Caretech Community Services (No.2) Limited

Cedar House

Inspection report

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Date of inspection visit:
16 June 2016

Date of publication:
03 February 2017

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

Summary of findings

Overall summary

This inspection took place on 16 June 2016 and was unannounced.

At a previous inspection in October 2015 we judged that people were receiving inappropriate and unsafe care at Cedar House. We found breaches of six of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. The home was rated as Inadequate and the service was placed into Special Measures. For adult social care services the maximum time for being in Special Measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in Special Measures.

We carried out another comprehensive inspection in January 2016 to see if improvements had been made to meet the fundamental standards. At that inspection we found breaches of five regulations. Improvements had been made and the home was rated as Requires improvement. The home remained in Special Measures as the leadership and governance of the home by the provider was still rated Inadequate.

At this current inspection we found further improvements. The home is still rated as Requires improvement but is no longer in Special Measures.

Cedar House is registered to provide accommodation with nursing and personal care, diagnostic and screening procedures, and treatment of disease, disorder or injury for up to 12 people.
There were six people living in the home at the time of this inspection. They all had multiple disabilities and needed full support with all aspects of daily living. The home is registered as a nursing home and there is one nurse on duty 24 hours a day plus support workers. The home is fully wheelchair accessible and has appropriate bathroom and hoist facilities for people with physical disabilities. Caretech Community Services (No.2) Ltd run this home and are referred to in this report as "the provider."

The home has had no registered manager since March 2015. 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. The current manager moved to Cedar House from another of the provider's homes in December 2015. She has applied to be registered with the Care Quality Commission.

At this inspection we found there had been further improvements since January 2016. The provider had improved their monitoring of the home to find any concerns and act on them more quickly. There was good communication between the provider, the management team in the home and relatives of people living in the home.

There were improvements in the record keeping and monitoring of people's needs. People's fluid intake

was now being recorded properly so that staff could ensure people were getting enough to drink. Staff supported people to change position regularly so that they did not get uncomfortable or develop pressure ulcers. People were taking part in more activities and were receiving regular physiotherapy from staff in the home. Staff had set up a sensory room and people were going out more. All these improvements had led to a better quality of life for people. Their relatives and professionals working with them said that the quality of care had improved.

We found breaches of one of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was where the provider was not meeting the standard for safe care and treatment relating to medicines, diabetes and epilepsy. This regulation was breached at the previous two inspections. We are considering our regulatory response to ensure that these matters are addressed and will report further on this once this is complete.

We have also made two recommendations: to provide further training for staff in supporting people to eat and in making best interest decisions in accordance with the Mental Capacity Act 2005.

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 consistently safe. Medicines were not managed appropriately at all times. There had been minor medicines errors and some medicines issues which the provider had not identified through their medicines auditing.

The cleanliness and safety of the home and medical equipment was good. Staff had been booked on classroom based first aid training and staff knew how to safeguard people from abuse.

People had risk assessments detailing risks to their health, safety and wellbeing and advising staff how to reduce the risks.

Is the service effective?

Requires Improvement

The service was not consistently effective. Nurses had not followed guidance on treating a person with diabetes on three occasions. There was insufficient monitoring of people who may have seizures at night.

Staff received training in the areas needed in order to work with people with multiple disabilities and further training was planned. Staff were receiving regular supervision and most had had an appraisal since the last inspection.

Staff supported people with their nutrition and ensured they had enough to drink to prevent dehydration. Staff also supported people with physiotherapy programmes and ensured people saw relevant healthcare professionals when needed.

There was a new clinical lead nurse to lead and support the nurses which was a positive improvement.

Is the service caring?

Good

The service was caring. Staff had formed good relationships with people living in the home and understood their communication methods. Staff were kind and sensitive when interacting with people and respected their dignity and privacy.

Is the service responsive?

Good

The service was responsive. It was becoming more person centred and the provider had planned further training for staff in working in a person centred way.

Staff responded to people's individual needs and preferences. People were supported to do more activities in and out of the home. The provider's response to complaints and concerns had improved though recording did not always reflect the outcome and action taken.

Relatives said that they felt listened to and that when they had any concerns the manager would resolve the matter immediately and that the provider communicated with them.

Is the service well-led?

Requires Improvement

The service was not consistently well led. The provider had made improvements since our last inspection, including their monitoring of the home. Audits carried out by the provider were more effective in identifying areas for improvement but these still did not pick up all issues of concern.

