been abused. However, when we asked staff if they had referred the concerns in relation to the medicine errors and the person's unexplained bruising to the local safeguarding team, they told us they hadn't because they had not identified it as potential abuse or neglect. Not all staff had received safeguarding training. Improvement was needed to ensure staff would always identify potential abuse, including neglect, so that action could be taken to report and investigate these concerns to protect people from potential harm.

Systems were not operated effectively to investigate, immediately, any allegation or evidence that abuse might have occurred. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

From our observations there were sufficient staff deployed; for example, we did not notice any people being left waiting to be attended to when they asked for assistance, and on the occasions when we heard the call alarms being sounded these were responded to quickly. The people we spoke with said that staff would always respond promptly to any requests for attention. The manager told us they adjusted staffing levels when people needed more support and described how additional staff were provided when people were receiving end of life care.

Requires Improvement

Is the service effective?

Our findings

Staff told us they felt supported by the interim home manager. Their comments included ''She is always available for support'', ''We have regular meetings to discuss issues'' and ''She will always help us''. Staff told us they had received regular supervision with the interim home manager and that this gave them the opportunity to discuss any concerns and their skills development needs. However, we found staff supervision had not been effective in identifying gaps in staff's knowledge, for example in relation to medicine management and care planning, which could be supported if necessary by additional training and development.

Staff told us that they had completed training to make sure they had the skills and knowledge to provide the support people needed. However, training records showed all staff had not completed the registered provider's mandatory training in moving and positioning, dementia, safeguarding, infection control, fire training and the Mental Capacity Act. We found staff did not always have the skills to support people's needs. For example, staff showed a lack of understanding in supporting people who lived with dementia. This was observed by the lack of interaction with people, not always picking up on people's non-verbal communication and not effectively supporting them during meal times. The interim home manager told us there was not a rolling programme of training and training was arranged when needed. This meant that staff who had completed training in, for example, fire and first aid had not had their skills updated through refresher training in the past five or more years. Staff skills and knowledge might therefore not reflect current best practice when supporting people.

Some new staff had been recruited and employed without previous experience of working in the care industry. They received support from other staff to show them how to perform their role; however, there was no comprehensive induction to ensure they would gain the necessary competencies or training required to perform a carer's role. There was not a structured programme that showed how new staff would be supervised until they could demonstrate the required competencies and skills to carry out their role unsupervised. The registered provider had recently employed new staff and there was a risk they would not receive sufficient support to adequately prepare them for their role in accordance with national good practice guidance. The interim home manager was not aware of the Care Certificate standards and these had not been introduced in the home to ensure new staff were supported, skilled and assessed as competent to carry out their roles. The Care Certificate standards are nationally recognised standards of care which care staff need to meet before they can safely work unsupervised.

Staff had not all received the training and support necessary to enable them to carry out the duties they were employed to perform. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people living with dementia did not have the mental capacity to independently make decisions about their care arrangements. 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.

Staff understood the importance of gaining people's consent before undertaking care tasks. They were observed seeking consent before carrying out tasks and explaining the tasks they were about to carry out, for example, when asking a person if they wanted their medicines or if they wanted to see a doctor. Some staff still needed to complete training to develop their understanding of the principles of the MCA so that they would be able to identify when people's capacity was deteriorating and a mental capacity assessment might be required.

Records showed that mental capacity assessment and best interest decisions had been made on some people's behalf, in accordance with the MCA. However this had not been completed for all people who could not make the decision about living in the home and receiving support with their medicines or personal care. The interim home manager did not know what the process would be for assessing people's mental capacity. We met two people that had been admitted since the registered manager had left in November 2016 and had doubts about their capacity to consent to their care arrangements. The interim home manager had not identified the requirement to assess their mental capacity to ensure if they lacked capacity to make decisions about their care their rights would be upheld in accordance with the principles of the MCA.

Where people lacked the mental capacity to make informed decision, or give consent, to their care the registered provider did not always act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service had applied for the necessary authorisation when depriving a person of their liberty. The interim home manager did not know whether DoLS applications had been made for any of the people living with dementia. Following our inspection they informed us that five applications had been made to the local authority's DoLS team for assessment and they were still awaiting the assessments to be completed.

