

Tri-Care Limited

The Sycamores

Inspection report

Norton Road
Wakefield, WF1 3BD
Tel: 01924 379994
Website: www.orchardcarehomes.com

Date of inspection visit: 19 November 2015
Date of publication: 08/03/2016

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?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

This inspection took place on 19 November 2015 and was unannounced.

We previously inspected the service on 18 October 2013 and at that time we found the registered provider was meeting the regulations we reviewed.

The Sycamores is registered to provide care for up to 40 older people. Accommodation is available on two floors accessed by a lift. All bedrooms are single occupancy with en-suite facilities. At the time of our inspection there were 40 people using the service.

The service is required to have a registered manager. 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. The service had not had a registered manager since 24 February 2014. A manager had been in place since that time and had left the service on 9 October 2015. The current manager was the registered manager at another location run by the same provider and had submitted their application to commence registration with CQC at this location. At the time of our inspection this was not finalised.

Summary of findings

People who lived at The Sycamores told us they felt safe. Staff had a good understanding about safeguarding adults from abuse and who to contact if they suspected any abuse. However systems were not in place to immediately investigate evidence of abuse because a medicines error had not been reported to safeguarding or investigated. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Risk assessments minimised risk whilst promoting people's independence. There were enough suitably trained staff to meet the assessed needs of people who used the service.

Medicines were managed in a safe way for people.

People's capacity was considered when decisions needed to be made and support provided when necessary to support and enable people to air their views. This helped ensure people's rights were protected when decisions needed to be made.

People were supported to eat a good balanced diet and people enjoyed the food served. A range of healthcare professionals were involved in people's care as the need arose.

People's individual needs were met by the adaptation, design and decoration of the service.

Staff were caring and supported people in a way that maintained their dignity and privacy and people were supported to be as independent as possible throughout their daily lives.

People's needs were reviewed as soon as their situation and needs changed, however some records were not updated and contained minimal information. Accurate and secure records were not always maintained in relation to care that was being delivered. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The new manager was addressing this and some improvements had been made.

People and their representatives were involved in care planning and reviews.

People told us they knew how to complain and told us staff were always approachable.

The culture of the organisation was open and transparent and the manager was visible in the service.

The manager held meetings with people who used the service, relatives and staff to gain feedback about the service they provided to people.

The registered provider had an overview of the service. They audited and monitored the service to ensure the needs of people were met and the service provided was to a high standard. However, this system had not addressed some of the problems we found with reporting and investigating safeguarding concerns and keeping accurate and secure records.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Staff had a good understanding of safeguarding adults from abuse, but procedures were not always followed to keep people safe.

Identified risks to people were managed well.

There were enough suitably trained staff to meet the assessed needs of people who used the service.

Medicines were managed in a safe way for people.

Requires improvement



Is the service effective?

The service was effective.

Staff had received specialist training to enable them to provide support to the people who lived at the Sycamores.

People's consent to care and treatment was sought in line with legislation and guidance.

People were supported to eat and drink enough and maintain a balanced diet.

People had access to external health professionals as the need arose.

Good



Is the service caring?

The service was caring.

Staff interactions with people were supportive, caring and enabling.

People were supported in a way that protected their privacy and dignity.

People were supported to be as independent as possible in their daily lives.

Good



Is the service responsive?

The service was not always responsive.

Accurate and secure records were not always kept.

People and their representatives were involved in the development and the review of their support plans where possible.

People told us they knew how to complain and told us staff were always approachable.

Requires improvement



Is the service well-led?

The service was not always well led.

The culture was positive, person centred, open and inclusive.

The manager held meetings with people who used the service, relatives and staff to gain feedback about the service they provided to people.

Requires improvement



Summary of findings

<p>The service's quality assurance systems had not addressed problems we found at the inspection</p>	
--	--

The Sycamores

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 19 November 2015 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. Their area of expertise was consulting people who use services and supporting an older family member.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider and feedback from the local authority safeguarding and commissioners. Before this visit we had received information of concern about record keeping, managing the risk of falls and responding to complaints.

We used a number of different methods to help us understand the experiences of people who lived in the home, including observations and speaking with people. We spoke with nine people who used the service, four members of staff, three relatives, the manager, the operations manager and three community professionals. We looked in the bedrooms of five people who used the service with their permission. During our visit we spent time looking at four people's care and support records. We also looked at two records relating to staff recruitment, training records, maintenance records, and a selection of the service's audits.