The acting manager had developed good relationship with the deputy and the clinical lead nurse and they were forming a strong internal management team. They had introduced night time unannounced visits which was identifying areas for improvement in care at night. Relatives had improved confidence in the management team.

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 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 16 June 2016 and was unannounced.

The inspection team comprised of one inspector, a specialist professional advisor who is a nurse, a pharmacist inspector 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. This expert had experience with people with a learning disability.

Before the inspection we reviewed all the information we had about Cedar House including notifications and safeguarding alerts made by the provider, information provided by other interested parties such as the local authority and relatives, and the provider's action plan to comply with the regulations breached at the last inspection and weekly improvement plan updates sent to us by the provider.

At this inspection we talked to the manager, deputy manager, lead clinical nurse who had just started at the home, two nurses, the regional manager, six support workers and the activities coordinator. We met, spoke on the phone or had written feedback from 11 people who were the relatives and/or professionals involved with people living in the home. We asked the views of the three local authorities responsible for monitoring the care of the six people living in the home.

We read five people's care files and carried out pathway tracking for three of them, which involved reading all the care plans, risk assessments, reports from other professionals and records of care provided (fluid charts, repositioning charts, daily progress notes, activity records, medicines records and seizure charts) to check if people's assessed needs were being met and whether they received the care and treatment planned for them.

We looked at staff training and supervision records, the staff recruitment records for all staff employed since

our last inspection plus another employed within the last year. We looked at fire and health and safety records, checks of the cleanliness and safety of medical equipment, audits, quality monitoring records and records of meetings with staff and people's families. We also reviewed feedback from families, complaints records and we inspected the premises. We checked all communal rooms and three people's bedrooms. We also requested and received documents from the provider after the inspection relating to health and safety, staff training and audits.

We observed interaction between staff and people living in the home and observed what was happening in the home throughout the day at various times including observation during two mealtimes and a medicines round. We observed staff supporting people to get ready to go out and welcoming them back later in the day. None of the people in the home were able to tell us their views on the care so our expert by experience stayed with two people continuously for five hours to assess their experience throughout the day.

Requires Improvement

Is the service safe?

Our findings

All staff had been trained in safeguarding adults and reporting allegations of abuse There was written information to assist staff with understanding safeguarding procedures. Staff were aware of safeguarding issues, what to look for and how to report any concerns. The acting manager had reported safeguarding alerts to the local authority and the Care Quality Commission when there were errors with medicines and any other incidents where people had not been safeguarded. This was evidence that they knew how to follow appropriate safeguarding procedures to report any abuse.

The provider looked after three people's money as these people did not have capacity to do so themselves. There were some safeguards in place to prevent financial abuse such as senior managers having to approve large expenditures. We looked at the financial records for one person. There was a clear record of money spent on their behalf and the balance of money they had left. Some entries just recorded a shop name. The receipts showed the purchases made in those shops but we brought the lack of detail in the records to the acting manager's attention. She said she would ensure that staff recorded what was purchased and not just the shop name.

A whistleblowing poster was displayed which offered appropriate information so that staff knew what to do if they had concerns about the care provided. We asked staff about this and they said they would report any concerns using the whistleblowing procedure and that if they felt the provider was not responding to any concerns they would be confident to tell CQC or visiting professionals from the local authority.

The provider increased staffing levels in the home in October 2015 after our inspection highlighted inadequate staffing levels. The increased staffing level has been maintained and staff and relatives told us that there had been a positive impact . Staff had more time to spend with people since an extra member of staff had been deployed in the evenings and early mornings and there was an extra staff member cleaning the home and preparing meals. On the day of the inspection the cook/cleaner had a day off and one of the care workers was working an extra shift to clean and cook. The staffing levels were able to meet the needs of the six people living in the home at the time of the inspection. The manager and deputy worked full-time and were able to help with care as needed.

At the last inspection in January 2016 we found that the provider did not have an effective system in place to ensure their recruitment team checked all recruitment of new staff was in accordance with Regulations. There had been improvements in the safe recruitment of staff since then. However we told the provider in January that they had not requested a reference from one staff member's previous employer in health and social care and they had taken four months to send off this reference request so had still not received it. Neither had they verified with the employer by phone that the person was employed by them. We checked the files of new staff employed since January and found improvements In safe recruitment of staff. The provider had checked new staff identity, criminal record and other relevant checks before they started work, to ensure that they were suitable to be employed working with vulnerable people.