People told us they liked the food and we saw during meal times people ate most of their food. People's comments included ''The food is always good'', ''I get what I like'' and ''You can always ask for something else and they will make it''. Staff understood the importance of supporting people to drink enough to prevent dehydration and associated complications. People told us drinks were placed within their reach and we saw people were encouraged to drink throughout the day. The cook was kept informed of people's dietary needs and they were able to describe people's preferences. We saw soft foods were prepared for people when they experienced difficulty chewing and the information available to the kitchen staff about people's needs and preferences was up to date. People received a varied diet and this included a different main meal option throughout the week.

People were supported to access health practitioners when needed. A local GP visited the service when needed and records showed staff were in regular contact with the GP practice to discuss people's health concerns. One person told us "When I need the doctor they [staff] always phone him so he can come and see me''. Records showed people had received visits from the district nurse team, chiropodist and the community psychiatric nurses (CPN).

Good

Is the service caring?

Our findings

People and relatives told us they liked the staff at Sycamore Cottage Rest Home Limited. People's comments included, ''Everyone is very friendly and very kind to me'', ''The staff are very nice'', ''Staff know me''. Relatives told us that they found staff were caring and kind to people. One relative said ''They always speak to him [my relative] with respect''.

Interactions between people and staff were good humoured and caring. Throughout the inspection, staff showed care and concern for people's wellbeing. People appeared relaxed, comfortable and responded positively to staff when asked what they wanted to do or eat. Staff gave people time to respond to their questions and told us they used short sentences and visual prompts to support people to make their meal choices. We observed a staff member showing a person the choice of cake available when the person struggled to make a decision.

People were encouraged to be as independent as possible and were involved in making decisions about things that affected them. For example, people were encouraged to manage their personal hygiene and appearance. Staff told us they respected people's wishes on how they spent their time and the activities they liked to be involved in. When people chose to spend time in their rooms we saw people's tables were near them and their glasses, remote controls and books were within easy reach. People had been involved in decisions about the décor of their rooms and were surrounded by objects they held dear.

We observed laughter and banter between people and staff. The language heard and recorded in care records was appropriate and respectful. Staff used touch to support people to understand instructions, we saw this was done appropriately and people seemed comfortable and reassured through physical contact with staff. Contact was unrushed, with smiles and kindly gestures, such as when asking where people would like to sit or when people appeared not to understand what was asked of them.

Relatives told us family and friends were encouraged to visit whenever they wanted and staff supported people who wanted to have regular and frequent contact with relatives. Two friends told us ''They always welcome us and offer a cup of tea, I think they know how much he looks forward to our visits''.

Staff explained to us that an important part of their job was to treat people with dignity and respect. Our observations confirmed that staff respected people's privacy and dignity. Staff used people's preferred names and spoke with them in a kind and patient manner. We observed people being introduced to visitors when the need arose. If people required support with personal care tasks this was done discreetly, behind closed doors to ensure their dignity was maintained.

Requires Improvement

Is the service responsive?

Our findings

People's needs had been assessed prior to them moving into the home and the information used to plan people's care. Many people in the home lived with dementia and we looked at how their needs were being met.

During the two days of the inspection we did not see any structured activities taking place. People were sitting in the lounges or their bedroom with little opportunity to keep mentally and physically active. We asked about activities and were told that there were none taking place on the two days we were at the home. Staff told us they provided some activities themselves during the day.

People living with dementia were largely dependent on the staff to interact with them and to show initiative in creating opportunities for them to live a stimulating and meaningful life. When we spoke with staff they told us they had not all had dementia training, which records confirmed. We saw some staff lacked an understanding of the needs of people living with dementia and did not always identify people's attempt to communicate and engage with them, which was evident from the way they delivered care.

As noted in the caring section of the report, when staff engaged with people, they did this in a caring way. However, we also saw that staff missed opportunities to engage with people to help them maintain their social and independent living skills. For example, one person sitting in the small lounge reached their arms out on three occasions when staff walked past and became increasingly anxious when staff did not pick up on their need for reassurance. After 40 minutes one staff member realised the person wanted some reassurance and started talking with them which promptly reduced their anxiety. However, this support had not been provided to the person in a timely manner and people who could not clearly indicate their need for assistance might be kept waiting and become increasingly distressed.