Is the service safe?

Our findings

People we spoke with told us they felt safe and visitors we spoke with told us they felt confident their relative was safe at The Sycamores. People who used the service said, “You can have a key and I have never felt the need to use it. You can be confident you can leave your door open.” One person who used the service said they were ‘quite happy’ with the way risk was managed. Another person said, “They do very well.”

We saw most safeguarding incidents had been responded to appropriately and action taken to keep people who used the service safe. We saw the home had a safeguarding policy which had been reviewed and signed as read by staff and was visible around the home. However, we spoke to a general practitioner (GP) from the local practice on the day of our inspection. They expressed concern that a medicines error had occurred in the last couple of months whereby a person had been given an incorrect prescription which was not in line with their prescribed script; staff had continued to give incorrectly for three days. The GP felt this should have been noticed sooner by staff administering medicines. There was no impact of harm to the person using the service from this error.

We discussed this issue with the manager and operations manager on the day of the inspection. An incident report regarding the error could not be located. The manager and the area manager had not been in post at the time of the error and investigated the incident after the inspection. There was no record of the medicines error being referred to the local authority safeguarding team or being notified to CQC in line with legislation. This demonstrated the home did not always have robust procedures in place for identifying and following up allegations or incidents of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The manager had a good understanding of safeguarding and the procedures to follow to keep people safe. Staff told us they had received training in safeguarding and they were able to tell us what they would do if they had any concerns. One staff member said, “If we have a safeguarding concern we tell the manager or deputy. We can notify head office. There is information on the office door about where we can go if we have any concerns.” Staff gave us a description of the different types of abuse they may come across in their

work. This showed that staff were aware of how to raise concerns about harm or abuse and recognised their personal responsibilities for safeguarding people using the service.

Prior to this inspection we received information of concern that the risk of falls to people who used the service had not been managed well. We looked at the care records of people who used the service and saw risk assessments were in place for a range of issues including skin integrity, use of bedrails, mobility and falls. We saw these assessments were reviewed regularly, signed and up to date. Risk assessments were tick box in nature with minimal detailed information. However we saw appropriate action had been taken to reduce risks. For example, one person fell forward from a self-propelled wheelchair when outside in the garden unsupervised. The person initially agreed to be supervised following the incident and their health was reviewed by their GP. The person informed staff they preferred not to be supervised and constant supervision was removed, following improvements in the person’s health and a review of the risk assessment, with occasional visual checks replacing supervision. Following a fall for one person we saw a moving and handling assessment had been completed and suitable equipment put in place to prevent further falls and a new care plan was being implemented. The members of staff we spoke with understood people’s individual risks and how to ensure risks were minimised whilst promoting people’s independence.

Staff told us they recorded and reported all accidents and people’s individual care records were updated as necessary. The manager and staff members were able to describe the procedure to follow and explain what action had been taken following falls and incidents. We saw accidents and incidents were recorded and appropriate action was taken to ensure the safety of people who used the service.

We saw the registered provider had analysed accidents and incidents across the service to look for themes and lessons. A weekly accident report was sent to managers and action was advised by regional managers depending on the number of falls and any patterns that occurred.

Is the service safe?

A series of risk assessments were in place relating to premises and equipment, for example: kitchen safety, water temperatures, use of bedrails, waste disposal, slips, trips and falls, moving and handling equipment, waste disposal and hazardous substances.

We saw servicing and maintenance of equipment such as hoists had been completed regularly and was up to date. We saw documents were maintained in relation to premises and equipment.

This showed the registered provider had taken steps to provide care in an environment that was adequately maintained

People who used the service and staff told us they knew what to do in the event of a fire and fire drills were completed regularly. This showed us the home had plans in place in the event of an emergency situation. We saw from records that fire alarm tests and fire door checks had been completed regularly and checks on fire safety equipment were up to date.

We saw from staff files that safe recruitment practices had been followed. For example, the registered manager ensured that references had been obtained and Disclosure and Barring Service (DBS) checks had been carried out. These were updated around every three years. The DBS has replaced the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) checks. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

People who used the service said, "I think everywhere is short staffed. It is a little bit here. You can always find staff. I've never needed staff and not had them." and "We could do with more staffing. At night I have to buzz. They will come, but I have to wait to go to the toilet." Another person said, "Staff are fully occupied and they do their best." One visitor told us they visited regularly at different times of the day and whilst numbers appeared low sometimes the staff were really good and, "They do their best well."

