Cedar Care Homes Limited

The Orangery

Inspection report

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Date of inspection visit:
05 November 2019
06 November 2019

Date of publication:
04 December 2019

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service
The Orangery is a nursing home providing personal and nursing care to 40 people aged 65 and over at the time of the inspection. The service can support up to 40 people.

The Orangery is laid out over two floors, Azalea Wing, supporting people who require general nursing care and Gardenia Wing, supporting people who are living with dementia. Gardenia Wing includes a communal dining area and rooms are set out around the 'orangery', a glass roofed space used to accommodate activities. A smaller communal lounge is situated next to the nursing station. Azalea wing offers one large lounge that is converted into a dining space during meal times, when tables are pulled into the centre of the room. All of the rooms offer en-suite facilities and there are communal bathrooms and toilets available for people on both wings. A lift ensures people can access all areas of the home and there is level access to the garden from both floors of the building. The manager's office is situated adjacent to the communal entrance on the ground floor.

People's experience of using this service and what we found

People told us they were supported by staff who were kind and caring. We observed many kind and caring interactions between people and staff. Considerations were given to people's equality characteristics. Staff practice ensure people's dignity and privacy was respected.

People told us they felt safe. Risk assessments were in place and provided sufficient guidance for staff about how to protect people from potential harm. Staff we spoke with were confident about how they would identify potential abuse and actions they would take if abuse was witnessed or suspected. The home was clean and free from malodours. Medicines were managed safely.

The provider responded to complaints and concerns appropriately, relatives said they felt able to raise complaints and concerns. People received a responsive service that was personalised to meet their individual needs. Activities were available for people and the provider had recently employed an additional staff member to assist with activity provision. People with a disability or impairment were supported to access information that was relevant and important to them.

The provider ensured notifications were sent to the commission in line with statutory requirements. Staff were involved with a research project in partnership with a local university and national researcher. Links with the community included those with a local school and religious organisation. There was a person-centred culture and staff spoke about people in a person-centred and respectful way. Staff told us they worked as a team.

People's oral healthcare needs were not always assessed and people were not always supported to access dental check-ups in line with published guidance about best practice. People were supported to access

healthcare, however there was a risk people may not be supported to access the dentist as required. When fluid targets were in place for people who were considered at risk of dehydration, fluid charts did not always show staff were acting to improve the person's fluid consumption. However, we did not find evidence that people were dehydrated.

People's end of life care preferences were explored and the provider had received compliments from loved ones of people who had passed away about the care they received during the end of their life. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

We have made one recommendation about oral healthcare assessment and support.

Rating at last inspection Good (published May 2017)

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
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 The Orangery on our website at www.cqc.org.uk.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe. Details are in our safe findings below.	**Good**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our responsive findings below.	**Good**
Is the service well-led? The service was well-led. Details are in our well-Led findings below.	**Good**

The Orangery

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.

Inspection team
The inspection consisted of one inspector and one 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.

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

The manager was in the process of registering with the Care Quality Commission.

Notice of inspection
The first day of the inspection was unannounced, the second day was announced.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service and five relatives about their experience of the care provided. We spoke with eight members of staff including the provider, registered manager, chief operating officer, named carers, care workers and the activities coordinator.

We reviewed a range of records. This included ten people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, quality assurance audits and checks.

After the inspection
We continued to seek clarification from the provider to validate evidence found. The provider sent us a copy of the oral healthcare audit they completed after our inspection.

Good

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 good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe and relatives confirmed this. Comments from people included, "I do feel safe but for no particular reason – I think it's just knowing that someone is there if you need them" and one relative said, "I do feel [relative's name] is safe – I couldn't leave them if I didn't know they were safe."
- Staff spoke confidently about how they would identify potential abuse and told us what actions they would take if abuse was witnessed or suspected. Comments from staff included, "Abuse? If you see it, first stop it and check they [the person] are ok. Separate and report. I would report to the manager or the nurse in charge. [There are] many types of abuse, but it could happen between residents, carers and residents - it could be physical or psychological - if you see something report it".
- Staff told us they would escalate their concerns if they felt the manager was not responding appropriately to safeguarding information. For example, one staff member said, "If the manager didn't do anything, I would report to the area manager, then head office and then the local authority."
- The provider made referrals and worked with the local safeguarding team when it was appropriate.

Assessing risk, safety monitoring and management

- Risk assessments were in place and these included guidance for staff. For example, one person was assessed as being at risk from falling, the guidance for staff included to ensure the person was wearing their glasses and that they were clean and unbroken.
- Environment checks were completed daily to ensure people were protected from avoidable harm. Checks included those on equipment people were using, such as specialist beds and wheelchairs.

Using medicines safely

- Medicines were managed and stored safely.
- Information relevant to the administration of medicines was available to staff. For example, how a person preferred to take their medicines, allergies and details of the person's GP.
- The provider was working with the local pharmacy to improve the protocols for 'as required' (PRN) medicines.

Preventing and controlling infection

- The home was clean and free from unpleasant odours. One relative said, "One of the nicest things is the home is very clean and pleasant."
- Staff wore personal protective equipment (PPE) including gloves and aprons.