We observed some areas of good practice in regards to social stimulation, but this was not consistent. For example two staff members sat with people in the lounge and discussed the music and sang along with them. However, they did not make their way to people sitting on the opposite side of the lounge and we saw some people spend long periods with no acknowledgement or interaction from staff. We observed some people appearing lost and disorientated in corridors, sometimes worrying about things but not being spotted by staff so that they could be reassured. Staff did not always identify when people wanted interaction and therefore did not always support them to have positive experiences. The home environment did not support people living with dementia to orientate themselves or make it easier for them to identify their rooms and communal areas.

People were supported to be as independent as possible to manage their personal hygiene and appearance. Staff told us they asked people if they wanted a bath or shower and respected their wishes if they declined. Some people living with dementia looked unkempt and might not be aware of the support they needed to complete their grooming tasks to the standard they were used to or remember when last they had a bath or shower. Staff did not keep a record of the grooming tasks people had completed or if a person had refused care so that the interim home manager could take action to ensure people maintained

their appearance. It was not clear from people's records or appearance that they had received the support they needed to maintain their preferred levels of personal hygiene.

The care provided to people living with dementia was not always appropriate to meet their needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with did not always know or understand how to raise their concerns or provide feedback about their experience of the care they received. Relatives told us staff often asked them for their views about their loved ones wishes and preferences to support them to understand what people liked. Evidence of people and their relatives' involvement in their care plan reviews were not always recorded in people's care plans to ensure staff would know how people would prefer to receive their care. We saw the interim home manager was preparing to send out the 2017 satisfaction survey. They told us people and their relatives had fed back during the 2016 survey that ''Some improvements could be made to the appearance of the home''. We saw some refurbishing work had been planned and a kitchen extension was underway. People and their relatives were given the opportunity to provide feedback about the home and be involved in planning people's care.

The registered provider had received five complaints in the past year. Records showed the previous registered manager had investigated the complaints in accordance with the provider's complaints policy and had written to people and relatives with the outcome of their investigation. The interim home manager could not explain what learning had taken place from these complaints. For example, we found a complaint about the cleanliness of the home and one relating to concerns that a person was not supported to maintain their appearance had not been used as an opportunity to improve housekeeping and personal care systems.

Inadequate

Is the service well-led?

Our findings

The home did not have a registered manager in place. The registered manager had left their post in November 2016. The deputy manager had worked at the home for some time and had taken on the role of interim home manager whilst the provider was recruiting a new registered manager. People and staff were complementary about the interim home manager. One relative told us ''I would not have managed my mum moving if it was not for the deputy manager's support and kindness''. Staff described the interim manager as ''supportive'', ''available'' and ''understanding''. Although people and staff told us this, we found there were shortfalls in the management of the home which compromised people's safety and placed people at risk from receiving unsafe care.

The interim home manager told us that the provider was supportive and available if any practical issues for example, relating to the premises was to arise. However, they held responsibility for the day to day management of staff and people's care. They had not received an induction into their role and regular supervision to support them to understand their responsibilities. For example, the provider had not ensured the interim home manager was aware of their responsibility to notify the Care Quality Commission when specific incidents occurred. These included safeguarding concerns, deaths of people who lived in the home, DoLS authorisations and serious injurious. Some of the required notifications had not been made the CQC as required and we could not monitor that appropriate action had been taken when these incidents had occurred. The interim home manager also spent a significant amount of time providing care and had limited time to complete management tasks. During the inspection we became aware that the interim home manager did not understand the legislation that the home was required to meet in order to run a safe service. They had not received practical support and guidance from the provider to understand their role to support the provider to fulfil their overall responsibility to ensure the safety and welfare of people.

There was a lack of governance or management input to ensure safe and efficient operation of the home, especially during the period when there was no registered manager in post. There were no effective systems of monitoring or quality assurance in the home. The provider's policies for example in relation, to staff recruitment, medicine management, falls, and nutrition management had not been reviewed to ensure they were sufficiently comprehensive to guide staff's practice. For example, the nutrition policy did not inform staff what action to take if people were losing weight and what the trigger points would be for referral to other health professionals. Staff did not have sufficient guidance to know how to manage risks to people's health and wellbeing.

