Care Quality Commission

Cedars Health Care Limited

The Cedars

Inspection report

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

Summary of findings

Overall summary

The inspection took place on 23 August 2017 and was unannounced.

The Cedars provides nursing and residential care for up to 56 older people some of whom may be living with dementia or physical disabilities.

At the last inspection, the home was rated good. At this inspection we found the home remained good.

The provider had a set of audits in place to monitor the quality of care provided. However, we found that they had not identified concerns around recording of wound and continence care. In addition, they had not identified that topical medicines such as creams were not appropriately managed.

We have recommended the provider follow the best practice guidelines in recording care around these areas.

There were enough staff available to meet people's needs and staff received appropriate training and support which enabled them to provide safe care to people. Appropriate recruitment checks were completed to ensure staff were safe to work with people living at the home.

Staff were kind and caring and knew how to provide care which supported People's individual needs. Staff knew how to identify and report abuse and the registered manager investigated concerns raised. Risks to people were identified and care was planned to minimise the risks to people's wellbeing.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the home supported this practice. Where necessary people had been referred for a Deprivation of Liberty Safeguards assessment and staff supported people to make choices about their care.

People were supported to take part in a wide range of activities which included accessing the local area. People were encouraged to identify activities that they would enjoy and staff worked to help them completed these activities.

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 and remains good.

Is the service effective?

Good

The service was effective and remains good.

Is the service caring?

Good

The service was caring and remains good.

Is the service responsive?

Good

The service was responsive and remains good.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had systems in place to monitor the quality of care provided. However, they had not identified concerns around wound management recording, continence care recording and the management of topical medicines.

People living at the home and staff had confidence in the registered manager.

People had their views of the care they received gathered and these were used to improve the quality of care people received.

CareQuality Commission

The Cedars

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 home, and to provide a rating for the home under the Care Act 2014.

This inspection took place on 23 August 2017 and was unannounced. The inspection team consisted of an inspector, a specialist advisor and an expert by experience. The specialist advisor was a nurse. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care home.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the home. We also reviewed information sent to us by the local authority who commission care for some people living at the home. 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 home, what the home does well and improvements they plan to make.

During the inspection we spoke with eight people who lived at the home and three relatives and spent time observing care. 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 spoke with the area manager, the deputy manager, two nurses, the housekeeper, two care workers and a visiting healthcare professional.

We looked at seven care plans and other records which recorded the care people received. In addition, we examined records relating to how the home was run including staffing, training and quality assurance.

Good

Is the service safe?

Our findings

People told us that they were supported to take their medicines in the way they preferred. Where people may be unable to remember to take their medicines staff stayed with people to ensure that the medicines were taken. One person told us, "The nurse bring my tablets and makes sure I take them." A family member said, "I've seen them make sure they stay while tablets are being swallowed." However, where people had capacity and chose to take their medicines in private this was also supported. One person said, "They trust me to take mine. I have my own way of taking tablets and prefer to be left alone. I like to know what they're all for. They sort of tell me." Where people were able to maintain some independence with their medicines this was supported. For example, one person told us how they were able to still inject their own insulin.

Medicines were safely administered and systems supported staff to administer medicines at the right time. For example, we saw that one person was given medicines at 2pm as stated on their prescription. This helped the person to control the symptoms of their long term condition which meant that they were better able to enjoy their day. Medicine Administration Records (MAR) had been appropriately completed for medicines given routinely. However, we saw that for medicines prescribed to be administered as required the MAR had not been completed. The administration was recorded on a separate form which did not have the prescription information recorded for staff to verify the correct dosage.

People told us they felt safe living at the home. One person told us, "I do feel safe. I'm very well cared for and I only have to ask for something." A family member said, "I've no concerns at all. She's so much safer here than at home."

Staff told us that they had received training in how to recognise different types of abuse and how to respond if they thought a person was being abused. They knew how to raise concerns with the registered manager and their training also included information on how to contact the local authority safeguarding team.

Records showed that the registered manager investigated any concerns raised with them. Where needed they took disciplinary action against staff including dismissing staff and referring them to the appropriate authorities so that they would be unable to work with vulnerable people in the future.

Care plans had identified the risks to people while living at the home and what care staff needed to provide to keep people safe from predictable harm. For example, where people were at risk of developing sore skin through sitting in one place for too long care plans indicated that they should be regularly repositioned. Where people needed equipment to keep them safe, it was available for them with instructions for staff on how to use the equipment safely. An example of this was one person who had an alert mat near their bed. This would let staff know if the person got up so that staff could go and support them.

The provider had effective plans in place in case of an emergency. For example, the local fire brigade had been out to assess the home and their plans to keep people safe. In addition, each person had a record of the help they would need to move to a safe area in an emergency.

People living at the home and their relatives told us that there was enough staff to support their needs. One person told us, "Oh yes, I think there's enough to care for me." Another person said, "As far as I'm concerned, there are enough on duty." In addition, while some people told us that the response to the call bell varied, especially at busy times, all the people we spoke with told us that their care was provided in line with their care plan and risk assessments. One person told us, "I get a regular check at night." Another person said, "They always pop in and out to see if I need anything." A family member commented, "[Name] has regular two hourly turns, being in bed all the time."

