Cedar House Company Limited

Cedar House

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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 7 June 2017 and was unannounced. At our last inspection in December 2015 the service was rated 'Good'. At this inspection the service has been rated as 'Requires Improvement'.

Cedar House is a privately owned care home for older people in Enfield. The home is registered to accommodate 17 older people, most of whom are living with dementia.

There was not a registered manager in post at the time of this inspection. 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.

People told us that there were not enough care staff to meet all their needs. Staffing levels were not being calculated based on peoples' level of dependency and current assessed needs.

Parts of the home were not cleaned to a satisfactory standard and infection control procedures were not always being followed appropriately.

There was not a satisfactory management structure at the home and it was often unclear to people who was in charge. Relatives and health and social care professionals had concerns about effective communication between themselves and management.

People using the service told us the quality of meals was not always of a satisfactory standard.

Staff were not always able to provide sufficient, meaningful activities for people who used the service.

Although most staff were up to date with their training requirements, all staff needed to undertake dementia awareness training as most people at the home were living with dementia.

There were systems in place to make sure staff were safely recruited and received regular supervision.

People told us they felt safe at the home and risks to people's safety and been identified, acted on and,

where possible, were being reviewed with the person.

Staff knew the signs to look out for that may indicate someone was being abused and they knew who to contact if they thought anyone was being abused.

There were systems in place to ensure medicines were handled and stored securely and administered to people safely and appropriately.

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 service supported this practice.

People had access to healthcare professionals such as district nurses, doctors, dentists and dieticians.

Staff understood that people's diversity was important and something that needed to be upheld and valued.

People knew how to raise any concerns or complaints about their care and treatment at the home.

People were asked about the quality of the service and had made comments about this. These comments had been included in an overall improvement plan for the home which senior managers were working on.

We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to staffing levels, infection control and good governance. You can see what action we told the provider to take at the back of the full version of the report.

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.

The registered provider could not be assured or evidence that there were always enough staff to meet the needs of people using the service.

Infection control practices were not being consistently applied or followed at the home which was putting people and staff at risk.

Staff were aware of their responsibilities to keep people safe from potential abuse.

There were systems in place to ensure medicines were handled and administered to people safely and appropriately.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always have the knowledge and skills necessary to support people properly and effectively.

Staff understood the principles of the MCA and knew that they must offer choices to people around making day to day decisions about their care.

Not everyone enjoyed the food provided at the home. This had been identified by senior management who were working to improve the quality and variety of food provision.

People had access to healthcare professionals such as district nurses, doctors, dentists and dieticians.

Is the service caring?

Good

The service was caring.

We observed staff treating people with respect and kindness.

Staff knew about the various types of discrimination and its

negative effect on people's well-being.

Staff respected people's privacy and people told us they had input into their care provision.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People using the service and their relatives were not always satisfied with the amount of activities provided at the home.

People told us that the management and staff listened to them and acted on their suggestions and wishes regarding their care. People's care requirements were recorded and staff understood people's individual needs.

People told us they knew how to raise any concerns or make a complaint and we saw that complaints were taken seriously and investigated appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People who used the service and their relatives were unclear about the management structure which they told us had led to poor communication.

Staff were not always clear about who was in charge or who their line manager was.

The provider had systems in place to gain the views of people, their relatives and staff. People's views and concerns about their care were collated and incorporated into an overall improvement plan.

Cedar House

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 checked 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 unannounced inspection was undertaken on 7 June 2017. This inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This 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 reviewed the completed PIR and previous inspection reports before the inspection.

We also reviewed information we had about the provider, including notifications of any safeguarding or other incidents affecting the safety and well-being of people using the service.

We met with 12 people who use the service and asked them if they were happy with their care and if they liked the home and the staff who supported them. However, due to people's cognitive impairments, some of the conversations with people were limited and we were only able to say hello and ask how they were feeling. Because of this we spent time observing interactions between people and the staff who were supporting them.

We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people was having a positive effect on their well-being.

We spoke in detail with five people who were more able to give us their views. We spoke with six relatives and four social and healthcare professionals who had regular contact with the service.

We spoke with five staff, the acting manager, the area manager, the chief operating officer, the quality manager and two directors of the service.

We looked at five people's care plans and other documents relating to their care including risk assessments and medicines records. We looked at other records held at the home including staff meeting minutes as well as health and safety documents and quality audits.

Requires Improvement

Our findings

People we spoke with and their relatives told us they liked the staff but sometimes had concerns about staffing levels at the home.

One person told us, "The girls are lovely you know." Another person commented, "They haven't got enough staff no, they take a long time to assist me to the toilet, I need two staff for that."

Relatives told us that they had experienced times when staffing shortages had impacted on care provision.

