Cedars Castle Hill

The Cedars Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10 March 2016. It was carried out by one inspector.

The Cedars Nursing Home provides nursing, personal care and accommodation for up to 31 people. There were 30 people living there at the time of our visit some of whom were living with dementia or other mental health conditions.

There was 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.

There was a system for assessing people's level of dependency in order to calculate the correct numbers of staff needed to provide the right level of care for people. The systems manager told us that the staff rostered for the day of our inspection was correct based on people's assessed needs. However staff and healthcare professionals told us there was not always sufficient staff to meet people's needs.
There had been staff changes and new staff had been recruited. There was some use of agency staff to cover gaps in the duty roster. The registered manager told us they had recruited two activity staff so that care workers would remain on the roster to provide care for people. Staff told us that during our inspection some people had a delay in receiving personal care.

People's risks were assessed and care plans developed to minimises their risks. One person, who was at high risk of skin damage because of a medical condition, developed a wound. The person was referred to the tissue viability team and their care plan was reviewed. Their care plan was updated as necessary.

Some people remained in their rooms to have their meal and some people stayed in the lounge. Most of the people who stayed in the lounge were sat in an armchair with a small table in front of them. The meal time was not a social experience for people. We saw staff standing when supporting some people with their lunch and one person was asleep with their meal in front of them. Another person who was in their room alone had their pudding in front of them untouched an hour later.

People had personalised care plans which included their likes and dislikes however this was not always reflected in the care people received. One person's care plan stated they liked to go to the lounge. We saw they had gone to the lounge four times in one fortnight period. We spoke with staff about this they told us the person sometimes got agitated in the lounge however their records did not demonstrate if the person had been offered a choice.

There was an activity calendar which included room visits each day. They were for people who were unable to attend the lounge. Staff completed a room visits diary however we saw there were some gaps and staff were unclear if room visits had taken place on those days. There were a variety of activities which people

could participate in, these included quizzes, exercise to music and poetry. On the day of our inspection there was a fitness instructor who provided exercise to music for an hour in the afternoon.

There were systems for monitoring the quality of the service. When there was a quality check which identified the service was not meeting an acceptable standard, actions were taken. We identified some gaps in recording in peoples fluid charts and charts to record if people had their cream applied, the quality checks had identified these gaps and the deputy manager was able to tell us what actions they had taken to make improvements.

People were treated with respect and their privacy was maintained. Staff responded positively to people and used appropriate non-verbal communication skills to demonstrate they were listening and attentive to people.

Concerns and complaints were managed appropriately. There was a complaints policy and we saw complaints were resolved within the times specified.

The service maintained links with the community, such as they held regular coffee mornings and a twice yearly friends and family forum.

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. Staff did not consider there were enough staff to meet people's needs in a timely and individualised way.

People's risk were assessed and plans developed to minimise risks.

Medicines were stored and administered safely.

Staff were aware of how to identify and respond to actual or suspected abuse.

Is the service effective?

Requires Improvement

The service was not always effective. Some people did not receive support with their meal in a dignified and timely way. Meal times were not a social experience.

The manager had made appropriate DoLs applications to the local authority

Staff received appropriate training, supervision and an annual appraisal.

People had access to healthcare when they needed it.

Is the service caring?

Good

The service was caring. People were cared for by staff who treated them kindly.

People's privacy was respected

Is the service responsive?

Requires Improvement

The service was not always responsive. People had personalised care plans which identified likes and dislikes. However one person was not always supported to go to the lounge which was identified as something they liked.

The room visits diary was not always completed and staff were

unclear if people had received a room visit on these days.

People and their family were asked for their views about the service

Is the service well-led?

Good

The service was well led.

There was a system of quality monitoring checks.

Staff told us management were open and approachable.

There was a culture of learning from accidents/incidents.

The Cedars Nursing Home

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 10 March 2016; it was carried out by one inspector and was unannounced.