Staff said, "There are enough staff. We would always like more." "We could do with one more staff member on each floor. Everyone wants a bath at the same time. I managed to do five yesterday." "There are not enough staff to meet people's needs. If five people want a bath we have to prioritise. If they want a bath they should get it."

The manager told us there were enough staff to meet people's needs and they used a dependency tool to ensure staffing was sufficient. On the day of our inspection the manager told us three members of staff were absent from work through ill health and these absences had been covered by familiar staff from the provider's own staff bank. Three carers were on the duty rota for 20 people who used the service on each floor from 8am until 8pm daily. Two of these carers were senior carers. The manager and the deputy manager were also on shift from Monday to Friday 9am until 5pm. However there was no deputy manager on the day of our inspection due to ill health. Two cooks were on duty 9am until 5pm every day. One housekeeper was on shift Monday to Friday. A laundry assistant worked 5 hours a day and the service was recruiting to a vacant post for a second laundry assistant. An activity co-ordinator worked 30 hours a week, however they were absent from work on the day of our inspection. At night there were three carers and one senior carer for 40 people who used the service. We saw the number of staff identified as being required by the dependency tool were deployed on the day of our inspection and we observed people's needs being met in a timely manner. We saw from records that people who used the service had received baths in line with their care plans

The manager told us senior carers at the home completed training in safe administration of medicines every year and we saw certificates to confirm this. We saw medicines competence was also assessed annually. This meant people received their medicines from people who had the appropriate knowledge and skills.

We saw people's medicines were stored safely. The medicines room was spacious and clean with hand washing facilities available. Temperature checks were recorded daily for the room where medicines were stored and for the medicines fridge. The senior carer administering medicines ensured the medicines trolley was locked if unattended and administered medicines to one person at a time.

The service used an electronic system for recording the administration of medicines. Each carer had a unique log-in which meant a record of who had administered the medicine was recorded on the system and the medicine stayed on the electronic list until it had had been administered.

We saw a monitored dosage system (MDS) was used for the majority of medicines with others supplied in boxes or

Is the service safe?

bottles. We found the medicines we checked could be accurately reconciled with the amounts recorded as received and administered. This meant we were assured that people who used the service were protected against the risks associated with medicines.

We noticed that the box of an opened bottle of eye drops was annotated with the date of opening which prevented the person receiving medicine which was out of date. However, the person administering eye drops did not wash their hands before or after administering the eye drops which could lead to the spread of infection. We addressed this with carer at the time.

Care plans also contained information about medicines and how the person liked to take them. Some people were prescribed PRN medicine. This is medicine that is taken 'as and when required'. PRN protocols were not in place for

people; however staff told us all the people who used the service were able to tell them when they required PRN medicines and we saw staff asking a person if they needed pain killers when administering their other medicines.

We noted the staff completed a stock check of all the medicines stored in the controlled drug cupboard to ensure that all the stock was accounted for. Each entry was completed and checked by two staff on the electronic record.

Where people were prescribed topical creams the electronic record informed staff to refer to the 'topical application record'. These were retained in their bedrooms and detailed the name of the cream, where to apply it on a body chart and when. Staff recorded on the form when they had applied the cream. This meant the records accurately reflected when creams were applied to people and by whom.

Is the service effective?

Our findings

People who used the service told us staff were able to support them well. People said, “Yes, they seem to know what they are doing,” and, “Yes, staff are great.”

Staff were provided with training and support to ensure they were able to meet people’s needs effectively. Staff told us they completed an induction including a week of training and between three and six days shadowing more experienced staff before starting work at the service. Staff recruitment and training records confirmed this to be the case.

We saw evidence in staff files and training records that staff regularly undertook training to enhance their role and to maintain their knowledge and skills relevant to the people they supported. Staff told us and we saw from training records staff had completed training in areas including moving and handling, first aid, fire safety, health and safety, The Mental Capacity Act, safeguarding, infection control and dementia awareness. Training was a mixture of computer based and practical face to face training.

One member of staff said, “We are a team. We all get on. There is a nice atmosphere.” Staff told us they felt supported and staff meetings were held approximately every three months. They told us they had regular supervision, as well as an annual appraisal and supervision records confirmed this. We saw from records supervision was often used to highlight issues to all staff and there was not always opportunity for joint discussion. The new manager showed us a supervision planner and a reflection sheet they had introduced to allow staff to reflect on their own work. We saw evidence they were well organised and planned. This showed staff were receiving management supervision to monitor their performance and development needs.

