Sentinel Health Care Limited

Cedar Lawn Nursing Home

Inspection report

Cedar Lawn
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 31 August and 1 September 2016 and was unannounced.

Cedar Lawn Nursing Home is an older style property which has been adapted to provide accommodation for up to 30 older people who require nursing care. The home is set over three floors with the accommodation being situated on the ground and first floors which are accessed by a lift or by stairs. Three of the rooms are for double occupancy. At the time of our inspection there were 28 people living at the home. The home does not provide specialist support for people living with dementia or those who might display behaviour which might challenge others. The service has a selection of communal sitting areas, a dining room and conservatory and a garden with outdoor seating areas. There is parking to the rear.

The manager was not currently registered with the Care Quality Commission. 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 and associated Regulations about how the service is run. The manager had submitted an application to register and this was currently being assessed.

Medicines were not always administered as prescribed and care plans or information within the care plans about medicines was not always complete, current or followed by staff.

Improvements were needed to ensure that there were at all times sufficient numbers of staff deployed to meet people's needs in a responsive manner.

Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised.

Staff had a good understanding of risks to people's health and wellbeing and measures were in place to protect people from risks associated with the environment.

Staff understood the signs of abuse and neglect. They were aware of what to do if they suspected abuse was taking place.

Staff felt well supported and received an induction and on-going training which helped to perform their role effectively.

Where people lacked the mental capacity to make decisions staff had undertaken mental capacity assessments and care plans had been agreed which described the support that was to be provided in the person's best interests.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS)

which applies to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations had been applied for or were in place.

People received a choice of meals and were supported appropriately to eat and drink.

People were supported to access healthcare services when needed.

People told us they were cared for by kind and caring staff. Staff respected people's choices, their privacy and dignity and encouraged them to retain their independence.
Care plans were developed that provided guidance about how each person would like to receive their care and support and about their individual needs and risks.

Staff recognised and responded to changes in people's health care needs.

A range of activities was provided which people enjoyed.

People and their relatives were able to express their views and give feedback about the service. Their views were listened to and acted upon. .

Complaints policies and procedures were in place and displayed within the home and within the information pack given to new people when they arrived.

People, their relatives and staff spoke positively about the manager and their leadership of the home. Staff told us that the service was a good place to work and that they enjoyed their job.

Systems were in place to monitor the quality and safety of the service.

Staff worked and interacted with people and visitors in a manner that was in keeping with the organisation values, aims and objectives.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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

People were not protected against the risks associated with medicines. The provider did not have appropriate arrangements in place to manage people's medicines safely.

The way in which staff were deployed required improvement to help ensure that people's needs were met in a timely and responsive manner.

Staff had a good understanding of risks to people's health and wellbeing and measures were in place to protect people from risks associated with the environment.

Staff understood the signs of abuse and neglect. They were aware of what to do if they suspected abuse was taking place.

Is the service effective?

Good

The service was effective

Staff acted in accordance with the Mental Capacity Act 2005.

Staff felt well supported and received an induction and on-going training which helped to perform their role effectively.

People received a choice of meals and were supported appropriately to eat and drink.

People were supported to access healthcare services when needed.

Is the service caring?

Good

The service was caring.

People told us they were cared for by kind and caring staff. Staff respected people's choices, their privacy and dignity and encouraged them to retain their independence.

Is the service responsive?

Good

The service was responsive.

Care plans were developed that provided guidance about how each person would like to receive their care and support and about their individual needs and risks.

Staff recognised and responded to changes in people's health care needs.

A range of activities was provided which people enjoyed.

People and their relatives were able to express their views and give feedback about the service. Their views were listened to and acted upon. Complaints policies and procedures were in place.

Is the service well-led?

Good

The service was well led.

People, their relatives and staff spoke positively about the manager and their leadership of the home. Staff told us that the service was a good place to work and that they enjoyed their job.

Systems were in place to monitor the quality and safety of the service.

The leadership team demonstrated a commitment to driving improvements.