Before the inspection, the provider completed a Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications we had received from the service. A notification is information about important events which the service is required to send us by law.

We spoke with four people, three people's relatives and a visitor. We also spoke with nine staff which included the registered manager, the home manager, the systems manager, the deputy manager, a registered nurse, four care workers and the cook. We looked at four care records and five staff files. We also spoke with three healthcare professionals and contacted a representative from the local authority. We saw four weeks of the staffing rota, the staff training records and other information about the management of the service.

We used the Short Observational Framework for Inspection (SOFI).This is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe. Staff did not consider there to be enough staff. Some staff told us there were not always enough staff to provide the care that people needed. One member of staff told us "People were left longer between hygiene care." Another member of staff told us that no one had received a shower that morning and that some people were late receiving continence care. The registered manager told us people had not received a shower as they were waiting for a delivery of a new shower sling. One member of staff felt the impact of there not being enough staff was that people received care that became "institutionalised." They told us they felt rushed when supporting people and felt care became task orientated. Other staff confirmed this was their experience.

There was a system for planning how many staff were required to meet people's needs. People's dependency levels were reviewed on a weekly basis and this information together with how many people were living in the home formed the basis for calculating how many staff were needed on each shift. During our inspection there was two registered nurses one of whom was the deputy manager. The care workers were allocated to either the top or bottom floor and one was described as a "Floater." One of the care workers had a dual role and worked as a care worker up until 11.00 then they switched to become an activity coordinator. The activity coordinator told us that the care worker who was allocated as the floater had responsibility for providing people with room visits in order to offer them an activity or social time. This meant there were seven care workers until 11.00 which then dropped to five care workers to support people with personal care. Feedback from staff was that the roster was not planned sufficiently to provide people with the care and support they needed. We spoke with the registered manager who told us they had recruited two activity staff. They would be additional staff and it meant care workers would be on the roster to provide the care and support people needed and activity staff would be responsible for providing people with one to one time in their rooms or organising group activities in the lounge.

We spoke with the management team about staff comments that there were insufficient staff and the impact it had on care that morning. They were surprised that staff had not spoken with them and told us they would have been able to support staff to provide the care that people needed. The registered manager told us recruitment was challenging and they used various strategies to recruit sufficient staff. They had a number of staff leave in the last 12 months and had recruited to vacant posts. They were waiting for recruitment checks to be completed on two applicants and others had started. The registered manager told us that with staff vacancies and new staff starting there was an impact on the service. A health and social care professional described staffing "The registered nurses appear to be few and stretched and given the overall dependency, agency nurses are used." A relative told us they did not think there were always enough staff particularly at weekends, they told us the lounge area was often empty and people were in their rooms.

There was some use of agency staff to cover some shifts, which the home manager told us would reduce as new staff started. The home manager told us they were always recruiting bank staff. Staff were recruited safely. The provider ensured all the necessary checks were carried out prior to the applicant starting work, for example references were obtained and relevant criminal records checks were completed.

People's risks were assessed and plans were developed to ensure their risks were minimised. A variety of risks were assessed which included, risk of falls, skin damage and risks associated with food and drink. One person was identified as having developed skin damage, they had been identified at risk and there was a plan in place which included four hourly repositioning and use of a pressure relieving mattress. Once the staff had identified the person had developed skin damage they took appropriate action which included photographing the sore and referring the person to the tissue viability team. The persons care plan was reviewed and the frequency of repositioning them was amended. This meant that staff assessed and monitored risk and amended care plans to ensure that people's risks were safely managed.

People received the correct medicines at the correct time. When a medicine was administered, the registered nurse signed the Medicine Administration Record (MAR).There was a system in place to highlight if staff had not signed the MAR as required so that it was rectified. This meant that people received their medicines as prescribed. Staff were trained and had a competency assessment to ensure they were safe to administer medicines. Medicines were stored appropriately and at the correct temperatures. The MAR were clear and legible and we saw the registered nurse remained with people and gave them a drink when administering their medicines.