Learning lessons when things go wrong

● Learning from other services within the organisation was used to drive improvement at The Orangery. For example, people's manual handling assessments had recently been reviewed and updated in response to findings at another home.
● The provider reviewed accidents and incidents as a way of identifying themes and trends and preventing a recurrence.

Staffing and recruitment
● Staff were recruited safely. Checks included those with previous employers and the Disclosure and Barring Service (DBS).
● The provider used a staffing dependency tool to determine the numbers of staff required in relation to individual needs, for example the assistance people needed to mobilise. The tool was reviewed monthly and when there were changes, including when new admissions moved into the home. The staffing rota we reviewed showed staffing levels were maintained according to this assessment.
● We received mixed comments about staffing levels in the home. Comments from people included, "'Staff drop in occasionally, but they are so busy there's no time to stay and talk" and one relative said, "We could do with extra carers at times – there can be a wait or just no one around at times. Weekends can be difficult." Comments from staff included, "We have enough staff to meet the needs of people" and, "[We have] enough staff to meet the needs [of people], the mornings can be busy, afternoon is quieter and we get time to talk to people."
● When staff absence did occur, the provider worked with staff from local homes in the organisation. The manager told us this helped to ensure people were cared for by staff who knew people's needs and who people were familiar with.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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 effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support

- Oral health care-plans were not completed in line with published guidance about best practice and there was limited information available to staff about people's oral healthcare needs. For example, oral health care-plans did not always include information about when the person had last visited the dentist or which dentist the person was registered with. There was no further evidence to show people had been asked if they required assistance to find a dentist.
- We discussed oral health care-plans with the provider during the inspection and found they had identified that oral health care-plans did not reflect current best practice guidance and were in the process of introducing a more comprehensive version. However, sufficient progress had not been made and at the time of our inspection only five of the re-designed oral health care-plans were in the process of being completed, none of which were complete.
- There was a risk that people may not be supported to access routine dental care. Published guidance about best practice recommends people should be offered the opportunity to have a 'dental check-up' when first moving into a home, however people were not always offered this opportunity. This meant the dentist could not then direct the person about the frequency of future dental check-ups.

We recommend the provider review published guidance about best practice in relation to the provision of access to, and assessment of, oral healthcare in care settings.

- We did see evidence that the provider made referrals to the dentist when concerns were identified. For example, when one person's dentures were damaged.
- The provider contacted us after the inspection and told us they had completed oral healthcare assessments for all those who consented and were in the process of registering people with local dentists.
- Overall assessments reflected the needs and choices of people and provided guidance for staff about how to ensure people's needs and choices were met. For example, one person could become distressed when being supported with personal care. Their care-plan said, "Talk to [person's name] calmly and with soft tone of voice while explaining the procedure."
- People were supported to access healthcare when it was required, this included the GP and local mental health team.

Supporting people to eat and drink enough to maintain a balanced diet

- During the inspection we observed people being supported to drink, offered drinks and people had jugs of

squash or water available to them. However, when people had fluid targets set because they were identified as being at risk of dehydration, the records did not always show actions had been taken to increase the person's fluid intake.

● We spoke to the provider about our concerns regarding fluid monitoring. The provider told us they were in the process of discussing how fluid monitoring forms could be re-designed to reflect a more risk-based approach, for example looking at how much fluid intake was usual for the person and factors that may impact on fluid consumption.

● We were not concerned that people were dehydrated and saw evidence that healthcare professionals, including the GP had recently visited the people we identified.

● The provider contacted us after the inspection and told us they had liaised with the GP who was not concerned and advised that, "Due to [the] resident's frailty and advanced dementia, the [fluid] target was not realistic and achievable."

● People were supported to eat enough to maintain a balanced diet and people told us they enjoyed the food. Comments from people included, "I enjoy the food and [relative's name] who has stayed to lunch told me they liked the food too. Mostly it is the sort of food I would have."

Staff working with other agencies to provide consistent, effective, timely care

● Staff worked with external healthcare professionals and organisations effectively. For example, the diabetic nurse, speech and language therapy team and physiotherapists.

● When a person became distressed after the chair they were using was no longer suitable for their needs, staff worked with the occupational therapist to ensure the person had a new more appropriate chair. The manager said, "This resulted in the person getting a suitable chair which helps to improve quality of life and comfort."

Adapting service, design, decoration to meet people's needs

● The manager told us there were plans to improve the environment for those living with dementia. This included working with families to personalise doors with numbers and photographs relevant to the person living in the room.

Staff support: induction, training, skills and experience

● Staff told us they were supported to access training relevant to people's needs. Comments from staff included, "[There is] plenty of training but also I can go and speak to [clinical lead's name] who is a good source of information" and, "[The provider] has a nice policy - when the new starters [new staff] come they have a very good induction."

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being

met.

● Staff spoke confidently about how they applied the principles of the MCA in practice. Comments from staff included, "Assume capacity, people can make bad decisions, empower people to do as much as they can for themselves, take the least restrictive" and, "Encourage people to make their own choices."

● Decision specific capacity assessments were completed and decisions were made in the person's best interests.