Staff worked and interacted with people and visitors in a manner that was in keeping with the organisation values, aims and objectives.

Cedar Lawn 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 was an unannounced inspection which took place over two days on 31 August and 1 September 2016. On the first day of our visit, the inspection team consisted of two inspectors. On the second day, an inspector was accompanied by a pharmacist specialist.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the service tells us about important issues and events which have happened at the service. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, such as what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with eleven people who used the service and six relatives. We also spent time observing aspects of the care and support being delivered. We spoke with a Director, the Director of Care, the manager, two registered nurses and four care workers, the chef and a member of the activities staff. We reviewed the care records of four people in detail and aspects of the care records for a further seven people. Our pharmacist specialist viewed the medicines administration records (MAR) for 16 people and the topical medicines administration records (TMAR) for three people. We also viewed other records relating to the management of the service such as audits, incident forms, policies, meeting minutes, training and supervision records and staff rotas.

We sought feedback from five health and social care professionals about their views about the care provided at Cedar Lawn Nursing Home.

The last inspection of this was service was in October 2013 when we found no concerns in the areas inspected.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Cedar Lawn Nursing Home. One person said, "I definitely feel safe, the staff are well trained". One person told us how they felt safe when staff were helping them to transfer into their wheelchair despite this being a new experience for them following a stroke. All of the relatives we spoke with were confident that the service provided safe care.

We found, however, that some areas required improvement. Medicines were not always managed safely. Medicines administration records (MARs) were used to record when medicines were administered, however, we identified a medicine had been administered three times a day although it had been prescribed twice a day. A further medicine was not being administered as prescribed. This showed that not everyone was receiving their medicines in the way prescribed for them. Staff were not able to demonstrate that they had obtained confirmation from a health care professional of one person's insulin dose.

A care worker explained how they applied creams to people as part of their personal care. We viewed administration records for three people with a care worker. These records indicated the name of the product, and when the creams had been applied to people. However, the records lacked details of where to apply the creams. Therefore it was not possible to be sure if people's creams or other external items were being used in the way prescribed for them.

The effectiveness of medicines was not always being appropriately monitored. One person was prescribed a medicine "for the management of aggression" on an "as required basis". However, the care plan indicated the medicine was "to help settle at night" and the records showed the medicine was being administered every evening. We reviewed the care plans and records for two people prescribed medicines that required blood monitoring. These records contained test results, subsequent scheduled tests and the exact dose to administer. However, for one person only one blood result within the previous month had been within the range stated in the care plan and this had not been escalated. Escalation care plans were incomplete for two people prescribed other medicines.

The failure to ensure the proper and safe management of medicines was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Medicines were only administered by staff that had been appropriately trained and assessed as competent. Systems and processes were in place for the ordering of medicines. Medicines were stored securely by staff in locked trolleys or cupboards. We did note that products used to thicken drinks for people who had swallowing problems were readily available in people's rooms. We discussed this with the provider who took immediate action to obtain secure storage for these products. All medicines, including those requiring refrigeration, were kept within recommended temperature ranges, this meant they would be safe and effective for people.

Homely remedies (medicines which the public can buy to treat minor illnesses like headaches and colds) were available within the home. This meant staff could respond to people's minor symptoms in a timely

way. Information about allergies, "when required" and "variable dose" medicines was held within each person's medicines administration record (MAR). People told us they received their medicines on time and we observed that they were supported to take these medicines in a person centred manner. We observed staff encouraging one person to take a drink with their medicines, ensuring they had swallowed this. The member of staff knelt down at eye level with the person and chatted to them whilst they took the medicines in their own time. We also observed staff explaining to people what their medicines were for and asking them if they needed pain relief or other 'as required' medicines.