People told us they were safe living in the home. One person said, "I feel much safer here than I would on my own." Health and social care professionals told us the home was a safe place for people to live. People were at reduced risk of abuse. Staff had received training in safeguarding vulnerable adults and were able to describe to us how they would recognise abuse. Staff were aware of the correct processes to follow in order to report abuse, including how to report concerns about poor practice. Staff were aware of whistleblowing procedures.

There were systems for ensuring the home was well maintained. There was a schedule which indicated when relevant checks were due and when they had been carried out, such as checks on electrical equipment and water temperatures.

Requires Improvement

Is the service effective?

Our findings

People did not always receive an effective service. Some people stayed in their rooms to eat their lunch, we were told this was their personal choice. One person was able to confirm they had chosen to remain in their room however other people we asked were not able to converse with us about their choices. There were seven people in the lounge area for lunch with one person sat at a dining table. People were not asked if they would like to go to the dining area instead they had a small table put in front of them. One person struggled with the small table and put their plate on their lap, they were able to eat independently however the plate was tipping to one side. This meant that people were not offered a choice of moving to the dining area to eat and to have the opportunity of sitting in a social situation during their meal.
Other people in their rooms were at varying stages of the meal time experience. As we walked around we saw one person asleep with their meal in front of them. This meant their food was at risk of being cold. Some people needed support from staff to eat their food, we saw two occasions where staff were standing while supporting people with their meal. One person was in their room with the door closed; they had finished their meal. Food was seen on their clothes. We checked on them again and they had been supported to be cleaned however their pudding remained untouched over an hour later. This meant that two people who remained in their room did not get the support they needed when their food arrived. Two people were not supported to eat their meal in a dignified way.

There was a choice of two hot meals at lunch time. The cook told us people could have what they liked at breakfast and we saw some people had a cooked breakfast. There was a list of people's special diets, likes and dislikes in the kitchen. The cook told us they had worked in the home for a number of years and had got to know people well and knew what they preferred. They planned menus in advance based on seasonal influences as well as what people enjoyed. Although people were offered a choice of their main meal we saw people were all given the same cold drink at lunch without being asked. People looked like they were enjoying their meal and when asked we were told the food was hot. Two people told us the puddings were very good.

Some people had a poor appetite, needed encouragement to drink and had lost weight. Staff were aware of who needed to be monitored and there were measures in place to check people's food and fluid intake. The deputy manager told us that they had introduced weekly weighing for some people and had commenced food charts so that if a person had a poor appetite staff knew what they had eaten. Staff had calculated how much to drink each person should have a day and staff recorded when a person had some. The amounts were added up each day and if a person did not have enough to drink this was discussed. The deputy manager told us they would allocate a member of staff to the person to encourage them to drink small sips more frequently. However if there was a risk of the person becoming dehydrated they told us they would seek medical advice. They had also introduced smoothie drinks for some people who needed additional nutritional supplements and staff told us they offered these when providing refreshments.

People had access to a range of healthcare when they needed it. Some people received input from a variety of healthcare professionals such as community mental health nurses, the GP and the Speech and Language Team (SALT). We saw recommendations were clearly documented. For example, one person had been seen

by a physiotherapist who gave specific instructions on how the person was supported to walk. Healthcare professionals told us staff referred people appropriately and followed recommendations. One healthcare professional told us staff were "very receptive." They told us staff recognised when people had deteriorated in health and referred people appropriately for healthcare.

People received care and support from staff who had the appropriate skills and training. Staff told us they had received sufficient training to carry out their roles. They had essential training in subjects such as health and safety, food hygiene, fire safety and safeguarding adults. Registered nurses received additional training in clinical skills such as catheterisation. There was a colour coded system for recording what training staff had completed and when they were due to repeat it. If it was flagged as amber staff knew training was due or if red it was overdue.