The registered provider had policies in place in relation to the Mental Capacity Act 2005 (MCA). 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 at The Sycamores had

completed training and had a good understanding of the Mental Capacity Act 2005. Staff we spoke with said, “Everyone has to have capacity to make their own decisions. Any changes in capacity we report to seniors and they assess them.” And, “(person) smokes. They had a fall when out smoking, but we can’t stop (person) as they have capacity. Some people have fluctuating capacity.”

We saw in the care records we sampled people’s capacity had been considered when decisions needed to be made. Each file contained a capacity check list and a mental capacity assessment had been completed where necessary. For example one person was documented to have the capacity to make decisions regarding personal care by the home, but some of the person’s relatives felt the person did not have the capacity to decide. A further mental capacity assessment meeting with a social worker, the person and their family had been arranged to discuss this. This demonstrated people’s capacity was considered when decisions needed to be made so their rights were protected.

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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. The manager told us no DoLS authorisations had been applied for people who used the service as there were currently no people who used the service who lacked the capacity to make decisions about their care and treatment. We did not see any evidence that this was not correct on the day of our inspection.

People at The Sycamores were supported to have sufficient to eat and drink and to maintain a balanced diet. People we spoke with told us they enjoyed the food. People said, “The food is excellent. I have never had a bad meal yet.” And, “The food is beautiful.” “Food is reasonable, but I am very fussy.” And, “Excellent, can’t fault it”, “The food is very good, very nice.” One person said, “Yes, my diet and nutrition is different and they check it regularly to make sure it is correct.”

People who used the service told us there was a choice of food and drink and we saw this was the case. People told

Is the service effective?

us, “You can have what you want. I had a jacket potato.” And, “They come and ask what you want.” Staff told us they ask people what they want to eat after breakfast, but also confirm this when meals are served.

We saw that people chose where to sit at lunch time and people were offered a choice of juice or tea. Before meal service began staff offered people a wet wipe for their hands. Gravy was placed in a jug on each table and help was offered to pour the gravy if required. One person had not ordered lunch as they had been out and the carer offered them a taste of the various options to enable them to decide. Meals were served by carers from a Bain Marie and staff asked people how much they wanted to eat. This demonstrated people were enabled to make choices about their meals and drinks according to their tastes and preferences

Staff ensured people were supported to eat if required. Carers encouraged people to eat and were attentive to their needs, offering more when people had finished eating. We saw one person who used the service being supported to eat in their room. The carer explained what they were doing and supported the person at their own pace, offering drinks in between the food.

We saw mid-morning and mid-afternoon drinks and snacks were offered to people. Hot and cold drinks were observed being offered to people throughout the day in their rooms and also in the dining rooms and lounges. Bowls of fruit, cold drinks and snacks were available in the lounges with notices asking people to help themselves.

We saw in one person’s care plan their weight had been monitored and action had been taken when weight loss was recorded. A food diary was being kept, including the quantity of food being consumed and mid-morning and

afternoon snacks and supper. The person had been referred to a dietician due to weight loss following an operation, but had now been discharged as their weight had increased.

People who lived at The Sycamores were supported to access healthcare. People who used the service said, “Staff always called the doctor if needed.” And, “The chiropodist has just been. She has done mine today.”

Staff said people attended healthcare appointments and we saw from people’s care records that a range of health professionals were involved. People had accessed services in cases of emergency or when their needs had changed. This had included general practitioners, hospital consultants, community mental health nurses, speech and language therapists and dentists. A podiatrist was visiting during our inspection and told us they were called in for any new people or concerns and the regular podiatry service was offered to new residents. This showed people received additional support when required for meeting their care and treatment needs.

We saw suitable equipment was in place to meet the assessed needs of people who used the service for example: profiling beds, pressure relieving cushions, sensor mats and hoists.

People’s individual needs were met by the adaptation, design and decoration of the service. Rooms were personalised to people’s tastes and the building was clean, odour free and well maintained. The home was decorated with pictures on the walls of the corridors. Bedroom doors were numbered, but with no names for privacy. All rooms had an en-suite toilet and sink and some rooms had a fridge. The lounge upstairs was arranged in a way that encouraged social interaction. The dining table was set out with dark mats and white crockery to make plates more visible for people who may have visual impairments.

Is the service caring?