Improvements were needed to how staff were deployed. People gave us mixed feedback about the staffing levels. Some people told us that the staffing levels were adequate. For example, one person said, "They [staff] come within two to three minutes if I press my buzzer". However, some people told us that the staff were not always able to meet their needs in a responsive manner. One person said, "It's alright here….there could be more staff….you have to wait a long time while they get through us". This was a reference to being supported to get up in the mornings. On the second day of our inspection we spoke with another person who was waiting to be assisted with their personal care so that they could get up. It was 10.35am. We asked if this was their chosen routine. They told us they would have preferred to have been assisted to get up earlier. They said, "No-one has come". This person was assisted to get up at 11.15am. We observed that throughout the morning, staff were constantly busy supporting people. On both days of our inspection, personal care was being completed right up until lunchtime. We were concerned that this might mean some people missed the opportunity to be involved in social activities. At lunch time, whilst staff supported people in a kind and attentive manner, they were too stretched, this impacted upon their ability to provide person centred care. For example, one person was supported to eat by three different staff members as the care workers got up to attend to other tasks such as clearing meals or serving desserts. Another person was supported by two different care workers. A staff member told us, "It would be nice not to be constantly busy; I don't like having to leave people to answer a bell". Another staff member said, "The bells have been constant today, you could do with someone just answering bells. We are not always able to respect their [people using the service] wishes, it's hard to juggle everything, but people are safe".

Rotas showed that during the early shifts (8am – 2pm) there were two registered nurses and five care workers on duty. After 2pm this reduced to one nurse and four care workers. Night shifts were staffed by one registered nurse and two care workers. We reviewed the rotas for a four week period; these confirmed the home was mostly staffed to these target levels. The provider also employed a team of housekeeping staff, chefs and kitchen staff and two activities co-ordinators. There was also a maintenance person. Seventeen of the 28 people using the service needed two staff to support them with aspects of their morning care routine. Five people needed help to eat and drink. We discussed our concerns about staffing with the Director and the Director of Care. They explained that they used a systematic approach to determining staffing levels which was a reviewed on a weekly basis. Staffing levels were also reviewed on a daily basis by the matron to ensure they remained appropriate. They explained that they had already identified that additional staff were needed during busy periods and had advertised for additional staff to cover the lunch time service and a twilight shift between 5 and 8pm. They were confident that these additions once embedded would help to improve the responsiveness of staffing. We continued, however, to have concerns about the ability of staff to be responsive to people's needs at all times. This is a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Staffing.

Appropriate recruitment checks took place before staff started working at the home. The provider had obtained references from previous employers and checked with the Disclosure and Barring Service (DBS) to ensure the staff member had not previously been barred from working in adult social care settings or had a criminal record which made them unsuitable for the post. Checks were made to ensure the registered nurses were registered with the body responsible for the regulation of health care professionals.

A range of risk assessments were used within the service. People had moving and handling risk assessments and falls risk assessments. Post falls protocols were to be used to ensure that people were effectively monitored following a fall. Falls diaries were maintained so that staff were able to assess whether any pattern of falls was developing. Staff ensured that people had access to a call bell to summon help. Where people were at risk of falling from bed, bed rails were used once appropriate risk assessments had been completed. One person who was known to be at risk of choking had support plans in place to help minimise this risk. For example, their nutrition plan provided detailed guidance for staff on how they should support the person to eat and drink safely. We observed that staff understood and followed these guidelines. Screening for the risk of malnutrition was routinely undertaken and a nationally recognised tool was used to assess people's risk of developing skin damage. Staff acknowledged that some risks to people's health and wellbeing needed to be accepted and taken, in order to not limit people's freedom and independence. For example, one person had been advised by a speech and language therapist to have only thickened fluids. The person only wanted to have normal fluids and understood the risks associated with this. A registered nurse told us their choice was being respected but that staff ensured they only drank under supervision and in the right position. Handover meetings were conducted every day during which staff shared information about any new risks or concerns about a person's health. Overall, staff had a good understanding of people's risks and how to support them to maintain good health and stay safe.

Each person had a personal emergency evacuation plan (PEEP) which detailed the assistance they would require for safe evacuation of the home. However there was no PEEP for three people living at the home and one PEEP was for a person no longer living at the service. This could impact upon the emergency services being able to safely evacuate the home in the event of an emergency such as a fire. The provider had developed a detailed business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home and the steps that would be taken to mitigate the risks to people who use the service. Monthly checks were made of the call bell system and of the fire equipment and fire exits. Annual assessments had been undertaken of the fire risks within the service and of the water system to ensure the effective control of legionella.