New staff completed an induction, which one new member of staff told us was "very good, very detailed." It consisted of completion of an induction booklet, some on-line and practical training as well as shadow shifts. The manager told us the induction was tailored to individual staff and took into account past experience. Staff who were new to working in a caring role were enrolled on the care certificate. This is a nationally recognised industry specific training for staff with no previous caring experience.

Registered nurses were required to revalidate their professional registration with the Nursing and Midwifery Council (NMC). The service had made arrangements to support nurses through this process and were monitoring to ensure all nurses had up to date validation.

Staff received supervision four times a year and this was monitored by management. Supervisions were up to date and all staff had either had an annual appraisal or were booked to do so by the end of March 2016. Staff confirmed they received supervision although could not always tell us who provided them with supervision. They told us that they were encouraged to do further training during their appraisal. One member of staff told us about specific training they had identified. They were waiting for confirmation that this had been organised.

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 by 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service had made appropriate DoLs referrals to the local authority for some people to be assessed and were waiting for these to be completed.

Where appropriate staff had completed mental capacity assessments for specific aspects of care, although we saw some of these were dated 2013. For example one person was assessed as having capacity to consent to bed rails which was dated 2013; the care plan stated they could use a call bell to summon assistance. However a note was added in the care plan (date unclear) to say that they had put the call bell around their neck, the call bell was removed for safety reasons. It was unclear if the person continued to have capacity to consent to bed rails. We spoke with the management team about this; they told us that as part of their improvement planning they were reviewing how they developed and reviewed care plans. The registered manager told us they were currently researching electronic care planning and would be discussing options with the trustees.

Staff told us they checked with people before assisting them with personal care. Some people were unable to verbally agree to staff help and their care plans indicated that personal care was provided in the person's best interests. Staff told us that they encouraged people to make choices whenever they could, for example by offering people a choice of two items of clothing. Some people were sometimes reluctant to agree to help with personal care, staff told us they would give the person time, or try to distract them. One member of staff told us that one person "Calms down to music," so they would put the radio on during care.

Good

Is the service caring?

Our findings

People were cared for by staff who were kind and considerate. Staff approached people warmly and there was appropriate use of humour. We saw staff engaging with people positively, for example staff were sat with individuals painting their nails. Staff talked with people as they were passing and when they approached people to support them with personal care. We received positive feedback from people and relatives, such as; one person said "They are a very nice crowd." Another person told us "Staff treat me well." One relative told us, "They are considerate and caring." A healthcare professional told us "Staff are patient."

During the SOFI we saw staff engage positively with people. We saw staff talking with people on a one to one and using appropriate use of body language, such as eye contact and touching one person's hand. This meant that staff were using other ways of communicating with people as well as talking. We also observed staff using humour appropriately and being attuned to people. For example one person was laughing and smiling, they were unable to articulate how they were feeling but staff responded by smiling with them. Staff initiated conversations with people using examples of subjects relevant to them, such as one person loved to dance, staff were conversing with them about that.

One person told us they had everything they needed and felt they could express their views to staff. Relatives told us they had not been invited to formal reviews however they would talk with staff if they had any suggestions about the care and support that was being provided.

Staff were respectful of people's privacy and dignity. People were supported with personal care discreetly such as staff ensured people's doors were closed. Staff told us they closed curtains and ensured people were covered during personal care procedures.

Staff spoke with us positively about their work. One member of staff was especially proud of how they provided end of life care. The home was accredited with beacon status with Gold Standards Framework in Care Homes (GSF).This is a nationally recognised award which supports the high quality of care provided for people at the end of their life.

Requires Improvement

Is the service responsive?

Our findings

People's likes, dislikes and preferences were recorded in their care plans. In one person's care plan it stated they liked to spend time in the lounge. During our inspection they remained in their room. We asked staff about this and were told that they had either chosen to stay in their room and/or they became agitated if they were surrounded by too much noise. We checked their daily notes during one fortnight period they went to the lounge four times, it was unclear in the person's records if they had been offered the choice to go to the lounge or if they were too agitated to go. This meant the records did not demonstrate the person was being supported to do things they liked.