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people had completed application forms and the registered manager had completed structured interviews. The required checks had been completed to ensure that staff was safe to work with people who live at the home.

Good

Is the service effective?

Our findings

People told us they felt staff had the knowledge to look after them in a capable manner. One person said, "The nursing care is excellent. I enjoy the younger ones around us. They are full of sparkle. There's lots of courtesy towards the residents." A family member told us, "I think they handle [name] and the dementia well."

Staff told us and records showed that they completed a structured induction when they first started to work at the home. As part of the induction process staff were also observed giving care so that senior staff were confident that their skills supported person centred and safe care. On-going training was provided to ensure that all staff's skills remained up to date. Staff commented that the quality of training supported them to provide safe care. The training matrix showed that training had been delivered in line with the provider's plan.

Staff told us that they had regular supervisions with senior staff. They told us that the supervisions made them feel supported and that if they were struggling with anything they could request more training and if needed more frequent supervisions.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff had received training in the MCA and DoLS and had identified that some people living at the home may not have been able to make the decision about where they lived. The registered manager had completed applications for them to be assessed under the DoLS.

Where people were able to make decisions we saw they had been supported to do so and their decisions had been respected. People's ability to make decisions was recorded in their care plans. Where people may not have been able to make certain decisions we saw that their ability to understand the information was assessed. If people were not able to make a decision family, staff and healthcare professionals had been involved in making a decision in their best interest.

People were happy with the quality of food and were able to make choices. One person told us, "They offer us something different if we want. The food is fine though." Another person said, "I can pick about the menu for what I like, and ask. I'm quite a fussy eater. The tea is nice as they make their own cakes." A family member commented, "[Name] eats well here. It's all the things she fancies." Some people living at the home were vegetarians and the food offered to them supported their likes and dislikes. Each person had a food passport in the kitchen which listed their dietary needs and any allergies.

Where people were unable to eat safely they had been appropriately referred to a healthcare professional for assessment and advice. Where people needed a modified diet such as mashed or pureed food this was available for them and presented so that they had the same choices as everyone else. When people were unable to sustain a healthy weight, their food intake was monitored to ensure they were eating enough

food. Where this was not the case they were offered calorie rich food to increase their weight. If needed people were also referred to their doctor for nutritional supplements.

People told us they were able to access drinks whenever they wanted. One person told us, "I'm given lemonade and I've a jug of water in my room. We get fruit or crisps on the tea trolley too." Another person said, "When I have tea, I like it in a pot so they do that for me." A family member told us how their relative was not drinking a lot and that staff regularly went into them and encouraged them to have a drink.

People were supported to access appropriate healthcare professionals. One person told us, "I go out to the dentist and optician with my family." Another person said, "The doctor comes to do a regular check. The carers will take us out to the dentist but I have the chiropodist and optician here." A family member told us that staff were responsive to people's needs and would call the doctor if they had any concerns. A visiting healthcare professional told us that staff in the home worked as a team and knew the people living at the home and their care needs really well. They told us that staff referred people appropriately and that if the staff had any concerns they would contact healthcare professionals for advice.

Good

Is the service caring?

Our findings

Everyone we spoke with told us that the staff were kind and caring. One person told us, "They're all so friendly." Another person said, "I can't fault the staff." A family member commented, "They are very attentive." In addition, people told us that they got on well with the staff and were able to laugh and joke with them. One person said, "You can say what you like to them. We have a lot of banter." another person echoed this saying, "Everyone is really good. They tease the life out of me. I love a laugh."

Where people may not be able to verbalise their needs, staff knew them well enough to recognise if they needed care. An example of this was when a member of staff was supporting a person with their meal. The person kept turning their head away and moving around in their chair. The member of staff recognised that they were uncomfortable and took the person back to their bedroom. They returned to the dining room five minutes later and were offered a fresh dinner which they proceeded to eat.

We saw that lunch time was a pleasant experience for people. There was a menu on each table to support people to make choices about their lunch. However, we did note that the menu was printed in a font and colour which may not support people with vision impairment. People were able to personalise their lunch. For example, people were offered gravy in a gravy boat to put on their meal. In one dining room people did have a wait for their meals and people sitting on the same table were not always served their meal together which impacted negatively on some people's experience.

There were several lounge areas in the home and people could choose where they wanted to spend time. Staff told us that they worked across all areas of the home and so knew the needs of everyone. So if a person chose to spend time in another area of the home staff were aware of the support that they needed.

Staff explained how they encouraged people to be as independent as possible and to maintain or improve their abilities to care for themselves. People we spoke with confirmed that this approach had supported them to become more able to look after themselves. One person commented, "I just get on with as much as possible myself and they like to let me." Another person said, "I'm much more able nowadays than when I first came, so am encouraged to do as much as possible."