Staff followed correct moving and handling guidelines and the provider had ensured all staff were trained to do so. Personal equipment such as bedrails and hoist slings were checked every one to two months to ensure they were safe and fit for use.

Each person living in the home had risk assessments in place identifying all risks to their health and safety and advising staff how to care for the person in a way that reduced any risks to them. Risk assessments included use of hoist and bedrails, Waterlow assessments (to look at risk of sustaining pressure ulcer), MUST assessments (to look at risks associated with nutrition) and epilepsy.

People had a recognised (Waterlow) risk assessment to identify any risks of pressure ulcers. We saw that there had been an improvement in the care of people to prevent pressure ulcers. Staff completed charts recording when they had supported people to change position, what position they moved into and at what time. We saw staff support people to spend time in their wheelchair, adapted armchairs and bed to ensure they were comfortable and to reduce the risk of pressure ulcers and discomfort from staying in the same position all day. We were told that nobody had a pressure ulcer.

Medicines were not consistently managed safely and appropriately and in accordance with the home's own medicines policy. We checked all the medicines records for five of the six people and observed medicines being given orally and via PEG feeds, where a person is fed via a tube directly into their stomach.

Insulin had been kept out of the fridge in the cupboard but had no date recorded for when it was removed from the fridge. This medicine can only be used for 28 days after removing from the fridge.

We saw one person swallowing a tablet that the administration instructions on the dispensing label stated "to be sucked or chewed". We asked the nurse why the tablet was given on a spoon to swallow whole and not sucked or chewed and the nurse said the person was unable to suck or chew tablets. Staff had not told the GP that this person was unable to take this medicine according to the instructions and there was no record in their file about this so that the GP could prescribe a suitable alternative.
Only one nurse had a valid, in date competency assessment showing they were competent to give medicines.

Nurses recorded fridge temperatures appropriately for fridges, each medicines cupboard and the nutritional supplement feed cupboard.

The home's policy stated that individual epilepsy guidelines should be with the Medicines Administration Record (MAR) charts and the index of the MAR chart folder listed these guidelines. Five people had epilepsy and were stated to have an epilepsy protocol in the MAR folder but only two had an epilepsy protocol in the MAR chart folder. This meant that if nurses needed to look at an epilepsy protocol for a resident, they may not be able to find them so they may not know what emergency treatment the person needed. The deputy manager told us she would ensure that copies were put in the MAR folder for the three residents that had the protocol missing.

One resident that had a sheath did not have this administration recorded anywhere. The nurse and the deputy manager said that sometimes a sheath change was once a day and sometimes twice a day during personal care but this was not recorded anywhere.

People who had medicines given through their PEG feed did not have individual protocols for PEG administration. For example, some had tablets prescribed by the GP as "take one tablet daily via PEG". There was no information on how to administer the tablet, to crush it or dissolve it, in what vehicle, in how

much liquid etc. One medication was an oral liquid that was being administered via the PEG. There was no record that this medication was administered via the PEG and the only way we could tell was from speaking to the nurse and by reading elsewhere that this resident was nil by mouth. This meant there was a risk a new nurse might give the medicine orally and the person was at risk of choking.

The dose of insulin for one person had been changed. This was instructed by the diabetic nurse specialist on 11/2/16. Since that time, the nurses at the home had been handwriting the change of dose on the MAR chart and the pharmacy had not been instructed to issue a replacement MAR chart showing the correct dose. There was a risk that if the nurse forgot to handwrite the change on each MAR chart, the wrong dose could be given.

One person received an injection daily. There was no record kept of injection site which means that staff would not know which site was last used. This means that there is a risk that the same site is used repeatedly which is against the manufacturer's instructions as it can lead to an ineffective administration site due to a build-up of fatty tissue.

There had been two recent medicines errors, one where nurses had signed for liquid medicines they had not given and one where a person's medicine had not been ordered in time and they had two days without it. Both errors were under investigation to see how they happened and so nurses could learn from them.

The above amounted to a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The treatment room and the cupboards were always kept locked and the keys are kept by the nurse on duty. Controlled drug records were appropriate and tallied with medicines s administration on the MAR chart and the medicines in stock. Controlled drug stock checks were done at least twice daily. One drug was due to expire at the end of June and staff knew this.