Communication between staff and management was not always sufficient to support them to understand their roles and responsibilities in providing quality care. For example, one staff member was the 'skin champion' for the home and took the lead when concerns were identified with people's skin. However there was no wound review process in place and regular skin checks were not completed and recorded when concerns about people's skin had been identified. When the skin champion was not working, staff and the interim home manager was not clear whether people's skin had healed or deteriorated. There was a risk if people's skin deteriorated this would not be identified promptly and the district nursing team contacted in a timely manner to ensure people were protected from skin damage. Improvements were needed to ensure

staff were given clear direction and guidance to support them to undertake their roles and responsibilities.

The culture of the home was found to be reactive rather than proactive in ensuring that a good standard of care was provided for the people living in the home. Routine quality checks and audits had not been completed by the registered provider or interim manager to assess the safety and quality of the service for people. Infection control audits had not been undertaken to assess whether house cleaning, clinical waste management, hand hygiene and infection prevention practices were adequate. People could therefore be at risk of infection without the managers being aware so that action could be taken to keep people safe. Routine health and safety checks had not been completed to ensure equipment and the environment would be safe for people.

We identified multiple medicines, staff recruitment and care records shortfalls. No medicine audits had been completed and the registered provider had not identified the risks we found in relation to the storage, recording and management of people's medicines. Limited care plan checks had been completed and these had not been effective in identifying the shortfalls we found in relation to the absence of positive behaviour management plans, medicine risk assessments and moving and handling assessments for the use of the stair lift and the bath chair. The incident and accident system was not operated effectively to ensure risks to people's safety would be identified and managed appropriately to prevent recurrence. For example, incidents had not always been documented and reviewed by the interim home manager to ensure post falls observations were completed, all wound or skin concerns were managed appropriately and safeguarding referrals made as required. Staff recruitment records were not checked to ensure all the required pre-recruitment information would be available. Staff training and competency was not monitored effectively to ensure staff would receive up to date training and had the skills required to meet people's need safely. The lack of monitoring had meant that the serious concerns in the home had not been identified by the registered provider. Action had not been taken to improve the safety and quality of care people received and people had been placed at risk of receiving unsafe care.

Effective systems and processes were not in place to assess, monitor and improve the quality and safety of the service provided. The registered provider did not maintain an accurate, complete and contemporaneous record for each person, including a record of the care provided and of decisions taken in relation to the care provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following this inspection we wrote to the provider to request a plan of action setting out how they would address the immediate and urgent concerns identified at our inspection. We received an action plan from the provider that indicated that they had already started to take action to address the identified concerns.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care provided to people living with dementia was not always appropriate to meet their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people lacked the mental capacity to make informed decision, or give consent, to their care the registered provider did not always act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided to people in a safe way. This was a breach of Regulation 12 (1) (2) (a) (b) (d) (e) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a Warning Notice and told the provider and registered manager to make the required improvements by 2 May 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not operated effectively to investigate, immediately, any allegation or evidence that abuse might have occurred.

The enforcement action we took:

We imposed a condition on the provider's registration and told them they must undertake a monthly audit of all medicine errors, bruising and behaviour incidents of service users at Sycamore Cottage Rest Home Limited and submit a monthly report to CQC stating the action they have taken to protect people from potential abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not have appropriate checks and audits in place to assess, monitor and improve the quality and safety of the service provided. The registered provider did not maintain an accurate, complete and contemporaneous record for each person, including a record of the care provided and of decisions taken in relation to the care provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The enforcement action we took:

We imposed a condition on the provider's registration and told them they must undertake monthly audits in relation to medicine management, accident and incident management, infection control, care plans, staff guidance and CQC notifications. They must submit a monthly quality assurance action plan to CQC which confirms the dates on which these audits took place, states the action taken or to be taken as a result of these audits and an evaluation of the effectiveness of any actions already taken.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider had not protected people by ensuring that the pre-employment information required in relation to each person employed was available.

The enforcement action we took:

We imposed a condition on the provider's registration and told them they must submit to CQC a copy of a written audit of recruitment checks undertaken for all care staff working at Sycamore Cottage Rest Home Limited and state the action taken as a result of this audit in securing compliance with Regulation 19.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not all received the training and support necessary to enable them to carry out the duties they were employed to perform.

The enforcement action we took:

We imposed a condition on the provider's registration and told them they must submit to the CQC a copy of a written record of training undertaken by all care staff working at Sycamore Cottage Rest Home Limited in safe manual handling techniques, safe medicine management practices, fire safety, safeguarding adults and understanding and supporting people living with dementia safely.