Sycamore Park Healthcare Limited

Sycamore Park Care Home

Inspection report

Alandale Road
Off Bradley Road
Huddersfield
West Yorkshire
HD2 1QE

Tel: 01484426650

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27 November 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection of Sycamore Park Care Home took place on 22 and 27 November 2018. This is the service's first rated inspection since their registration with the Care Quality Commission on 1 December 2017.

Sycamore Park Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Sycamore Park accommodates a maximum of 46 people; there are three separate suites providing accommodation and communal areas located on the ground, first and second floor. The home provides care and support to people who are assessed as having personal care and support needs. The first floor provides accommodation specifically for people living with dementia. There were 44 people living at the home at the time of the inspection.

The service had a registered manager in place. 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.

People told us they felt safe. Staff were aware of the importance of reporting any concerns they may have about people's safety. Risks to people were assessed and reviewed. The premises and equipment were clean and well maintained. Staff had completed fire drills although they had not participated in a simulated evacuation.

There were sufficient staff on duty to meet people's needs. There was a process in place to reduce the risk of employing unsuitable staff. Medicines were stored safely and administered in a caring manner.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

New staff received an induction. There was a programme of training, supervision and appraisal in place to ensure staff had the knowledge and skills to meet people's needs. Staff communicated effectively and people had access to other health care professionals when needed.

Meals were home cooked, people could choose what they wanted to eat and were served adequate portions to meet their individual needs. Staff verbally prompted people to eat their meals and supported people to eat where this was needed.

Each suite was nicely furnished and there was access from the ground floor to a secure garden. The suite for people who were living with dementia had limited signage to enable people to orientate themselves to the location of key areas such as the dining room or a toilet.

People told us staff were caring and kind. People were relaxed in staff's company and we saw only nice, professional interactions between staff and the people they supported. People were supported by staff who knew them well. Staff took steps to ensure people dignity was maintained and respected people's right to privacy.

There was a range of activities provided for people who lived at the home.

Care records were generated on an electronic system although there were also some paper records. Care plans were not always person centred and where people's needs had changed, this information was not always easily seen. Improvements were needed to the quality of moving and handling information. Action was taken at the time of the inspection by the registered manager to address this.

Advance care planning around people's end of life care wishes were not always in place.

We have made a recommendation about improvements to record keeping.

People and staff spoke positively about the registered manager. Staff felt listened to and supported by the management team.

There was a programme in place to ensure regular audits were completed on various aspects of the service. Where concerns were identified, we saw these had been addressed. However, we have made a recommendation about improving the auditing system.

There was a system in place to gather feedback from people and staff. Regular meetings were held and a quality survey had recently been distributed to people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were safe from the risk of harm or abuse.

The management of medicines was safe.

Recruitment procedures were robust. □

Is the service effective?

Good

The service was effective.

Staff received induction, training and supervision.

Meals were appetising and nicely presented. Where people needed support to eat and drink, this was provided in a timely manner.

The requirements of the Mental Capacity Act 2005 were being met.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect.

People's right to privacy was respected.

Care records recorded people's religious beliefs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not always person centred. Where people's needs had changed, this information was not always easily seen.

Evidence of end of life care planning was limited.

The home provided a range of activities for people to participate in.

Is the service well-led?

Good

The service was well led.

There was a registered manager in post.

There was a system in place to monitor and assess the quality of the service people received.

Regular meetings were held with people who lived at the home and staff.

Sycamore Park Care Home

Detailed findings

Background to this inspection

This inspection commenced on 22 November 2018 and was unannounced. The inspection team consisted of two adult social care inspectors 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 on this occasion had experience of working in health and social care. One of the inspectors also visited the home again on 27 November 2018. This visit was announced and was to ensure the manager would be available to meet with us.

Prior to the inspection we reviewed all the information we had about the service including statutory notifications and other intelligence. We also contacted the local authority commissioning and contracts department, safeguarding, infection control, the fire service and Healthwatch to assist us in planning the inspection. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this service.

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. This information was used to help inform our inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time in the lounge and dining room areas observing the care and support people received. We spoke with 11 people who were living in the home, four relatives and a visiting health care professional. We also spoke with the operations manager, registered manager, deputy manager, two senior carer staff, two care staff, the activity organiser, maintenance person and three staff from the catering and housekeeping team. We reviewed four staff recruitment files, we looked at five people's care plans in detail and a further two care plans for specific information. We looked also looked at 10 people's medication administration records and a variety of documents which related to the management and governance of the home. Following the inspection we also received feedback via email form another external healthcare professional.