● DoLS authorisations were applied for in line with guidance and the law.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now remained the same.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us they were supported by staff who were kind and caring. Comments from people included, "I get so frustrated at not being able to move about but the staff are very understanding" and, "The carers are so kind making time for you even though they have so much to do". One relative said, "It doesn't feel like a care home – it's first rate – the general care is excellent!"
- People's equality characteristics were recorded and the service they received was tailored to meet those needs. For example, one staff member told us how they supported one person to attend a religious organisation. They said, "One [person] likes to go to the church - that's one of my favourite things."
- Staff spoke about people in a kind and caring way and worked to improve people's lives. Comments from staff included, "Never had to report abuse, we are not here to abuse these people - our job is to look after the resident, to make them happy and to be happy together."

Supporting people to express their views and be involved in making decisions about their care

- The provider had recently introduced the 'extra mile', an initiative that involved staff speaking with people about what they would like to achieve. Staff spoke passionately about this initiative. One staff member told us the provider had purchased a new photograph album and staff had assisted the person to fill the album with pictures that were important to them.

Respecting and promoting people's privacy, dignity and independence

- We observed staff treating people in a dignified way. For example, when one person soiled themselves the staff assisted the person to leave the lounge discreetly and reacted calmly to the situation.
- One relative said staff treated their loved one in a dignified way in difficult circumstances. The relative said, "I think the care is good – they always treat [relative] nicely in spite of [their] bad moods."
- People's privacy was respected. We observed staff knocking on people's doors before entering.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's preferences and choices were recorded in their care-plans. For example, one person's care-plan recorded they liked to have a daily wash and a weekly shower.
- People were supported to retain choice and control of their lives. One relative said, "One carer has taken particular interest in [relative's name], enabling them to grow a beard and moustache and now keeps it trimmed for them."
- When people were unable to communicate their choices and preferences, the provider worked with the person's loved ones to investigate them. One relative said, "As [relative's name] has difficulty communicating, the family were involved and helped to choose food he likes."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People with a disability or impairment were supported to access information that was important and relevant to them. For example, the menu offered pictures of food available and staff were available to explain and communicate information when it was appropriate.
- Care -plans included guidance for staff about how they could help people to better communicate and understand information. For example, one person's care-plan said, "Speak a little louder in a calm manner, using simple language and giving plenty of time to respond. Maintain eye contact when communicating."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- There was a programme of activities and events that people were supported to access, these included bingo and games. External entertainers visited the home, for example to engage people with music.
- The provider had recently employed an activities assistant to increase the number of staff dedicated to activities provision.
- The provider welcomed visitors into the home and there was guidance for staff to make visitors feel, "Welcome." Relatives were supported to maintain their relationships by being involved with their care. For example, one relative said, "I like to come and help [relative's name] eat as it is about the only thing I can do to help them – it allows me to fee useful, but I know that if I can't come then staff will assist [relative's name] and not just leave [them] to struggle."

Improving care quality in response to complaints or concerns

● Relatives told us they felt comfortable to complain and were sure their complaints and concerns would be dealt with seriously, one relative told us staff had acted to address their concerns. Comments from relatives included, "I haven't had to make a complaint but I know staff would take time and listen if I had a concern" and, "I did have a concern a little while back but staff listened and took action to rectify it."

End of life care and support

● People's end of life care preferences were explored when they moved into the home.

● The provider had received compliments from the relatives of people who had received care towards the end of their life. One compliment said, "I wanted to take this opportunity to say how all of you became an extended family to us. The compassion, care and understanding you showed [person] comforted us all knowing [they were] in safe hands and being looked after. I cannot thank-you enough for this and will be eternally grateful."

Good

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 remained the same. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

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

● Staff spoke about people in a person-centred way. Comments from staff included, "The residents [people] are the best thing about working here, it's what makes me want to come to work" and, "Leaving and knowing I have made someone's day makes me feel good". One relative said, "Staff have a very good knowledge about individual residents and it is well documented too."

● Staff said they worked as a team to support people. Comments from staff included, "We are a good team, we are working well" and, "We are a team and support each other."

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

● The provider offered people and staff opportunities to provide feedback about their experiences and suggestions to help drive improvement. These included annual surveys covering various topics such as activities provision and the environment, a suggestions box and through conversation. All staff were invited to attend quarterly staff forums facilitated by members of the senior management team.

Continuous learning and improving care

● The provider was working with a local university and national researcher to support students through nursing qualifications, this included the provider undertaking and recording observations of performance and feeding this information back to the participants and university.

Working in partnership with others

● The provider was building links with the local community, including a local school and religious organisations.

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

● Notifications were submitted to the Care Quality Commission (CQC) as required. All services registered must notify the CQC about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled.

● Overall quality assurance systems, such as audits, were used to identify issues, errors and omissions and actions were taken to rectify these. For example, checks identified that one person did not have a current

care-plan. We checked if this had been acted on and found an up-to-date care plan in the person's file.
● Audits and checks had not identified that when people failed to reach their target fluid intake actions were not always taken to review and amend the target or improve consumption.

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
● The provider was aware of their responsibility to act in an honest and transparent way when things went wrong.