Our findings

The service was caring. People told us they liked the staff and we saw there were good relationships between staff and the people who used the service. People told us, “They are very caring here. Their attitude is always happy to do things for you.” And, “The girls are very good. On my birthday they made chocolate eclairs. They knew it was my favourite.” “Definitely caring, you can have fun with them. They put a smile on my face.” And, “The staff here are very good, and do their best in some very difficult situations.” One person said, “I don’t like the home. They treat you like an inmate. Some carers are alright. I get on all right with a lot of them.”

Visitors said, “Yes, it’s very good.” “Some staff are really good. Certain carers are brilliant. Nothing is too much trouble.”

Staff we spoke with enjoyed working at The Sycamores and supporting people who used the service. A member of staff said, “It’s a nice little home. I treat people as if they were my parent.” Staff we spoke with had a good knowledge of people’s individual needs, their preferences and their personalities and they used this knowledge to engage people in meaningful ways. Staff told us they spoke to the person or family members about their likes or dislikes. We saw care files contained information about some of the tastes and preferences of people who used the service, including a short personal history of the person. This gave staff a rounded picture of the person and their life and personal history before they went to stay in the home.

People were supported to make choices and decisions about their daily lives. People who used the service said, “You can have a warm drink when you want. You can go to bed when you want. There are no restrictions.” “If I ask for a bath they give me one.” “If we ask for something they usually sort it, whatever it is.” One member of staff said, “It’s

their home. They can have anything they want. People can choose what time they get up. If they don’t want to get up they can stay in their pyjamas.” Another told us one person was supported in bed and it was their choice.

Carers told us they generally worked on the same floor for continuity. This meant most of the time people were supported and cared for by staff who knew them. We heard staff speak with people in a kind and caring way whilst supporting them to eat and also when offering a choice of meal and drink. We saw one member of staff used appropriate voice and touch to respond to a person and help them adjust their position in the chair.

Staff promoted people’s independence where possible. For example, we saw a member of staff encouraged one person to propel themselves in their wheelchair and offered assistance if required with negotiating the door riser. Another person recorded their own medical visits and staff assisted them with making the appointments.

We heard staff give good explanations to people to help them understand how they were being supported. We saw they waited patiently for people to respond and people were not rushed in their interactions. One visitor said staff often gave them information, “That we might need to help us make a decision about (person’s) care.” We saw information on the notice board in the foyer about the home’s “Older men’s champion” and information about how to access advocacy services.

The members of staff we spoke with were aware of how to promote the dignity and privacy of people who used the service. We saw staff knocked on people’s bedroom doors and asked permission to enter. A staff member told us, “I talk discreetly to people about bathing or the toilet. It’s the approach you use.” Another said, “I close the curtains and shut the door. I use towels to cover people so they aren’t exposed when we wash them.”

Is the service responsive?

Our findings

The service was not always responsive. People who used the service said, “There are loads of activities, shopping trips, swimming. The co-ordinator is good to talk to.” And, “A carer sorts it out if anyone is interested.” One person said, “We had a donkey in this week.” And another said, “Residents’ meetings I go to sometimes. There is one next week.”

One visitor told us their relative was too ill to take part in any activities and, “Staff are empathetic to the situation.” One visiting community professional told us, “The family are very happy with (person’s) care. All their needs are met.”

Prior to this inspection we received information of concern that care plans contained little information to enable staff to support people who used the service well and information relating to falls was incorrect or negligible. Care plans contained information in areas such as nutrition, sleep, medication, mobility, personal care, oral care and mental wellbeing. We saw in the care plans we looked at that mobility assessments were in place in the style of tick boxes containing the necessary basic information to support people who used the service safely, for example the hoist number, equipment required and support required. Risk assessments were in place related to use of bed rails and mobility. However, there was little detailed information for staff about how to support each person. This meant inappropriate care could be delivered by care staff who were new to the service.

We saw information in most of the care files we sampled had been updated to reflect people’s changing needs, for example a change in the support a person needed to transfer. However in one care file we sampled an out of date moving and handling risk assessment was present, along with one that had been updated when the person’s needs had changed in August 2015. The original risk assessment referred to a walking stick and the second risk assessment referred to a Zimmer frame and two staff being required to assist the person to mobilise. This could be confusing for staff and result in inappropriate care being delivered. The relevant care plan had been updated in September 2015.