Good

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe. One person said, "People have made me feel safe." Another person told us, "I used to worry at home before but now I am taken care of." A relative said, "[Person] is absolutely safe, they are not anxious."

Staff were clear about their responsibilities in reporting any concerns they may have about people being at risk of harm or abuse. A staff member said, "If I saw anything, I would tell [name of registered manager] or [name of deputy manager]. I wouldn't want anyone to be treated badly."

Peoples care and support was planned and delivered in a way that reduced risks to people's safety and welfare.

People's care records included a range of risk assessments including falls and skin integrity. Where people were identified as being at risk of falls or pressure ulcers we saw equipment was provided. For example, low height beds, floor sensors and pressure reducing mattresses. Some people required the use of a hoist to enable them to transfer; we saw equipment was available on each floor of the home and people had their own individual slings.

External contractors routinely serviced the premises and equipment, including fire system and electrical appliances. It is a requirement of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) that all lifting equipment is regularly checked to ensure it is safe. We saw LOLER checks were in place for the hoists and slings.

The maintenance person also completed several regular checks to reduce risks to people's safety. These included checks on the water temperatures, wheelchairs and the fire alarm. Regular fire drills were held, although staff had not participated in a simulated horizontal evacuation. Participating in a practical drill helps to ensure staff have the knowledge and skills required to ensure they act safely and effectively in the event of a fire.

We asked people if they felt there were sufficient staff on duty to meet their needs. One person said, "There's enough staff for my needs." A visitor told us, "They could always do with more staff but there is always someone if you want them." When we reviewed resident meeting minutes we saw people had commented on staff not having sufficient time.

Staff did not express any concern over staffing levels at the home. During the inspection we saw staff were visible on the floors and people's needs were met in a timely manner.

The registered manager told us they assessed the staffing numbers on a regular basis. They also said they tried to ensure an extra staff member was on duty in the morning on a weekend to counteract the absence of the management team.

Staff recruitment processes were safe. The four staff files we reviewed evidenced recruitment was safe. Each file included an application form, interview notes, a record of candidate's previous employment history, references and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions.

Medicines were stored safely and securely and the management of people's medicines was safe. We observed staff administering medicines to people, this was done in a kind and caring manner.

We checked a random selection of medicines and found the stock balanced with the number of recorded administrations. Some people were prescribed as required (PRN) or variable dose medicines. Protocols were not always in place on one of the suites. Having a protocol in place provides guidelines for staff to ensure these medicines are administered in a safe and consistent manner. We brought this to the attention of the registered manager and they told us they were in place when we visited for the second day of the inspection.

We saw evidence and staff told us, they had received medicines training and an assessment of their competency. The registered manager told us competency assessments were updated annually unless concerns raised initiated an earlier assessment. This ensured people received their medicines from staff who had the appropriate knowledge and skills.

The home was clean and odour free. We saw aprons and gloves were readily available for staff. Information about hand washing was displayed throughout the home. Thorough hand washing practices reduce the risk of infections spreading between people and staff.

Systems were in place for reviewing and investigating incidents and learning was shared with staff.

Staff told us they felt confident to report any concerns or incidents to the registered manager or deputy manager. Accidents and incidents were recorded and the report was passed to the registered manager for review. A log was kept of all reported falls and a monthly meeting was held to review this information. The meeting notes for April to October 2018 evidenced where individual concerns had been highlighted and action to be taken, although we noted there was no review the following month to see if the actions had been effective. We discussed with the registered manager at the time of the inspection.

Good

Is the service effective?

Our findings

People's care and support was delivered in line with current legislation good practice guidance. This was evidenced through the induction and training of staff, involvement of relevant external health care professionals and from good practice guidelines on display in staff areas. The registered manager also told us they attended good practice events run by the local authority.

People told us staff were suitably trained. One person said, "The staff are well trained. "Another person said, "Trained? I think so."

New staff were supported in their role. Staff told us they had completed a period of induction when they commenced employment. This included orientation to the building, formal training and shadowing a more experienced member of staff. Evidence of induction was in each of the staff's files we reviewed.

Each of the staff we spoke with told they had completed training in a variety of topics. This included moving and handling, infection prevention and control, safeguarding and dementia. This was corroborated when we looked at staff's personnel files and the registered manager's training matrix. The registered manager told us some staff had also attended more specialist dementia training. This had included a simulation of what it felt like to be living with dementia. This can help staffs understanding of the mental and physical challenges which can affect people living with dementia.