Staff had received training in safeguarding adults, and told us about what they must do if they suspected abuse was taking place. Information including the contact details of the local safeguarding team was readily available within the home. The provider had appropriate policies and procedures. Staff were able to tell us how they would respond to potential safeguarding concerns such as unexplained bruising and we were able to see that staff worked effectively with the local safeguarding teams to investigate concerns. Staff were aware of the whistle-blowing procedures and were clear they could raise any concerns with the manager. One staff member said, "The staff are 100% kind and caring, but if I saw a problem, that is where your whistle-blowing comes in, if I saw a problem I would say….you have got to think how would you want your relatives to be treated". Staff were also aware of other organisations with which they could share concerns about poor practice or abuse.

Good

Is the service effective?

Our findings

People told us the service provided effective care and were confident that the permanent staff had the right skills and knowledge to meet their needs. Their comments included, "I am well looked after" and "I am quite satisfied". Another said, "It's a very, very good service". A relative told us the staff were "Well trained and knowledgeable, nothing could be better". Another said, "We are utterly delighted, they take very good care". A third told us, "There is nothing they could do better, it's very homely, never any odours, never any problems". People were generally positive about the food. One person said, "The food is quite good, its cottage pie today….they make it taste nice, I can change it if I want to, if you want anything, they will do it". A health care professional told us, "I think everything is done particularly well and I cannot think of anything that they could do better because, as I am in constant contact with them, if there are issues, we discuss them at the time....I have no hesitation in recommending Cedar Lawn".

Staff received appropriate support to perform their role effectively. New staff completed an induction during which they learnt about their role and responsibilities and undertook some essential training. They also spent three days shadowing more experienced staff and reading people's care plans which helped to ensure that they were able to develop their understanding of people's needs. We were told that staff who were new to care were being supported to complete the Care Certificate and we were able to see one example of this. The Care Certificate which was introduced in April 2015 sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate. Agency staff also underwent an induction to the service which included a tour of the home and reading about people's needs and the fire procedures. Agency registered nurses were also advised about how the medicines routine of the home operated and a clinical report on the needs of each person.

Staff had completed training in a range of subjects such as infection control, Mental Capacity Act (MCA) 2005, fire safety, safeguarding and manual handling training. Where relevant to their role, some staff had completed additional training such caring for wounds or catheter care. The registered nurses had undertaken training in the use of medical devices used for managing people's medicines during end of life care. The provider had arranged for the staff responsible for leading activities to undertake training in leading an exercise group. Training took the form of face to face training or watching DVDs following which staff's understanding of the training provided was assessed by written question and answer exercises. The provider had also developed a very detailed learning and development training workbook. This contained information about the provider's philosophy of care, their values, safeguarding people from harm, basic life support, managing incidents of choking, caring for people who have a stroke and who are living with diabetes. Staff also had a pocket sized 'Clinical Experience Record' within which a mentor could record observations about their practice in a range of areas such as managing nutrition and moving and positioning people. Staff were positive about the training provided. One staff member said, "If we need training, we only have to say". Overall staff told us the training provided was adequate to enable them to perform their role effectively and records we viewed showed that this training was generally up to date.

Most of the supervision care staff received was through observation of their practice and feedback about this. One care worker said, "Yes it's useful, they can give me insight about where I can improve care, but I

don't have to wait [for supervision] I can go at any time to the matron or [director of care]". Some supervision was delivered by way of sharing memos with all staff about key issues. For example, staff had recently been given detailed information about supporting vulnerable people during a heat wave and dignity in care. Records showed that the manager and registered nurses were not receiving regular supervision sessions. We discussed this with the Director of Care, they told us that the nursing staff regularly took part in clinical governance meetings which were used to reflect upon the effectiveness of aspects of the nursing care provided within the service. For example, one such meeting had taken place the night before our inspection and had discussed matters such as medicines management, bowel and bladder care and infection control. All of the staff we spoke with told us they felt well supported and able to seek guidance about their role or responsibilities at any time. The Director of Care told us they would be reviewing their supervision policy and would ensure that the clinical staff would in the future receive regular supervision in addition to attending the clinical governance meetings.