A relative we spoke with said, "I don't think they have enough, whenever I come in [my relative] is always in the same position and we ask staff to sit her upright but they never do it." Another relative commented, "Staff are meeting people's basic needs okay. The issue here is holistic care people get. Staff do as much as they can to meet basic needs. But there's not much time for meaningful interaction. On occasions there hasn't been a full compliment."

We arrived at the home at 9:30am. There were three care staff on duty, one of whom was working in the kitchen as the cook was away. The staffing rota indicated that the acting manager was supposed to be on duty from 8am and the area manager was recorded on the rota as being on duty at 9am. We were informed by the area manager, who arrived at 10am that the acting manager had an appointment in the morning and would arrive later.

The staffing rota on the day the inspection did not reflect the staff who were on duty when we arrived or the number of staff who subsequently arrived at the home later that day.

One staff member told us, "I feel rushed." Another staff member told us, "It's very challenging, there are not enough staff." Some staff commented that staffing levels had reduced and staff also told us they did not always feel they were able to support everyone properly. We observed that some people at the home had not been supported to have their hair washed or their teeth cleaned.

Social care and healthcare professionals also raised concerns with us about staffing levels at the home. They told us they were worried that there were not enough staff to meet the needs of people, some of whom had complex needs because of their dementia.

We asked how staffing levels were assessed. We were informed that there were always at least three care

staff on duty throughout the day and two care staff on duty throughout the night. However, people's dependency levels were not being assessed based on their individual care and support needs. We were told that, as there were currently 15 people using the service, there were three care staff and when the home was full, meaning another two people bringing the total number of people to 17, then four care staff would be on duty. This staffing calculation was based on ratios of staff to people using the service rather than being based on staff meeting everyone's assessed needs.

This meant that we could not be assured that there were enough staff on duty to meet the assessed needs of people using the service.

The registered provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that there were areas of the home that were not cleaned to a satisfactory standard. These included a number of toilets, bathrooms and some people's bedrooms which were malodorous. A domestic worker was employed at the home for four hours a day, five days a week. At all other times staff were expected to clean the home.

One of the toilets on the ground floor, next to the lounge, contained a number of hairbrushes which had no names on them but were clearly being used to brush people's hair. When we pointed this out to the chief operating officer, who is the nominated individual for the service, he had them removed immediately.

Although we saw records of regular infection control audits, undertaken by the area manager, we identified a number of concerns during the inspection. We saw dirty light pull cords, soiled waste being put directly into the bin without being first sealed in a soiled waste bag and open bins of soiled waste in the garden.

The registered provider was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The chief operating officer told us that a thorough infection control audit would take place immediately and action taken to address the concerns we identified.

We checked medicines and saw satisfactory and accurate records in relation to the receipt, administration, storage and disposal of medicines at the home.

People we spoke with said they were satisfied with the way their medicines were managed at the home. One person told us, "Yes no problem at all." Another person commented, "I take some tablets which are allocated for me."

When we asked a relative about medicines management they told us, "Yes, she hasn't said anything about it being wrong, I think we are quite happy with it." Another relative commented, "Yes, as far as I know yes, she takes it alright and she knows what she is taking."

We saw records that staff who administered medicines had received medicine training. Staff told us they had undertaken an observed competency to check they were following correct policies and procedures.

However, we saw that some medicated creams were on a shelf in the toilet near the main lounge. When we pointed this out to the chief operating officer he had them removed immediately.

Most people told us that they trusted the staff and that staff were kind to them.

One person told us, "They are okay; I have no problem with staff at all." A relative told us, "They have a good attitude, doing their best to cope." One person told us about a particular staff member that they did not like because they said the staff shouted. The chief operating officer told us he was aware of this and that he was taking action to address the issue.

Staff could explain how they would recognise and report abuse. They knew that they could report any concerns to outside organisations such as the Care Quality Commission (CQC) the police or the local authority.

Staff we spoke with were able to tell us the potential risks to people in relation to their everyday care and treatment. These matched the risks recorded in people's care plans. We saw that risk assessments had been developed in relation to people's mobility, nutrition and pressure care management.

Environmental risk assessments, including a fire risk assessment had been completed and were accessible to all staff. Weekly fire tests and regular evacuation drills were being carried out. Risk assessments and checks regarding the safety and security of the premises were completed. Personal Evacuation Emergency Plans (PEEPS) had been completed for people that provided information on how to evacuate each person safely.

We checked a selection of five staff files to see if the service was continuing to follow appropriate recruitment procedures. Records showed the provider collected two references from previous employers, proof of identity, criminal record checks and information about the experience and skills of the individual. Staff members were not offered a post without first providing the required information to help protect people from unsuitable staff being employed at the home.

Requires Improvement

Our findings

We asked people if they thought the staff were well trained and good at their work. Responses were generally positive. One person told us, "They try their best, but of course some are better than others." Another person said, "Some are, some aren't, but I think they do try their best."