Staff received regular supervision. This was completed by either the registered manager or one of the two deputy managers employed at the home. The registered manager told us some staff had now been employed for 12months therefore some staff had also received a performance appraisal. Supervision and appraisal are used to develop and motivate staff, review their practice or behaviours, and focus on professional development

People's feedback about the meals served at Sycamore Park was mostly positive. Comments included; "The food is quite good, sometimes not good, it's usually all right", "Sometimes we moan about the food but it is very good" and "The food is lovely."

At breakfast time people were offered a range of choices including a cooked breakfast. We heard one person ask for toast with some jam on the side of their plate, this was provided for them. Staff asked people if they wanted tea or coffee and drinks were made to meet individual preferences.

We observed lunch on each of the suites on the first day of the inspection. Tables were laid with cutlery, crockery and a small vase of flowers. Although we did not see any menus displayed, people were told what was on the menu and encouraged to make their own choices. We noted on the suite which supported people who were living with dementia, some people seemed to struggle to make a verbal choice. We suggested to the member of staff they show people the meals plated up so they could make a visual choice. Although they said this was a good idea they did not act on our suggestion.

The meals looked appetising and nicely presented. People looked to be enjoying their meals including those who had struggled to make a choice. Portions were sufficient for people although we also heard staff asking people if they had had sufficient of if they wanted extra. One person who asked for a small portion was served their meal on a small plate.

Where people required support, this was provided in timely way. We observed one person being supported, the staff member sat down with them. They spoke to the person, telling them what was on their plate. The member of staff was patient and did not rush them.

A choice of two squashes and water was offered with lunch. One person left the dining table when they finished their meal. They asked staff if they could have their cup of tea served in their room. We saw this request was complied with. We saw drinks were offered to people and visitors hroughout the day.

People were weighed at regular intervals. Where people had problems swallowing, we saw referrals had been made to the speech and language therapy team (SALT). We noted one person needed their meals and drinks presented in a specific way to reduce the risk of choking. Their lunchtime meal and drink followed the guidelines from the SALT team.

Staff told us information was communicated effectively throughout the staff team. Staff attended a handover at the start of each shift to ensure they were up to date with peoples care needs. The registered manager told us they and the deputy managers spoke daily with staff in all departments to ensure staff were kept up to date regarding the day to day operation of the home.

People had access to other health care professionals when required. Peoples care records evidenced they received input from a range of health professionals. This included, GPs, district nurses, speech and language therapists, opticians and chiropodists. Following the inspection an external health care professional told us via email both they and their colleagues had always found their advice was implemented without delay by staff.

Sycamore Park comprised three separate suites and a large reception area. Bedrooms and communal areas were decorated and furnished to a high standard and there were a number of communal areas. There was access to a secure garden from the ground floor dining room. This was wheelchair accessible with a number of seating areas. A member of staff said, "Its lovely, we are really lucky. They love it."

The suite which supported people living with dementia had limited signage to orientate people to their environment. The communal bathroom and toilets had signage but this was words, there were no pictorial signs. These can be helpful for people who may struggle to understand written word. Although we saw the toilet seat and grab rails in a communal toilet were of a contrasting colour the rest of the fittings. This makes them more visible to people with cognitive or visual difficulties.

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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles

of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

Staff demonstrated their understanding of the mental capacity act. One staff member told us, "We don't assume people lack capacity. If they can't make more complex decisions, we act in their best interests. "It was clear from our observations staff asked people's consent prior to any intervention. People were offered choices and staff respected people's decisions.

An assessment of capacity was completed regarding people being able to choose if Sycamore Park was where they wanted to live. Where they lacked capacity regarding this decision, a DoLS application had been submitted to the local authority. The registered manager and the deputy manager expressed a good understanding of DoLS. A matrix was in place to record who had approved DoLS in place and where applications were still awaiting assessment by the local authority.

We saw capacity assessments and evidence of best interests decision making were in place. For example, the staff's management of one person's medicines and the use of bed rails for another person. However we saw this person was also prescribed a soft diet and thickened fluids but no assessment of their capacity regarding this decision was in place. We brought this to the attention of the registered manager and this was completed on the second day of the inspection.

Good

Is the service caring?