People, who were able, could join in activities which were organised by staff. There was an activity calendar, which included room visits and group activities, such as daily news, poem reading, ball games and movie afternoons. Sometimes an external person was booked to lead an activity. Such as, during our inspection there was someone doing exercise to music and the previous day there had been someone playing a ukulele. Some people were unable to visit the communal lounge and spent their day either in bed or sat in their rooms. Room visits were scheduled for one hour in the morning and afternoons. There was a room visits daily diary, we saw there were some gaps when staff had not recorded that room visits had taken place, such as the 7, 8 and 9 March 2016. We raised this with staff, they were not clear if room visits had taken place or not. This meant the records did not demonstrate if people had received a room visit. There was also an activities diary which staff completed as a record of which activities had taken place in the communal lounge. This was mostly completed and there was a record of how many people had been in the lounge and what activities had taken place. There were volunteers appointed who arranged some activities such as flower arranging or they did room visits.

Staff told us they reviewed peoples care plans on a monthly basis and we saw where reviews had taken place. Relatives were unaware of the review process however one relative told us they could talk with staff about their loved one. One relative told us the registered manager had told them that they would be invited to any future reviews.

The registered manager told us they have different ways of gathering people's view on the service. There was an annual questionnaire which people or their families could complete, although the registered manager told us the form was mainly in a tick box format and they were in the process of developing an alternative form. Some changes had been made as a result of feedback received, such as people could now choose the colour of their room and bring in their own furniture. There was also an online feedback form via an external website; information about this was on display . They also told us they have six weekly coffee mornings in which people and their families were able to talk with staff informally.

Concerns and complaints were managed appropriately. Staff told us they responded to concerns as they arose to avoid them being escalated into a complaint. We saw when there had been a formal complaint the registered manager had conducted an investigation and responded to the complainant. There was a clear audit trail of what actions had been taken and what the outcome was.

Good

Is the service well-led?

Our findings

The service was well led. There was a system for quality checks within the home . This included daily checks such as room temperature recording, although most were monthly. Such as, monitoring of the frequency of people's falls, repositioning charts, people's fluid charts and charts to record if their cream had been applied as prescribed. Results were collated monthly and were rated according to how well the service was meeting the accepted standard. When the service was not meeting the accepted standard it was referred to as non-complaint and there was an action plan to address the issues. For example during our inspection we saw there were some gaps in charts which staff were required to sign when they had applied a person's cream. We also saw gaps in people's fluid charts. The monthly audits had identified these gaps and there was an action plan to address both these areas. The deputy manager told us they had talked with staff and had advised them to record when they offered a person a drink even if they declined.

There was a clear management structure which included the registered manager, a home manager and a newly appointed deputy manager who had been in post three weeks. A systems manager was responsible for drafting the duty roster. There was a registered nurse on each shift with either a team leader or supervisor.

The registered manager told us the home was going through a period of change which had impacted some staff. Staff were adjusting to changes within the team, such as staff leaving and new staff starting, as well as plans from the management team to introduce changes to how people received care. For example the deputy manager had introduced some new recording charts.

There was a care committee which had been set up as a sub group of the board; its purpose was to review internal procedures and to undertake unannounced checks on the service. The care committee monitored quality during their meetings and ensured actions had been completed, such as risk assessment had been needed for anti- bacterial gel which was being used.

The service maintained links with the local community. There was a family and friends forum which was held twice a year in a community setting. Members of local community groups, friends and families were invited to attend the forum. A local church provided services to people within the home and one person was supported to attend the church.

Accidents and incidents were reported in accordance with the service policy. There was a culture of learning from accidents and incidents. For example during an emergency situation a person's medicine was used for another person. Learning actions from this included ensuring that all people had their own emergency medicine prescribed and kept in stock.