A falls risk assessment was present with a score of ‘High Risk’ if not using Zimmer frame dated 17 November 2015. We saw in this person’s file the accident log was blank,

however a fall had been recorded on 13 September 2015, where the person was found on the floor, but no injury had occurred. Personal evacuation plans (PEEPs) are a record of how each person should be supported when the building needs to be evacuated. In the same file the PEEP had not been updated to reflect the person’s changing need for support with mobility and stated, “Independently mobile.” This could be confusing for staff and result in inappropriate care being delivered. The file contained a blank ‘family and social contacts’ document and there was no record of the recent involvement of a dietician in the health section. This showed that accurate and up to date records were not always maintained and that people were not always protected from the risk of inappropriate care because of gaps in recording. The manager told us they would address these issues straight away.

Social activity records were kept for people; however these were located in the foyer of the home, where members of the public would be able to access them. This meant personal confidential information was not kept securely. We discussed this with the manager and they addressed it straight away.

The above issues meant people may be at risk of inappropriate care because accurate and appropriate records were not always securely maintained. This evidenced a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager showed us evidence they were in the process of improving information in care plans. The manager had held group supervision to discuss that care plans needed detailed information about how to support a person so new staff could support them well if needed. The manager had taken two random care plans and analysed them and then showed care staff examples of good practice and areas for improvement. Staff confirmed they had started learning new ways to complete care records with more detailed information.

One senior carer had a supervision planned with a carer on the day of our inspection and we saw the care plan entries they made were more detailed, for example in a person’s pressure care plan, “Applies moisturiser but needs some assistance to do their back.” We saw other examples where more person centred and detailed information had been recorded. For example, how the person likes to have their hair and their preferred terms of endearment, ‘not to be

Is the service responsive?

referred to as duck or chick,' and in another, 'likes supper before bed,' and the times they preferred to rise and retire for the day. Daily logs recorded the support people had received and the choices people had made.

The manager told us senior carers were now given two hours a day away from their care and support duties in order to improve and update care plans with people who used the service and staff confirmed this was the case. Care plans were updated monthly or as needed and review meetings were held every three months. People who used the service told us they were involved in planning their care.

The staff we spoke with had a good awareness of the support needs and preferences of people who used the service. Staff told us they try to offer person centred care and one member of staff said, "It is about what the person likes and what they want to do."

People told us they were involved in planning their care and we saw from care records this was the case. Where this was not possible or not desired by the person, their family and other relevant health and social care professionals had been involved. One visitor told us they were involved 'regularly as a family.'

We saw pre-admission assessments for two people that had been completed by the current managers and these were thorough and included detailed information about the needs and preferences of the people concerned.

Activities were provided for people at The Sycamores. One staff member said, "The activity coordinator is always looking for something different to do."

The manager told us an activity coordinator worked Monday to Friday 10am until 2.30pm, however they were absent from work on the day of our inspection. One person said, "I wanted to go to the church today. The activity coordinator is not in. They normally wheel me down. I asked the manager and he said the activity coordinator is not here." The activities usually provided by the coordinator had not been replaced on the day of our inspection; however the manager assured us they would replace activity hours on a temporary basis from the following week, if the absence was likely to be long term, "As it is important to residents."

We saw activity planners for the month were attached to the back of people's bedroom doors and people who used

the service told us these reflected the activities that were offered. One staff member said, "The activity coordinator is off sick today, but we had a donkey in last week. We had eggs hatching into chicks. They love animals coming in."

People told us there were no restrictions on visiting times. One relative told us their friends and relatives visited whenever they could and they "haven't found any restrictions." This showed people were enabled to maintain relationships that were important to them.

People who were able to do so and relatives, told us they would feel comfortable raising issues and concerns with any of the staff and they knew how to complain. People who used the service said, "I think it's marvellous. They look after you. They act on concerns. You can talk to the manager. They can't do enough for me." And, "If I had a complaint I would go to the manager. I would make sure they follow it up." One person said, "It's very good. No complaints." And another said, "The staff listen all the time."

A visitor said, "There are systems in place, but not everyone knows about it, and most times it's just a case of talking to someone and it gets done."

Prior to this inspection we received information of concern that the registered provider had not followed their complaints policy and responded to a written complaint or addressed the issues raised in the complaint within a reasonable time frame. We saw from the complaints record that the registered provider had now accepted the complaint, apologised and taken action to address the issues in the complaint, as well as improving their response to complaints.