Our findings

Feedback about staff's attitude and approach was positive. Comments included; "They are kind and courteous and we have a laugh", "The staff are brilliant all of them", "I have no reservations about the staff. We have a laugh and relate to them. They always knock and speak respectfully, it goes without saying. It's a nice homely place" and "They are perfect, all lovely, I have no complaints at all about the staff." A relative said, "They are lovely with [person]. They have encouraged [person] to get up out of bed." Another relative told us, "We had an NHS review and the care home staff's answers were impressive, they knew [person's] foibles it was enlightening. [Name of registered manager] knew details and knew [person] as an individual."

Through talking to staff, we were satisfied care and support was delivered in a non-discriminatory way and the rights of people were respected.

Staff we spoke with said, "I love my job", "I am patient, I try to understand them [people]. I could be in their position (one day) or it could be my relative. Treat them with respect, don't deprive them of their privacy or dignity."

Without exception we heard and observed all staff to be caring, kind and respectful towards the people they were supporting. All the staff, including the ancillary and maintenance staff each spoke with people, passing the time of day and making friendly conversation.

From speaking with staff and observing their interactions with people it was clear they knew people well. Although this knowledge did not stop staff from still offering people choices, for example, asking if they wanted tea or coffee to drink or brown or white toast.

People were appropriately dressed and looked clean and well cared for. A visiting health care professional told us, "The residents all look well looked after." The registered manager told us as part of their quality monitoring they checked people's toothbrushes were wet which indicated they had been used while staff were supporting people with personal care, they also observed people's finger nails to ensure they were clean.

Staff respected people's right to privacy and maintained their dignity. One staff member said, "We shut curtains, cover people with towels, close doors. If people undress out of their bedrooms we cover them straight away." We saw staff knock prior to entering rooms, where people did not respond, staff entered rooms slowly, announcing their presence to the person and ensuring they were happy for them to enter.

Care records noted if people had a preference regarding the gender of their care worker. Individuals religious beliefs were also recorded. For example, one person's care file noted, "Christian, non-practising". Another person enjoyed listening to religious music, staff told us this was very effective in reducing their anxiety.

Work had begun on learning about people's life histories. The registered manager told us booklets had been

passed to people and their relatives for them to complete. We reviewed two completed booklets which provided details about the person's life from childhood to older age. This information enables staff to have insight into people's background, promoting meaningful conversations and giving insight into people's current behaviours and personalities.

Requires Improvement

Is the service responsive?

Our findings

Prior to people moving into the home an assessment was completed to ensure the staff could meet the person's needs. This meant staff knew how best to support the person and enabled the home to ensure they had appropriate equipment in place.

Care records were predominantly electronic with some paper records. Care plans included areas such as mobility, eating and drinking, personal care and sleeping. Not all the care plans we reviewed were person centred. When a new care plan was initiated the electronic system had a default setting which staff were not always over-riding to personalise. For example, a care plan for two people who lived at the home noted they each had had black hair, bald and clean shaven. We brought this to the attention of the registered manager at the time of the inspection, they updated the records immediately. Other care plans were person centred. For example, a sleep care plan noted "Likes two pillows, the bedroom door ajar. Is an early riser".

From our observations of staff and speaking with them, we were assured people's needs were met safely and appropriately. Care plans were reviewed on a regular basis and changes to need were updated. However, we found this information was not always recorded clearly, the electronic information was presented to the reader with the most recent entry at the end and not at the beginning. For example, the falls care plan for one person noted "walks with a shuffling gait" but a further entry, three lines down the page dated 4 August 2018 noted "now nursed in bed".

Improvements were also needed to the level of detail in people's moving and handling records. The care records for one person who required a hoist to transfer included details about the hoist, sling and loops but there was no robust assessment of risk in place. We spoke with the registered manager at the time of the inspection. They promptly contacted the local authority moving and handling team for guidance. Following the inspection, we spoke with the registered manager who told us information had been put in place as an interim measure until they were able to discuss further with the local authority moving and handling team.

We recommend that the service seek advice and guidance from a reputable source about accurate, complete and contemporaneous record keeping.

Evidence of end of life care planning was limited. One person's care plan clearly recorded "Does not want to discuss." We reviewed the care records for another person. The registered manager told us they had been classed as being in the end stages of their life, although their health had recently improved and this was no longer the case. The advance care planning section included information regarding their end of life care needs. However, we looked at a further two peoples care records and found no evidence of end of life care planning.

