Shaw Healthcare (Nailsea) Limited

Sycamore Lodge

Inspection report

Lodge Lane
Wraxall
Bristol
Avon
BS48 1LX

Tel: 01275858000
Website: www.shaw.co.uk

Date of inspection visit:
11 June 2021
14 June 2021
17 June 2021

Date of publication:
06 August 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Sycamore Lodge is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Sycamore Lodge at this time provides care and support to 68 people, the service can support up to 78 people.

People's experience of using this service and what we found
Records relating to people's care, treatment and medicines were not always accurate and up to date. This included, care plans, pen portraits, nutrition and hydration charts, pressure care, times observation charts and handover sheets. People were not always supported by staff who were employed by the service and who knew them well. There was a high use of agency use in the service. The provider's audits were not identifying shortfalls found during this inspection.

People felt safe and staff knew the different types of abuse and who to report any concerns to. Incidents and accidents were monitored, and records confirmed actions taken along with observations taken following an injury. The service appeared clean and odour free and Covid-19 guidance was being followed apart from management were not always wearing face masks as required. The service liaised with other agencies and health care professionals to achieve good outcomes for people. The provider was in the process of implementing a new electronic care planning system.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Good (published October 2018). The service at this inspection has deteriorated to requires improvement.

Why we inspected
We carried out an announced focussed inspection looking at Safe and Well-led including infection prevention and control measures.

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Sycamore Lodge on our website at www.cqc.org.uk.

We found the providers audits were not always identifying shortfalls found during this inspection and records were not always accurate, complete and contemporaneous. This is a breach of Regulation 17 HSCA RA Regulations 2014 Good governance

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Sycamore Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measure in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors, one Expert by Experience and a Specialist Advisor. 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 Specialist Advisor was a nurse.

Service and service type
Sycamore Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not at the time of the inspection have a registered manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We gave a notice period so that we could ensure we managed the risks related to Covid-19 and to ensure the deputy manager and management team would be in the office to support the inspection.

What we did before the inspection

Prior to the inspection, we sent people within the service questionnaires. We received 26 responses back from people and five from relatives. We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a Provider Information Return prior to this inspection. This is information we require the provider to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service about their experience of the care provided. We spoke with eight members of staff including the deputy manager, four members of the senior management team including the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We used all of this information to plan our inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision along with a variety of records relating to the management of the service, including policies and procedures and audits.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We sought feedback from the local authority.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● People's care plans were not always current, and care was not always delivered as assessed. For example, one person's care plan and risk assessment confirmed they were at risk of their skin breaking down. They had been assessed as requiring a pressure cushion to sit on. We found them sat for long periods of time not on a pressure relieving cushion. We raised this with the operations manager. They took immediate action during the inspection to address this shortfall however on the next day we visited we found the person was again not sat on a pressure relieving cushion. The person was independent with their transfers and mobility however the person could be at risk of developing pressure sores due to not sitting on a pressure relieving cushion and sitting on a hard surface for a prolonged period of time. This information was not recorded on the daily handover sheet this document is used to prompted staff about people's care needs.

● People's pressure care charts were not always recording what care and support staff had provided. For example, one person was also at risk of their skin breaking down, they required three hourly repositioning. Their repositioning chart had not always been filled in to confirm they had been re-positioned as per their assessed risk. This information was also missing from the daily handover sheet.

● The person was also at risk of losing weight. Their care plan and risk assessment confirmed they required their weight to be monitored and a specialist diet however their care plan had no information confirming daily monitoring charts were to be completed by staff. Their pen profile was also missing this important information along with the daily hand over sheet.

This meant people could be at risk of not receiving their care as required due to a lack of accurate, complete and contemporaneous records. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had building checks in place. This included checks relating to portable appliance testing (PAT) testing, water temperature checks, fire alarm checks, electrical tests and legionella checks.

Using medicines safely

● People were receiving medicines as required but there were shortfalls in recording. People felt they received their medicines as required. One person told us, "Yes, I feel happy with the nurse giving me my medicines". Another person said, "I'm happy with the way my medicines are being managed". Another person told us, "I receive my medicines on time and promptly". One relative told us, "A complex regime is well-managed".

● Although people received their medicines safely, records were not always in place to confirm people

received their topical creams as required. For example, one person required a barrier cream to be applied after personal care. They had only received their prescribed cream 6 out of thirteen days. The recording of the person's soap substitute was also not being recorded to confirm the person received it daily along with their personal care routine.
● Topical medicines administration records (TMARs) did not always have clear guidance in place identifying where staff should apply people's creams.
● People's care plans were not always up to date to reflect medicines they required as and when. There was also inconsistent recording of the application and removal of pain patches and the monitoring of these including what signs staff should be looking out for if people were in pain.