Medicines which were to be given as and when needed (known as PRN) had protocols available and were clear and complete. A log was kept of all nurses that had seen the epilepsy protocols.

A separate record was kept of cream/topical application. There was also a body map available to show where creams should be applied and how often and what they are used for. This meant that nurses were able to give people their prescribed creams appropriately.

There were regular checks of the building for health and safety concerns. The gas and electrical installations had been inspected shortly before this inspection and the fire alarm and fire equipment was tested regularly. There was a clear fire procedure and night time evacuation plan plus individual emergency evacuation plans in place for staff to follow in the event of an emergency.

The home was generally clean and people's medical equipment was regularly cleaned and checked for safety.

Requires Improvement

Is the service effective?

Our findings

We found that there was insufficient monitoring of people who had epilepsy at night. Although the nurse and care worker on duty checked each person regularly during the night, they were unable to know when somebody had a seizure in between those times. Some people's care records showed they were to be checked once an hour. One risk assessment from November 2015 stated that the person was at risk of seizure activity at night. A nurse told us that two people would call out when they had a seizure so night staff would know and go to their assistance. However if night staff were in another person's room at the time they would not be able to know if somebody had a seizure. The provider had no means in place to monitor people other than hourly checking by staff.

Nurses had not followed guidance on treating a person with diabetes on three occasions. One person who had diabetes had a clear written protocol from a specialist giving clear instructions what to do if their blood glucose level was below or above specific levels. There were three occasions where nurses should have taken immediate action according to the protocol. Records did not show that any action had been taken on all three occasions. The regional manager assured us that this would be addressed immediately after the inspection.

The above was a breach of Regulation 12 of the Health and Social Act (Regulated Activities) Regulations 2014.

At the last inspection we found that the provider was not properly monitoring the training staff were completing and as a result some staff were working without having all the necessary training to provide safe care to people in the home. Since then the provider and the acting manager have improved the monitoring of training and acted to ensure staff had completed the training needed. Where some staff had not completed certain training courses, the acting manager had a good knowledge of what they needed to do and an action plan to ensure it took place. Therefore we were satisfied that the provider now had an effective system in place to provide and to monitor all the training that staff needed to work in this home. Most learning was computer based but the provider was planning more face to face training for example in first aid and as this training is more effective in practical training sessions

All staff had completed training in epilepsy and administering emergency epilepsy medicines. At the time of the inspection none of the care workers had given this medicine as nurses had continued to do so. Further training by the local authority was booked for July so that all staff are able to give emergency medicines when out with people.

Staff were receiving more regular supervision and care workers had recently had their annual appraisal. Appraisals for the nurses had been booked. Staff said they were supported in their work. The deputy manager and three support workers had a Diploma in Health and Social Care Level 2 and two support workers had a Diploma in Health and Social Care Level 3 which are appropriate qualifications for working in a nursing home.

Staff were knowledgeable about the people living in the home. Staff told us that there was a formal staff handover at each shift change where relevant information about people was shared.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The provider trained their staff in understanding the requirements of the MCA in general, and the specific requirements of DoLS. We saw mental capacity assessments in place and best interest decisions made when people were unable to give their consent to take medicines. Staff were aware of DoLS and the MCA but had less understanding of appropriate best-interest decision processes.

Some staff did not fully understand the process of making decisions in the best interests of a person who did not have the capacity to make an important decision, for example whether or not to have a flu vaccination and whether a person should pay for use of the home's minibus. One person had a best interest decision recorded that it was in their interests to have a flu vaccination with no record of who had made this decision on their behalf.

There had been one occasion where a nurse at the home had taken a blood sample from a person as the doctor had been unable to do so. Although the nurse was suitably qualified to do so, this was not usual practice at the home, there were no policies and procedures in place on taking blood to safeguard people and we did not see any record of a best interest decision or mental capacity assessment on this. The person was making small financial contributions for use of the home's minibus. There was no best interest decision recorded for this to show that this was appropriate.

We recommend that further training and advice is sought on best practice and the requirements of the Mental Capacity Act in relation to best interest decision processes.

Five of the six people in the home had a DoLS and another was in the process of being assessed. We noted that one person's DoLS had expired in February 2016. The acting manager said the re-application was in progress.