A relative commented, "I generally believe mum is in a good place." Another relative told us, "The majority of staff I can tell they are trained and good at their jobs."

However, some people we spoke with told us, "Now and then I don't because it looks like they have just hired the first people they found, and they haven't really selected anyone." A relative told us, "I don't feel a hundred percent confident because I feel like some of the staff aren't adequately trained and they cannot communicate properly with mum and also they do not explain or tell her what is going on." Another relative commented, "They try their best but they aren't well trained."

We checked training records and spoke with staff about the training they had undertaken. Records showed that most staff were up to date with their training and we saw a training plan in place for the rest of the year. Staff were positive about the training they had completed and confirmed they attended refresher training when required. One staff member told us, "Every year you learn new things."

The website for the home states that the service specialises in dementia care. However, not all staff, working at the home on the day of the inspection had completed training in dementia awareness. We spent time observing staff throughout the day. Some people were at times distressed and displaying repetitive behaviours. Staff were seen sitting down beside them and comforting by stroking their hands and gently speaking and reassuring them.

While there were times when staff were supporting people appropriately, we also saw examples where staff struggled to understand and respond to people living with dementia effectively. The chief operating officer told us that dementia awareness training would be prioritised.

Staff confirmed they received regular supervision and yearly appraisals and we saw records of these in their files. Staff told us that during these supervisions, performance and training needs were discussed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf for 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.

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).

The relevant policies and procedures in relation to the Deprivation of Liberty Safeguards (DoLS) were being followed appropriately and people had these safeguards in place and these were being monitored by the local authority.

Staff had received training in and understood the principles of the Mental Capacity Act and care plans made it clear to staff to make sure they always offered choices to people. One staff member told us, "People are not able to decide for themselves, we need to decide for them. Of course, even though they don't have capacity. We will still ask them."

We observed staff asking people for permission before carrying out any required tasks for them. We noted staff waited for the person's consent before they went ahead. People told us that the staff did not do anything they didn't want them to do. We asked people if staff sought their consent before supporting them. One person said, "Yes, they can't just do whatever they like." A relative told us, "I know they ask for permission."

People had mixed views about the quality of the food at the home. Comments about the food included, "You get choice but it's usually the same", "The food is alright, I like it", "Mum wants more variety in her food, because she's tired of having mash potatoes" and "The food isn't good enough."

The chief operating officer told us that they were aware there were on-going problems with catering. We were informed that, as the existing cook had not been working at the home for some time; care staff had been deployed in the kitchen.

On the day of the inspection two directors of the organisation arrived at the home and helped to cook lunch. This was spaghetti meatballs which looked and smelt appetising. People told us they really enjoyed this meal but the usual food provided was not of the same high quality.

One person told us, "That is the problem for me, we need better food and different variety, we had spaghetti today and I loved it."

Each person's personal records contained documentation of health appointments, letters from specialists and records of visits. We also saw evidence that following appointments, people's care plans were updated accordingly.

People told us that they generally had good access to health and social care professionals. One person we spoke with told us, "The doctor comes here every so often." A relative told us, "They are on top of it with the doctor." Another relative commented, "The doctor comes here, when it's an emergency they would call the ambulance, but for some reason the optician and chiropodist haven't come in yet."

We asked the chief operating officer to find out about routine visits by all healthcare professionals to ensure everyone had access to these professionals and received on going healthcare support.

Good

Our findings

People told us they liked the staff who supported them and that they were treated kindly. One person told us, "Yes, they are very caring; I have no problems with it." A relative commented, "Yes they are caring, as far as we know it yes." Another relative told us, "Staff are engaging. They seem gentle and caring with people."

We observed staff interactions with people throughout our inspection. Although staff were busy, particularly before lunchtime, we saw that staff were polite and friendly with people and people were responding positively to staff.

We saw that people or their relatives had commented and had input in planning their care and support, where possible, and where they wanted this input. We saw that care plans had been reviewed and updated where required and had been signed by the person or their family to indicate they agreed with the care plan. One person we were speaking with told us, "Yes I am [involved] and I always have been." Another person commented, "Yes in some ways, but it's difficult to say, nothing is explained properly at the moment."

We saw that people were able to express their views and make choices about their care on a daily basis. Throughout the day we observed staff offering choices and asking people what they wanted to do.

Staff told us they discussed people's cultural and spiritual needs and preferences with them and we saw this information had been recorded in people's care plans.

Staff understood equality and diversity issues within the service and told us that people at the home should not be disadvantaged in any way. Staff told us about people who used the service whose first language was not English and that some staff were able to communicate with people in different languages.

Staff gave us examples of how they maintained and respected people's privacy. These examples included keeping people's personal information secure as well as ensuring people's personal space was respected. One person told us, "They close the door behind, they are very professional." A relative commented, "Yes, they knock on [my relative's] door without fail, we usually spend more time in the room and they always knock."