The registered nurses employed by the service were being supported to access training to gain their revalidation. Revalidation is the way in which nurses demonstrate to their professional body that they continue to practice safely and effectively and can therefore remain on the nursing register. Staff also received an annual appraisal of their performance which reviewed any training or development needs they might have.

People living at Cedar Lawn Nursing Home were mostly able to make their own decisions and give consent to their care and treatment. Care plans contained signed consent forms which recorded the person's agreement to have their photographs taken or to the support they were to receive. We did note that in some cases consent forms were signed by relatives without there being evidence that the relative had legal authority to do so. We observed that staff sought people's consent before providing assistance, for example, we observed staff asking people, ""Do you want your lunch here or in your room", "Would you like a clothes protector on" and "Would you like some help with your meal". This helped to ensure that people remained in control of their care and support.

We looked at how the service was implementing the Mental Capacity Act (MCA) 2005. We looked at one person's care plan. As their ability to consent to live at Cedar Lawn or other aspects of their care plan was in doubt, a formal assessment of their capacity had been undertaken as part of the care planning process. Staff had been involved alongside other professionals and family members in reaching best interests decisions about how the person's care and support should be provided. The MCA 2005 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. These principles were embedded within people's care plans. For example, one person's plan noted that 'All steps must be taken to enable [the person] to make their own decisions' and 'If level of decision making is compromised a mental capacity assessment must be completed with any interventions being the least restrictive'. The care staff we spoke with had a basic understanding of the MCA 2005 and were aware of these key principles.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards are part of the MCA 2005 and protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. Relevant applications for a DoLS had been submitted by the home and were either awaiting assessment by the local authority or had been authorised.

People's nutritional needs were met. Kitchen staff had information about people's allergies and specialist diets including those that required diabetic meals and those that needed soft or pureed food. When people first came to the home, they were asked for information about their food likes and dislikes and this was also available within the kitchen. One person told us, "The chef comes up two or three times a week to talk with me about the food". Hot and cold drinks were readily available throughout the day and people could if they wished have a sherry prior to lunch. At lunch, meals were either served in the dining room, or taken on a tray to people's own rooms. Dining room tables were laid with clothes, napkins and condiments. The menu was the same across all of the provider's locations and was planned over a four week period. People had a choice of two options at lunch and supper was foods such as soup, sandwiches or a jacket potato. Most people told us they were happy with the food provided. One person said, "The food is out of this world…the cook does a good job". Where people required a pureed diet, the elements of the meal were all pureed separately which helped to ensure that people were still able to experience the individual tastes and flavours.

Upon admission, people were weighed weekly so that staff could assess and identify any nutritional risks. Where risks were identified, plans were in place to address these. For example, people losing weight were weighed more frequently. Staff had liaised with professionals such as speech and language therapists (SALT) to inform nutrition plans and manage risks such as difficulties swallowing. People unable to take food orally because of swallowing problems had suitable nursing plans in place to support this.

The kitchen was clean. Food stored in the fridge and freezer was being stored safely and in line with guidance from the Food Standards Agency. Temperatures were being taken daily of the fridge and freezer to ensure that foods were being stored at safe temperatures. Cleaning schedules were in place for the kitchen and were mostly complete. The service had been awarded the highest food hygiene rating when assessed by food safety officers.

Where necessary a range of healthcare professionals including GP's, tissue viability nurse, opticians and speech and language therapists, had been involved in planning people's support. A GP visited the service on a three weekly basis to do a 'ward round'. We were able to see that staff referred people for review by the GP if they were concerned about their dietary intake, following falls or due to showing signs of having chest or urine infections. A health care professional told us, "I am contacted by telephone or emails which demonstrates nursing staff are knowledgeable about patients healthcare needs in that the questions they ask are entirely appropriate". This helped to ensure that people received co-ordinated care, treatment and support. People's care records contained information about their medical history and records were maintained of the outcome of medical appointments and visits from the GP or other healthcare professionals.