People's nutrition and hydration needs were met. People had fresh fruit smoothies before breakfast in the morning and a home-cooked lunch and dinner. The cook knew people's dietary needs in terms of the consistency of food they needed (some had pureed or mashed food) and preferences. People's prohibited foods due to religion or food allergies were clearly recorded in the kitchen for the cook to refer to, and relatives said that suitable alternatives were always prepared for the person with food allergies. The food was fresh and we saw people enjoying their meals.

Guidance from a speech and language therapist to support people with eating and drinking was printed onto placemats on the dining table. However for three people we saw that staff were not following the guidance. This was either because the guidance on the placemat was out of date or staff did not understand

it. One person's guidelines said they should be supported by staff to feed themselves. We saw this did not take place at one mealtime. When we asked why the guidelines were not followed, staff went to find the person's adapted spoon but clearly did not know how to use it. People were at risk of choking or aspiration due to dysphagia but we saw both good and risky practices including where one staff did not give somebody enough time to swallow before giving them another mouthful. We concluded that some staff had not received enough practical training in dysphagia to support people to eat safely.

We recommend that further practical training on supporting people to eat safely is provided to staff by a suitably qualified professional.

Staff were completing fluid charts to record how much each person drank each day. Staff were now able to monitor people's drinking over a 24 hour period as day centre staff were now completing fluid charts for people too. Fluid records referred to "ideal" amounts that people should drink daily rather than recommended minimum amounts but the recording of drinks had improved since the last inspection.These records were now being checked by nurses so they could take action to ensure people were not dehydrated. A relative told us they were confident that people were now receiving enough drinks and were offered drinks regularly throughout the day.

People had specialist professionals to review their care and treatment, including epilepsy, asthma and diabetic nurses, physiotherapists and their specialist consultants. We found improvements in staff acting on the advice and recommendations of healthcare professionals. The physiotherapist reported a good improvement in staff understanding and carrying out people's individual physiotherapy programmes and assisting them to use equipment such as arm splints and standing frames. There were positive benefits for people from better attention being paid to the needs associated with their physical disabilities. Staff were making sure people changed position more regularly to reduce risk of pressure ulcers and stiffness. We observed people to be relaxed with no obvious signs of physical discomfort.

The building was fully accessible for people who used wheelchairs and other equipment.

Good

Is the service caring?

Our findings

One relative told us that people's emotional needs were being looked after. They felt staff understood their family member's moods, likes and dislikes and treated them with respect. Relatives gave positive feedback about new staff who they said were "lovely" and "really good" in their interactions with people in the home. A relative told us that the home had made "massive" improvements since the last inspection and said people "smile more" and we also saw people looked relaxed and were smiling which was an indication of wellbeing.

Staff had training in dignity and were caring and gentle in all their interactions with people.
Nine staff had completed training in Enabling Communication through Sensory, Intensive Interaction & Engagement which was relevant to their role in communicating with people.

We observed staff interacting with people in a gentle way and people responded by looking at staff and smiling showing that they were comfortable. Staff were aware of people's support needs and knew how each person communicated. Some people living in the home had complex communication needs so staff needed to interpret their body language, eye movements and sounds to understand their needs. One staff understood when somebody made an agitated noise that they didn't like being left out of the conversation and wanted staff to talk to them directly.
People's privacy was maintained. People were treated with respect and their needs were being met in a friendly and unhurried manner.

We saw that one woman had two female staff to support her with personal care in accordance with the wishes of her family and her religious needs.

Staff knew people's likes and dislikes. A staff member sat with one person continuously and every now and then rubbed and stroked their arm. They told us that this was to let them know that someone is there as this person was deaf and blind. One staff member kissed a person's arm and said, "[….] likes it when we kiss her arm, It's like a reassurance for her." All staff greeted each person when they arrived for work and said good bye when they left.

People's cultural and religious needs were met. One person was supported to attend a place of worship and religious festivals were celebrated in the home. Families provided cultural items such as food, music and pictures for people. Staff knew each person's cultural background and religion.

Good

Is the service responsive?

Our findings

Staff were responsive to people's needs and wishes. Senior staff had updated care and support plans, health action plans and other documents since the last inspection so staff were able to understand people's current needs and know how to meet them. Staff knew each person's current personal care requirements.