This meant people could be at risk of not receiving their care as required due to a lack of accurate, complete and contemporaneous records. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The providers first aid kits were being checked to ensure all items were available however, the expiry date was not. Action was taken during the inspection to get rid of and destroy products that were part used and that had expired.
● Medicines were stored safely and as required and people received their medicines from staff who had received training in the safe administration of medicines.

Staffing and recruitment
● People were not always cared for by sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet's people's care and treatment. For example, people were not always supported with their individual care needs. On both days of our inspection people sat around for long periods of time without staff interaction or support. One person expressed a wish to be taken back to bed. Staff were busy supporting other people and so the person was left in their chair instead of being taken back to bed as per their request. Another person was sat on a dining room chair on two separate days without sitting on their pressure relieving cushion. Staff were coming and going within the lounge area throughout the time that they were sat on the chair. However, no action was taken by staff to ensure they sat on a pressure cushion and appropriate chair.
● People, relatives and staff had mixed views on if there were enough staff. One person told us, "Sometimes and some are better than others". Another person told us, "We need more staff". Another person said, "They seem to be rushed a lot". One person told us, "First class. Great support, fantastic good very happy". One relative told us, "The staffing levels seem to be short as you never see them sat down just chatting, they are always on the go". One member of staff told us, "We're short of staff. It's difficult if they need a shower and there isn't enough time". Another member of staff also told us, "People are not given enough one to one time".
● The provider had various vacancies within the service. These included, catering and cleaning staff, a team leader, registered manager, driver, nurse and various support worker vacancies. In May a total of 276 agency nurse hours had been used and 2914 agency support worker hours. We reviewed the rotas for the last week and found that a total of 50 agency staff had been used across the service. On all three days of the inspection some agency staff had been used. The provider used a dependency tool this was to ensure staffing levels reflected people's needs. Following the inspection the provider confirmed staffing levels the week prior to the inspection were in line with their dependency tool. They also confirmed improvements had been made to recruiting permanent nurses therefore reducing the amount of hours covered by agency nurses.
● During the inspection we found one unit went below their allocated two staff. These two staff were allocated to support ten people. It was because a member of staff was away from the service supporting

someone with an appointment, leaving one member of staff to support the nine people remaining on the unit. Although the member of staff confirmed they could ask for assistance and support from other staff if they needed it those staff were responsible for other residents in another unit. The floor had units that interlinked, this meant people and staff could access all areas of this unit.

● One person who had a history of falls, had been identified by their GP to have their blood pressure checked sitting and standing. This was confirmed in the handover sheet. The nurse we spoke with thought blood pressure checks had been stopped however we found the handover sheet confirmed checks to be done. Staff were therefore not always familiar with what people's care and treatment needs were.

● During the inspection we were unable to find the daily records. We asked one of the agency members of staff. They were unsure where the daily records were and so started looking for them. They had been on shift for over two and a half hours no records had been filled in at this point in the day.

● Various incidents and accidents had occurred within the service. These related to unexplained injuries and medication errors. When we reviewed these incidents, people had been supported at the time by agency staff. This had an impact in the care people received.

We recommend the provider puts measures in place to ensure people are supported by sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet's people's care and treatment.

● Staff were recruited safely. All staff had received the required pre-employment checks including references, Disclosure and Barring Service (DBS) checks and had their identification checked.

Systems and processes to safeguard people from the risk of abuse

● Most people and their relatives told us they felt safe. One person replied, "Yes, very safe". One relative when asked if they felt their loved one was safe. Told us, "Yes". Another relative said, "Very much so". Another relative said, "Yes, very safe". However one person told us, "From my own experience, there are times I don't feel safe, due to staff attitude. Not very friendly sometimes".

● People were supported by staff who had completed safeguarding training and who knew how to identify concerns and how to report these. One member of staff told us, "Any concerns I would raise these with the manager". Another member of staff told us, "Abuse is financial, sexual, emotional, physical. I'd report to the manager or go to the team leader as well as the Care Quality Commission".

● Safeguarding's concerns were monitored on the provider's risk tracker. These could be monitored for any trends and themes. The provider had a safeguarding policy.

Preventing and controlling infection

● We were not always assured that the provider was using PPE effectively and safely as we found management were not always wearing face masks as required.