Good

Is the service caring?

Our findings

People told us they were cared for by kind and caring staff. One person said the care workers were, "Very good…very polite". They told us staff respected their privacy. Another person felt they were "Treated very well". A third person said, "I am as happy as you can be, they [the staff] are very kind and caring, they can't do too much, they treat you as a friend, I know all of their names". Another person told us that one of the best bits about the service was "The friendliness of the carers". A healthcare professional told us, "At all times patients and relatives have been treated with dignity and respect". Our observations indicated that staff interacted with people in a kind and caring manner. The service had received a large number of written compliments in the last 12 months, thanking the staff team for their kindness to people. For example, one compliment read, 'You were all patient and kind and kept smiling and got the job done, It was a delight to visit and be made to feel so welcome, you couldn't have done more'.

Staff spoke fondly about the people they supported and assisted them in a kind and caring manner. For example, whilst staff were very busy during the lunch time service, they tried to be as attentive as possible to people and whilst helping one person to eat and drink, the care worker told the person what nice hair they had and praised them for doing well with their meal". A staff member told us, "It's a nice home, small; we all do care about the residents". People looked relaxed and happy in the company of the staff who throughout our visit appeared jovial, attentive and happy in their work. One care worker said, "You have got to gain [people's] trust, then we can have a laugh". Visitors were welcomed and there was a notice board close to the entrance which contained photographs of staff members and said what their roles were. This helped to ensure visitors knew who staff were and their roles and responsibilities.

Many people living at Cedar Lawn Nursing Home were able to understand and make decisions about how their care and support was provided and we saw they were empowered and encouraged to do this on a daily basis. People with more complex needs were also encouraged to be as independent as possible. Staff told us how they encouraged people to complete small tasks such as washing their own face. A staff member said, "Every little bit they do is important".

Each of the people we spoke with said they were treated with dignity and respect. The provider's commitment to upholding the values of privacy and dignity was noted in the information pack given to each person coming to live at the service. The pack also contained a 'Residents Right to Privacy' statement which reminded people of their right to have access to their care plan and care records at all times. Staff told us how they knocked on people's doors before entering and of the importance of keeping a person covered as much as possible while assisting them to wash. They also told us how they used the privacy screens available in the shared rooms to protect people's dignity. A staff member said, "Privacy and dignity should be a priority". Team meetings were used to remind staff of the importance of providing care in a person centred manner, for example, not referring to people as 'feeds' but rather as someone who needs assistance to eat and drink. Personal care plans stressed the importance of staff being mindful of people's privacy at all times and for example, ensuring catheter bags were discreetly positioned.

People were supported to follow their religious and spiritual beliefs. Once a month, the vicar from nearby

Romsey Abbey visited to hold a service and to offer pastoral support. Clergy from other faiths also visited regularly. Some people had end of life or advanced care plans in place which had been drafted with the person and their relatives. These described the person's wishes in relation to how they would like their care and environment to be managed in their final days. For example, we saw that one person wanted their windows to be left open so that they could listen to the birds. Staff were undertaking training delivered by a local hospice. The training programme, Six Steps to Success is a recognised programme of learning for care homes to develop awareness and knowledge of end of life care. A health care professional told us, "End of life care is managed beautifully in the home".

Good

Is the service responsive?

Our findings

Overall people told us their care was provided by staff who knew them well and understood their needs. A relative told us, "The staff here stay, I am very happy with the care". Some people did express a view that the agency staff were "Less effective" and "Could not always understand you". People told us their concerns were taken seriously and that their views were listened to. Relatives also felt that staff listened to their views. One relative told us, "We attend relative meetings, they act on our suggestions".