The activities co-ordinator said that people, " have a wider variety of opportunities now." There was a new activities room with sensory equipment but this was not homely as it had been set up in a bathroom rather than a spare bedroom or lounge. The deputy manager said that staff took people to this room regularly and people enjoyed relaxing there listening to music. One staff member said, "It was very hard and difficult to take the clients for outings because of their needs" however we found people were going out more regularly.

Staff supported two people every Friday to visit a disco in a nearby town in turn so each person attended every third week. Two people had a weekly massage by a visiting therapist and manicures by staff in the home.

On the day of the inspection one person went to a day centre for the day and two people went out bowling, shopping and to a cafe.

Relatives told us that staff had organised an Easter party and a party to celebrate the Queen's birthday. Families were invited too and at the time of the inspection a birthday party was being planned which all relatives were invited to.

People's rooms were homely and personalised with family photographs and personal belongings.

Relatives told us they were confident that their views were listened to by the management team in the home and also by the provider. Quarterly meetings with the managing director took place and they said any concerns they raised were acted on quickly. They said the acting manager resolved any concerns "immediately." This responsive approach had reduced the number of complaints in the home.

The complaint logging form did not have sufficient space to record the outcome of the complaint and the record did not always say whether the complaint was resolved to the complainant's satisfaction. The provider planned to review the recording form. The most recent complaint was clearly recorded.

Requires Improvement

Is the service well-led?

Our findings

Since the last inspection the provider had improved their monitoring of the quality of care delivery in the home. The standard of care had improved and relatives were more confident that their family members would be able to stay at the home and receive good care. One relative said the improvements made since the last inspection in January 2016 were "massive" and that Cedar House was now the "best it's ever been." One professional told us Cedar House was, "a very different place." Another person said that the provider had "picked up their game."

Relatives said the organisation treated them with more respect and they had regular meetings with the manager, regional manager and managing director where they were kept up to date with developments.

The manager had been at the home for six months at the time of this inspection. She was working with the deputy manager in overseeing the home. They had carried out an unannounced visit at night at which a concern had been found and was being investigated. This was evidence of improved management oversight of the care in the home.

The home was well supported by the regional manager who visited at least three times a week, supported the management team and carried out audits. This person had been instrumental in improving the quality of care provided which was rated as inadequate eight months ago. At a higher level in the organisation there had been improvements in the monitoring of risks and quality in the home since the last inspection.

There were regular internal audits carried out by the manager and deputy. However, these audits were not always effective enough to ensure a good standard of care. These audits had not identified a medicines error where one person did not receive two prescribed medicines for several days. An audit by the provider found this issue. Following that another error was found by the manager's audit. There was evidence of learning from these errors.

Staff wrote contemporaneous daily records of the care provided to each person. These included which staff had supported them, any appointments attended, food eaten, nursing and personal care provided and activities. This was supplemented by fluid intake records, seizure records and repositioning records. Staff told us that previously there were gaps in the written notes, where staff had forgotten to complete records of care. This was discussed and a suggestion was made that a chart be made where one member of staff would check that everything was up to date.That took place and records were now more accurate. This was an example of learning from errors.

A provider audit in May 2016 found that care plans and health action plans were not up to date and set a date for this to be completed. This had been acted on and the plans had been reviewed by the time of the inspection. We did not ask to see the new plans as they were due to be printed that day.

Despite the improved auditing we still found areas of concern that the provider had not picked up in their own audits. This included nurses not consistently following an agreed treatment protocol for a person with

diabetes. Risks to people's health and safety at night had not been assessed and despite regular audits there were still some areas for improvement relating to the safe management of people's medicines. These left people at risk of receiving inappropriate or unsafe care.

Staff told us that they have monthly meetings and all staff usually attend even those who are not due to come in that day.

The overall filing system was complicated to follow (especially for new and agency staff member) as each person had information and care records in 4 different files. However when put together the files showed people's needs, wants and wishes were identified.

Representatives from the local authority continued to visit the home weekly and monitored the quality of care as they continued to have some concerns. Two other authorities said they were satisfied with the care provided at Cedar House.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Specialist advice on the care and treatment of people with diabetes was not been followed. 12(1)(2)(a)(b). There was a failure to monitor people who have epilepsy for seizures at night. 12(1)(2)(a)(b). Medicines were not always stored and managed safely. 12(1)(2)(g).

The enforcement action we took:

warning notice