Requires Improvement

Our findings

Staff understood the current needs and preferences of people at the home which matched information detailed in people's care plans.

Care plans included a 'family tree' and a section called 'who am I?' which contained information about the individual including a brief life history, daily choices and preferences.

People told us they had been involved in the development of their plans. Relatives told us that they had been involved where the person was unable to provide detailed information because of their cognitive impairment. Some people we spoke with could not remember if their care plan had been reviewed and some relatives told us they trusted the service to review their relative's care. One relative confirmed that that they had reviewed the care plan with a social worker.

People who use the service told us they wanted more opportunities for activities both in and outside the home.

People's comments about this included, "Very little activities, I think it's hard when people don't want to do any", "Well I like to watch TV, there is not much going on", "I get bored here to be honest" and "Not enough things to do, they [the staff] are so busy."

Relatives also wanted more activities to be provided. Their comments about this included, "I don't think she has enough things to do here and I am sure she's meant to do some exercise while being supervised with staff", "There is nothing to occupy my mum, she needs more motivation and encouragement from staff", "I have seen them a few times doing group activities such as sing-a-longs and stuff like that, but there are not enough" and "The activity coordinator hasn't been in for a while and she's here today."

The registered provider had employed an activity coordinator to provide activities for everyone at the home twice a week on Tuesdays and Thursdays. We met with the activity coordinator on the day of the inspection. We saw various activities being provided including board games and we saw that some people were having their nails painted.

A staff member we spoke with told us, "We usually have time in the afternoons. Some are still able to talk. Some have dementia. We sit and hold their hands, give a hand massage, nail painting. Some can read, we read together."

The issue of providing more meaningful activities had been identified as needing improving in February and had been included in the most recent improvement action plan.

People we spoke with told us that they did not have any current complaints about the service but would make an official complaint if they did. One person we spoke with told us, "I have never made a formal complaint but I have made a verbal one." A relative said, "I had to make written complaint back in December 2016 about a carer shouting with mum and managers took the right approach and reassured me it wouldn't happen again."

We checked the record of complaints to see how these were had been dealt with. We saw that concerns or complaints had been taken seriously and had been investigated and dealt with properly.

Requires Improvement

Our findings

Since the new provider took over the running of this service, two years ago, there have been three managers all of whom left the service. The chief operating officer told us that he was currently recruiting for another manager but, as yet, no one had been successful in meeting the criteria. He told us it was very important, given the high turnover of managers, that the new manager was a fully qualified professional with experience of dementia care.

In the absence of a manager the provider had put in place a temporary management structure. The rota indicated that an area manager and an acting manager worked five days a week at the home.

However, people using the service, their relatives and staff were unclear about who was in charge and unclear about the overall management structure of the home. When we asked staff who the manager was they gave us the names of various senior managers in the organisation but did not always know who their line manager was or who took overall responsibility for the home.

People and their relatives told us they were unhappy about the way the home was managed and told us this had negatively impacted on both care and communication. They told us they did not know who to talk with or who should be updating them about their relative's care and support.

Peoples' comments about the management included, "Well, I think they are lacking management, at the moment they do not have a manager in place and staff do whatever they want", "I don't know, maybe it's very well run but I don't know who the manager is" and "Well from my point of view it is not organised, but the majority of time they leave me alone which I am quite happy about, but I have never met the manager."

Relatives' comments included, "Well at the moment we don't know who is who, and they need to sort out a few things, but apart from that things are okay", "The last manager was really good and then disappeared, I don't know why it happened but at the moment I am very confused because I don't know who to speak to" and "Management is conspicuous by its absence. I don't see them very often. I don't see them directing staff or interacting with residents."

Heath and social care professionals told us they were also concerned about the lack of leadership and the possible impact this had on communication between themselves and the service.

The registered provider was in breach of Regulation 17 (1) (2) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

There was a yearly quality monitoring survey that was given to people and their relatives so they could give their views about the service. The chief operating officer told us the response to these surveys had been poor. Despite this, responses had been collated and a summary was available detailing where improvements would be actioned. Issues that had been highlighted by these surveys included, staffing levels, food provision and inconsistent management.

There were regular residents' meetings where people could give their views about the service and make suggestions for improvement. An action plan was then developed so these suggestions could be acted on. All of these action plans fed into an overall improvement plan that was overseen by the chief operating officer.

We saw that risk assessments and checks regarding the safety and security of the premises were taking place on a regular basis and records of maintenance and servicing of the building were being maintained.

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	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Parts of the home were not cleaned to a satisfactory standard and infection control procedures were not always being followed appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was no clear and consistent management structure at the service and line management arrangements were not satisfactory.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not being calculated based on peoples' level of dependency and current assessed needs.