Before people moved into the home they and their families participated in an assessment of their needs to ensure the service was suitable for them. This included a 'Lifestyle Profile' which contained information about their lives before coming to live at the home. Following this initial assessment, care plans were developed that provided guidance about how each person would like to receive their care and support and about their individual needs and risks. For example, people at risk of developing skin damage had skin integrity plans which described the actions staff should take to promote healthy skin. These included, a repositioning regime and daily visual checks of skin most at risk of damage. People at risk of poor nutrition had eating and drinking plans which described how they should be offered fortified diets. Where there were concerns about a person's food or fluid intake we were able to see charts were used to monitor this. The charts we viewed were mostly fully completed. Care plans were in place in relation to reducing the risk of acquiring infections and safeguarding people from abuse. Breathing care plans were in place and included information about the signs and symptoms which might indicate a person was developing a chest infection. Staff told us that the care plans told them what they needed to know to manage people's care.

We did find that one person's skin care plan did not reflect their current needs. Another person's pain care plan told staff to 'observe for non-verbal clues of discomfort'. The plan did not say what these were. Photographs of wounds did not include a measurement so it was not possible to clearly ascertain the size or dimension of the wound to track the healing process. Overall people and their relatives told us that staff were good at recognising and responding to changes in their health care needs. We were able to see that health care professionals were consulted on a regular basis helping to ensure that people's healthcare needs were well managed. One person said, "If you want a doctor, they get one for you". A visitor told us how their relative could develop frequent urine infections, they said, "They are on to it so quickly so it doesn't develop".

The service employed two people to lead the activities provision. A schedule of activities was advertised and included 'Room visits' which were used for chats with people on a one to one basis about topics such as 'What's in the newspaper'. There were also posters advertising an autumn fair in September, bingo and films to watch. A member of staff responsible for leading activities said, "We had a film on Sunday afternoon, we had ice creams, [people] really enjoyed it". A 'Dates for your Diary' leaflet showed that singers and other external entertainers were booked each month. We observed people taking part in quizzes and crafts and making cards to sell at the upcoming fair. The provider had a mini bus which was shared with their other four services. Cedar Lawn Nursing Home used the mini bus on Fridays for trips which included visits to places like Salisbury Cathedral, a local farm shop and a pub in Romsey. We were told that the trips out were often limited to a maximum of three people per trip as this was all the staff member could support safely.

We also noted that whilst the activities lead started at 9.30am, there was often no-one, or very small numbers of people up, ready to take part in any organised activities until much nearer lunchtime as everyone took breakfast in their rooms. We spoke with the provider and registered manager about this. They told us they would review the arrangements and ensure that the quiet time in the morning was used as an opportunity for activities staff to spend more one to one time with people who were cared for in their room or perhaps set up a breakfast club. The provider also said they would review how staff were deployed to try and ensure that more people were able to join in the trips within the local community.

People told us they were able to express their views and to give feedback about the service. An annual survey had recently been undertaken with people. The survey asked people and their representatives to rate and comment on aspects of the service such as the staff within the home, their daily care and the cleanliness of the home, food and activities. We saw that the overall responses were complimentary. The results had not yet been collated into an action plan, but we saw that following similar surveys in 2015, where areas for improvement had been identified, actions had been taken to address these. Meetings with people took place regularly. These mainly focused on discussing the activities programme and upcoming events. The people we spoke with felt that they could also make suggestions about how the service could be improved. One person told us, "They [the service] take notice of what you say".

Relatives told us they were kept well informed and that communication with the home was good. People's relatives and friends were able to visit throughout the day, and we observed them sharing in aspects of their relative's care. One relative told us, "I feel welcomed, the staff are great". This was echoed by a second relative who said, "Everyone is so friendly, we are offered tea, cakes and biscuits". We were able to see evidence that relatives had been involved in planning people's care and were encouraged to express a view about how they would like this to continue in the future. A relative told us, "Yes they keep us informed, we have seen the care plan…they are very open about everything". Relative meetings were held and were an opportunity for them to be kept informed about matters affecting the service. Minutes showed they were able to make suggestions about improvements and that in many cases these were acted upon. The director of care and a number of staff commented about the positive relationship they had with relatives and how this helped to develop the service for people, for example, relatives had got involved in developing the vegetable garden and had in the past supported staff to take people out on trips.