Advance Care planning is key means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live well and die well in the place and the manner of their choosing. It enables people and their families to discuss and record future health and care wishes, thus making the likelihood of these wishes being known and respected at the end of life.

We checked to see if the provider was compliant with the Accessible Information Standard which requires that people who have sensory impairment or a disability have information available for them about their care in a way they can understand. Care plans recorded people's individual communication methods and the registered manager told us information could be provided in alternative formats if required.

There was a range of activities provided for people to participate in. One person told us, "I am new, my family says I have to join in and not sit out which would be easy because they don't push you." Another person said, "Activities are all right we do keep fit and quizzes, we had Elvis! I don't like bingo."

On the first day of the inspection we observed a session of bingo in the morning. Eight people took part, clearly enjoying it. The activities organiser supported people to take part and winners chose their own prize. In the afternoon there was a fitness activity session provided by an external company and a number of people took part.

Following the inspection, a health care professional told us via email, "When I have visited the home there has always been activities going on to engage residents and encourage socialisation and mental stimulation."

In the reception area there was an activities book for the month of October 2018. This had photographs of flower arranging, fitness sessions, a singer, walks in the community, a choir, a keyboard player, Halloween decorations and a Sunday karaoke.

The activities organiser told us they had been in post for six weeks. The current programme of activities included; cinema, bingo, quizzes, fitness, arts and crafts, baking, sensory and aromatherapy. A daily walk was organised most days, weather permitting and there was a monthly church service.

People were aware of how to raise a complaint. One person said, "I would complain to the staff or [name of registered manager]." Another person told us, "I would complain to the office. I complained about the food at one meal, they sorted it."

The registered manager told us the home had only received one formal complaint. We saw the complaint had been investigated although the matter had not yet been resolved the complainant's satisfaction. Minor concerns were not recorded. Logging minor concerns are a further means of monitoring the quality of the service and identifying trends at an early stage.

Good

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of our inspection and therefore this condition of registration was met.

People spoke positively about the management of the home. Comments included; "[Name of registered manager] is the manager she is friendly, I see her every day", "I can't fault anything. I wouldn't change anything. Yes, I go to resident meetings they do what we want", "Name of registered manager] is nice, you can talk to her comfortably. I'm comfortable here, everything is lovely" and "The best thing about here is the friendliness of the staff. They know me by name."

Following the inspection, we received the following feedback via email from a health care professional, "I have visited Sycamore Park on approximately six occasions in the past 12 months. On each occasion I have found the manager and her deputy very approachable with clear understanding of the client's needs. All suggestions were acted upon and care plans put in to practice in a timely manner."

All the staff we spoke with told us they felt listened to and supported by the management team. One staff member said, "[Name of registered manager] is excellent, really helpful and friendly. You can talk to her about anything." We asked one of the staff what they thought the vision and values for the home were. They responded, "To provide a homely environment, the best care." They told us the registered provider was a regular visitor to the home.

Regular audits were completed to monitor and assess the quality of the service people received. A matrix listed each audit and the frequency of completion. Audits included, health and safety, the kitchen and catering service, infection control, medicines and care records. Each audit clearly recorded where issues were identified and when they had been addressed.

However, we noted in some of the audits staff ticked each point to indicate the service was meeting the requirements. Details of how the judgement was met were not recorded. For example, the care plan audit asked, "There was a full review of the moving and handling assessment within ten days?" The response was ticked to evidence compliance but there was no evidence the auditor had checked the care record for accuracy and quality of content. The shortfalls we identified in people's care records had not been identified through the organisations auditing system. We recommend the registered manager seek advice and guidance from a reputable source to ensure audits are suitably robust.

There was a system in place to gather feedback from people who lived at the home. Resident meetings were held monthly. One person said, "At resident meetings we complain about lunch, it works." We saw minutes from monthly resident meetings were retained. Regular relatives' meetings had been scheduled but the records noted no-one had attended. The registered manager told us the feedback survey was completed annually. Surveys had recently been sent to people and their families as the home had been open for nearly a year.

Staff meetings were also held on regular basis. One staff member told us, "We get asked if we have anything for the agenda." A record of attendees and topics discussed were retained. Meetings are an important part of a registered manager's responsibility to ensure information is disseminated to staff appropriately and to come to informed views about the service.

The service worked in partnership with other agencies. This included GPs, pharmacist, the district nurses and Locala, an independent company who provide NHS community services to people living in care homes.