People told us that staff respected their privacy and dignity during personal care, and knocked before entering a room. One person told us, "They always knock, even with my door open." Another person said, "They shut my curtains for privacy. They always knock as well." We saw staff speaking respectfully to people and also knocking on doors before entering. We also saw curtains being closed and doors shut when personal care was being given.

People were able to make day to day choices about the care they received. For example they could choose their own bed times, clothing and where to spend their day. One person told us, "At 7.30pm they ask if I'm ready to put my nightie on. Then I'll ring at 9.30pm to say I'm ready to go into bed and have a hot chocolate." Another person said, "I do everything to suit me. I even make my bed, as I see it as therapy and keeping busy."

Good

Is the service responsive?

Our findings

All the people we spoke with told us that their family member had been involved in the care planning. One person told us, "My daughter comes in to do it all for me and has meetings." another person said, "My children do it all and check on things for me and my entitlements. They [registered manager] chat to me about my care plan and if I'm happy."

Records showed that people has been assessed before they moved into the home. This allowed the registered manager to be sure that they could meet people's needs. People also received regular reviews of their care to ensure that it was still meeting their needs. Care plans contained the information needed to support staff to understand people's care needs and to provide person centred care. Staff told us that they had time to read the care plans so that they knew people's needs and that any changes were discussed at the start of each shift. People told us that they felt their care was personalised to them. One person told us, "I get looked after very, very well. I couldn't moan about anything."

People told us that a range of activities was available and people could choose whether to participate. Outings were arranged and family participation was encouraged. One person told us, "I join in if I want to but prefer to be on my own. I read or play cards and watch TV. I've been on a few outings to places like parks and houses." Another person said, "We have a lot going on and I usually join in. I'm a great knitter of blanket squares. We can sit in the garden if we like. I've been on some outings but won't go for the sake of it as it stops someone going who might be really keen." A family member told us, "I get roped in to help as I'm here most afternoons. I like to see my wife enjoying herself too."

The provider had embedded activities into the heart of the care provided and believe that keeping people happy, active and entertained improved their overall health and wellbeing. We saw that there was a wide range of activities for people to take part in and during our inspection we saw that the activity co-ordinator encouraged people to participate in activities. In addition to the planned activities the staff asked each person living at the home to identify a magic moment that they wished to experience. This could be anything that the person wanted and staff worked to make these magic moments happen. An example of this was one person who wanted to go shopping in the local city. Records showed that they had a lovely day out.

People told us that they were happy to raise any concerns with staff but had not had any need to complain. One person told us, "Not once have I had to complain here." Another person said, "I'll raise any issue with staff and everything gets sorted out quickly." Records showed that any complaints made had been thoroughly investigated and resolved to the satisfaction of the person raising the concern.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager for the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.'

The provider had a system of audits to monitor the quality of care provided. We saw that concerns were identified and action taken to improve the quality of care that people received. However, we identified areas where the provider and registered manger had not ensured that the care records met current guidelines and the issues had not been identified through the quality audits. While there was no identified impact on the people receiving care following best practice guidelines reduces the risk of people receiving poor care. For example, records around wounds were not effectively managed, photographs were not labelled and did not contain measures to record the length of the wound. People's continence needs around catheter size and continence pad size were not consistently recorded. Best practice around the management of creams to keep people's skin healthy were not followed.

We recommend that the provider takes notice of the best practice guidelines for recording of wounds, the recording of continence care needs and for the management of topical medicines.

People living at the home told us that it had a good atmosphere. One person said, "It's a nice place and feels good." The registered manager was visible in the home. People living at the home and their relatives felt that they could approach the registered manager about any concerns they had. One person told us, "She comes around once a day to say hello usually."

Staff felt supported by the provider and registered manager and this was reflected in the way they worked together and supported each other. The deputy manager told us that the home never had any problems covering annual leave or sickness as staff were willing to work extra shifts. The deputy manager told us that the registered manager would listen to them and the staff and was always willing to support staff. Another member of staff told us, "The [registered] manager is very supportive, she backs us up and listens to us. We have a really good team here." Staff told us that they were supported with team meetings and that if they were unable to attend then the minutes were available to them.

The provider had developed an initiative called pacesetters. This was about ensuring that the home had a happy 'can do' culture. Members of staff were identified to receive training on improving the staff culture as this impacted on people's experience of care. They had five statements around the project which they were putting into their everyday working lives. These were, keep it simple, do it from the heart, make every moment matter, choose to be happy and sort it. All the staff we spoke with knew about the pacesetter initiatives and were keen to tell us how they were putting this into practice. For example, they had developed some values which were on display in the home to remind staff what was important to people living at the home.

People living at the home had their views about the care they received gathered to monitor the quality of care provided. A family member told us, "I have a questionnaire given now and then." A person living in the home commented, "We get a form at times, so we can say how we rate the place." Records showed that the provider had analysed the survey results and used these to improve the quality of care in the home.

In addition, there were regular residents' meetings people could choose to attend to discuss menu concerns and activities. One person living at the home told us "I've been to some of the meetings. We can speak up. If we don't, they won't know."