● We were not always assured that the provider's infection prevention and control policy was accurate and up to date. For example, areas for improvement included; what, how and when to clean equipment such as wheelchairs and commodes. The policy required updating to reflect changes in government guidance relating to face masks.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service.

● We were not always assured testing was in place for all staff. This related to the testing of agency staff only.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong
● Incidents and accidents were being recorded and analysed so that action could be taken to reduce the risk of them occurring. Referrals were being made to GP's and specialists when required.
● There was a high number of falls being recorded in the service. These were monitored through the providers monitoring risk audit. Falls were recorded on incidents forms and these were monitored by the management in the service.
● The provider had a policy in place for staff to follow should people experience a head injury. Records confirmed observations were undertaken and recorded following a head injury.
● During the inspection we found a number of unidentified prescribed glasses. One set of prescribed glasses were named and so could be returned to their owner. The others were not. We raised this with the management so that they could review how items such as these could be labelled and returned to people if lost.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had quality assurance systems in place, however shortfalls identified during our inspection had failed to identify, the gaps in recording of food and fluid charts, pressure care and 15-minute observations. These were not always accurate and up to date. We also found care plans were not always up to date or accurate providing staff with an accurate record of information they required.
- Systems in place to support agency staff were not always accurate and effective. For example, handover sheets and pen portraits of people did not always have accurate and up to date information to assist agency staff with people who they were unfamiliar with. This at times did impact on people.
- Following the inspection, the provider sent us their infection control audit. This was dated following our inspection. The provider following our inspection had highlighted the need to record agency staff Covid-19 test results although this had not been identified before.
- The providers audits relating to medicines management had failed to identify shortfalls relating to the recording of topical creams, expired first aid items including part used products, inconsistent recording of pain patches, inconsistent recording of medicines as and when required.
- The management met weekly to monitor the quality of the service. This included staff rotas, sickness, agency use, incidents and accidents, audit completion and recruitment. These meetings had failed to identify the shortfalls found during the inspection.
- The risk within the service was monitored by the management within the service. This covered the training, agency use, audits complaints, falls, medication audits, pressure ulcers and any over-due actions. Shortfalls had failed to be identified through the monitoring of the service.

This meant the providers audits and systems had failed to identify shortfalls found during this inspection. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The regional manager had recently undertaken an observed practice which included looking at the quality of activities, meal-time experiences, interactions with people, recruitment, training and the implementation of the new electronic care planning system.
- Weekly Covid-19 audits were in place. These monitored the cleanliness of the service, the use of personal protective equipment and cleaning regimes.

● At the time of the inspection the service had no registered manager in place. The nominated individual confirmed the post was currently in the process of being recruited. As an interim measure there was a covering manager seconded from another of the provider's services. They were being supported by a management team and deputy manager.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Staff spoke positively about their colleagues and how they supported each other. One member of staff told us, "Such as good staff team. We always help each other". Another member of staff told us, "Staff are very good at helping each other – teamwork is good".

● We received mixed feedback from people on the culture of the service. One person told us, "Not very friendly, sometimes very annoying to patient. Some staff have the right attitude others are not respectful". Another person told us staff were, "Good, but sometime disappointing". Another person told us, "Very caring, friendly and attentive". Another person said, More than happy with the home and care". This meant people's care experience was varied and some staff did not have the skills or a good understanding of how to promote people's individual goals and outcomes.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Notifications where made when there were certain changes, events or incidents occurred that affected the service or people.

● The provider was displaying the rating on their website and within the service. This was in line with requirements.

● People and staff were supported by the provider in relation to their equality and diversity.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were supported to stay in contact with their loved ones throughout the pandemic. This was through telephone and video calls, face to face visits indoors and out. These visits were in line with government guidance.

● One person said, "Communication is good". Another person said, "I'm very satisfied and I'm very happy". One relative told us, "Yes, good communication practice and I am informed of any changes". Another relative told us, "This has been a very difficult time during the pandemic and staff have worked hard to keep us informed".

Continuous learning and improving care; Working in partnership with others

● There was an open culture when things went wrong so that improvements could be made. For example, there was a log of incidents and accidents which were monitored so that any trends could be identified along with any improvements and lessons learnt.

● The service worked in partnership with the local authority and safeguarding team. There were thirteen discharge to assess beds within the service. People placed in these beds were there for around 6 weeks whilst they had their on-going care needs assessed. People having their on-going needs reviewed were monitored by the local health service.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's audits were not identifying shortfalls found during this inspection. Records were not always accurate, complete and contemporaneous. Regulation 17 (1) (2) (a) (c)