The service had a complaints procedure which was visible in the home. The manager told us verbal or written complaints were recorded and logged with the registered provider's compliance team and a standard letter issued. The registered provider would then investigate and reply to the complainant within 28 days. We looked at the complaints log. We saw complaints had been recorded and action taken to address the issues identified. One complaint related to missing clothing had been responded to in July and September; however the same issue was raised to staff by a family member on the day of our inspection. The staff member told us everyone was doing a bit of laundry at the moment. The manager told us they had recruited a new laundry assistant post but had to

Is the service responsive?

re-advertise the position, as the person had not started work as planned. The manager had tried to improve the laundry system with a new laundry trolley system and advertised again for a laundry assistant.

One relative told us they had complained when their relative's recliner chair, in which their relative chose to sleep, had been left with blood on following an injury to their leg and admission to hospital. The manager at the time had apologised. The relative had also complained

about the cleanliness of their relative's room and cleanliness had improved as a result. One visitor told us they met with staff and managers regularly and if they had any concerns they raised them and they usually were dealt with quickly, but they had rarely had to do so. This demonstrated people's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Is the service well-led?

Our findings

People who used the service said, "If you have to be in a care home you couldn't do better. I used to be a nurse and I was always impressed when I came here." And, "We couldn't live anywhere better." Another said, "I think it's pretty good care here. It's a pretty good standard. I've been in a few respite places." One relative said, "On the whole it is one of the better places."

The service had not had a registered manager since 24 February 2014. A manager had been in place since that time and had left the service on 9 October 2015. The current manager was the registered manager at another location operated by the same provider and had submitted their application to commence registration with CQC at this location. At the time of our inspection this was not finalised.

There was an open door to the manager's office and people, staff and visitors had free access to discuss any relevant matters. Staff told us they were encouraged to raise any concerns with the manager and they felt confident to do so. One member of staff said, "I feel OK to speak up if I have any concerns. I would rather say and then it can be resolved straight away." This helped to create a culture of openness and transparency.

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. A customer satisfaction survey was available on the notice board in the foyer. A 'You said, we did' notice was on the board in the corridor along with a suggestion box and an iPad was available for people to give feedback on the service provided.

Service user and relatives' meetings were usually held twice a year and one had been held in October 2015 attended by 13 service users and relatives. The meeting discussed topics such as staffing and activities. The new manager was planning another meeting in November 2015. Meetings with staff, people who use the service and their relatives are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and treatment.

The manager said, "We have a really good staff team. It is now a case of developing it." Staff told us meetings were

held several times a year and a meeting had been held by the new manager last week. We saw staff meetings were held regularly and topics covered included cleanliness, activities, keyworker role, care plans and quality assurance

The manager said their aim for the service was, "To make this the best care home in Wakefield and to have a nice safe homely atmosphere." The manager had developed an action plan on commencing work at the home, including possible provision of a bar area. The manager was in the process of completing their level five manager qualification. This meant the manager was keen to learn from others to ensure the best possible outcomes for people living within the home.

There was evidence of internal daily, weekly and monthly quality audits, for example a monthly audit of people's weight to check for any changes across time, and this had been followed up where a problem had been identified. Medicines audits were completed weekly on the new electronic system and any identified problems had been addressed. An audit of advanced decisions had been completed in October 2015 and a care profile audit completed on 1 November 2015 had identified that improvements were needed in care profiles. The new manager showed us evidence they had begun to address the care profile issues.

Prior to the manager and area manager being in post at the service a medicines error had occurred. This was reported to CQC by a local GP. The manager conducted an incident review and found that pre-planned training for all staff who administered medicines had been updated on 16 October 2015. The new manager provided evidence they had conducted group supervision with the staff team and implemented new systems to reduce the risk of a future occurrence of a similar incident.

The manager told us they felt supported by the registered provider and told us, "I can always pick the phone up." The new operations manager was visiting the home for the first time on the day of our inspection. A temporary operations manager had normally visited the home every two to three weeks and at least monthly and discussed the audits and checked records. An action plan was completed and the August 2015 report showed that the actions had all been completed. This demonstrated the management of the organisation were reviewing information to improve quality

Is the service well-led?

in the organisation, however they had not identified and addressed the problems we found with reporting and investigating safeguarding incidents and keeping accurate and secure records.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Systems and processes were not established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of abuse.

Regulation 13 (3)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The registered person did not always maintain securely an accurate, complete and contemporaneous record in respect of each person who used the service

Regulation 17 (2)(c)