Complaints policies and procedures were in place and displayed within the home and within the information pack given to new people when they arrived. There had been two complaints within the last 2 months. Records had been kept of the actions taken in response to each of these. People told us they were confident they could raise concerns or complaints and these would be dealt with.

Good

Is the service well-led?

Our findings

The service has not had a registered manager since July 2015. This is when the current manager stepped down from this role to instead work as a registered nurse within the service. Since July 2015, the management responsibilities have been shared between the senior nurses and the deputy manager supported by the Director of Care who visited the service two to three times a week. The previous registered manager had now decided to reapply for the role of registered manager and their application is being assessed by the Care Quality Commission.

We did note that the clinical staff were not receiving regular supervision. This meant the provider was not able to fully demonstrate how they were monitoring the competency of the registered nurses and manager. However, staff felt well supported and people, their relatives and staff spoke positively about the manager and their leadership of the home. One person said, "The matron is very good, the slightest thing they get it done". A relative said, "I am confident, [the manager] is very lovely and talented". Another said, "They are the best, you can really talk to her, the deputy is very good too". A staff member said, "[the manager] knows what's going on, they always check, Saturday was very busy with quite a few agency staff, she kept checking we were ok….they are a good boss". Another staff member said, "We love her, she is very helpful". A health care professional said, "The service is well managed and I have very close contact with [the manager] and the senior staff nurses....and as a consequence patients needs are met quickly as they are able to contact myself and get a response almost immediately".

Staff told us that the service was a good place to work and that they enjoyed their job. They said that morale was generally good. One care worker said, "I love it here, I really enjoy it". Some staff felt that at times morale could be affected by the workload, but they generally felt that they worked well as a team. Staff meetings took place periodically. These meetings were used to share developments with staff and to discuss how the delivery of care could be enhanced. For example, we saw that the meetings were used to discuss the key worker list and the role of team leaders. Where suggestions or requests had been made, we saw that these were being actioned. For example, staff had requested more call bell panels so that they did not have to go such a distance to see which person was ringing their bell. The provider told us they were taking action to address this. A staff member said, "You can always put points across, [the manager] does something about it".

There were a range of systems in place to monitor the effectiveness of the service and to identify any potential risks or shortfalls that might compromise its quality and safety. Incident and accidents were monitored by the provider and we were able to see that they maintained a record of the actions taken in response to mitigate any risks and prevent reoccurrences. The number of infections experienced by people each month was monitored as was the nature and number of wounds being treated. A clinical auditor visited the service on the regular basis and undertook a variety of audits including care plan documentation and infection control. Where areas requiring improvement were identified, we were able to see that these had been completed. We were shown the most recent monthly medicines audits which had been undertaken during August 2016. This had not identified the administration errors and other issues we identified during the inspection. We discussed this with the Director of Care who told us they would review

the audit tool to ensure this was more robust. An external organisation was contracted to undertake health and safety audits within the service and a social care observer undertook general observations within the service and provided feedback about this. They had commented in August 2016, 'Atmosphere very friendly and residents and staff very positive'.

The leadership team demonstrated a commitment to driving improvements. Where people and staff told us about areas of the service that could improve, many of these had already been identified by the provider and plans were in place to address these. For example, a staffing review was underway to help ensure that sufficient numbers of staff were deployed at all times to meet people's needs. The provider took prompt action to ensure that drinks thickener could be stored safely and not present a risk to people. The provider was investing in the building and environment to ensure that this continued to be pleasant and safe for people to live within. The provider's statement of purpose set out their aim and objectives and the organisational values which included promoting independence, supporting choice, privacy, dignity and respect. Throughout the inspection, we saw that staff worked and interacted with people and visitors in a manner that was in keeping with these values.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the safe administration of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff were deployed in a manner that ensured they would be responsive to people's needs.