Cedars Castle Hill

The Cedars Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 22 May and was unannounced. The inspection continued 23 May 2018 and was announced.

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

The Cedars Nursing Home is a large detached property in Shaftesbury. The home provides long term accommodation for up to 31 older people with personal care and nursing care needs. At the time of our inspection 27 people were living at the home.

The service had a registered manager in post. 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.

Safe care and treatment was not always being delivered at The Cedars nursing Home. Medicines were not always stored and administered safely. Times of time critical medicines were not recorded which meant that the nursing staff administering medicines could not always be sure that medicines were administered consistently with the appropriate time gaps between doses. Safety needles in line with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 were not being used by clinical staff within the home. A medicine capsule was found in a person's care file and pressure relieving mattresses were not always set at the correct setting. Risks had not always been assessed for everyone who was living in the home and catheter care procedures were not in place.

Mental Capacity Act records were not completed accurately and there were areas of care and equipment which had not been assessed or best interest decisions recorded in line with the Mental Capacity Act 2005 (MCA). These included the use of tilt and space chairs for people which restricted movement and the administration of medicines prescribed as required (PRN).

We reviewed the current audit processes The Cedars Nursing Home were using and found that the audits continued to be ineffective and inaccurately completed since our last inspection. For example, care plan audits did not cover capacity assessments or best interest decisions. This meant that gaps we found were not identified or actions taken to improve these in line with the MCA. Records and audits had not been completed accurately for example mattress audits had ticks in the wrong boxes and personal care charts had not recorded oral care for the past three months.

People, relatives, health professionals and staff told us that The Cedars Nursing Home was a safe home. Safeguarding alerts were being managed and lessons learnt by the home. Staff were able to tell us how they would report and recognise signs of abuse and had received training in safeguarding.

There were sufficient numbers of safely recruited staff at the home. A dependency tool was used to calculate the number of staff hours required to meet people's needs.

Care plans were in place which detailed the care and support people needed to remain safe whilst having control and making choices about their lives. Most people had a care plan and associated files which included guidelines to make sure staff supported people in a way they preferred. Staff had access to people's care plans and daily records.

Staff had a good knowledge of people's support needs and received regular local mandatory training. They also received training in response to people's changing needs for example dementia care.

Staff told us they received regular supervisions which were carried out by the management team. Staff told us that they found these useful. We reviewed records which confirmed this. People and relatives told us that the food was good. We reviewed the menu which showed that people were offered a variety of healthy meals. People were supported to access healthcare appointments as and when required and staff followed professional's advice when supporting people with ongoing care needs. Records we reviewed showed that people had recently seen the GP, district nurses and a chiropodist.

People, professionals and relatives told us that staff were caring. We observed positive interactions between staff, managers and people. This showed us that people felt comfortable with the staff supporting them. Staff treated people in a dignified manner. Staff had a good understanding of people's likes, dislikes and interests. This meant that people were supported by staff who knew them well.

People had their care and support needs assessed before being admitted to the service and care packages reflected needs identified in these. We saw that these were regularly reviewed by the service with people, families and health professionals when available. People were encouraged to feedback. There was an active system in place for recording complaints which captured the detail and evidenced steps taken to address them. The registered manager told us that lessons were learnt and shared with staff in meetings. This demonstrated that the service was open to people's comments and acted promptly when concerns were raised.

Staff had a good understanding of their roles and responsibilities. Information was shared with staff so that they had a good understanding of what was expected from them. Staff felt recognised and that team moral was good. People, relatives, professionals and staff felt that the service was well led. The registered manager encouraged an open working environment. The service understood its reporting responsibilities to CQC and other regulatory bodies and provided information in a timely way. The service worked in partnership with other agencies. Professionals told us that communication with the home was good.

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 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.

Medicines were not always managed safely, securely stored or correctly recorded.

Risks had not always been assessed for everyone who was living in the home and catheter care procedures were not in place.

Pressure mattress settings were not always set at people's weight meaning some people were at risk of pressure ulcers.

Areas of the home were kept clean to minimise the risks of the spread of infection.

There were sufficient staff available to meet people's assessed care and support needs.

Staff had completed safeguarding adults training and were able to tell us how they would recognise and report abuse.

Lessons were learnt and improvements were made when things went wrong.

Is the service effective?

Good

The service was effective.

Consent to people's care was sought. However records did not always capture that outcomes of decisions were in people's best interests.

People's needs and choices were assessed and systems were in place to deliver care and treatment.

Staff received training and supervision to give them the skills they needed to carry out their roles.

People were supported to eat and drink enough and dietary needs were met.

The service worked within and across other healthcare services to deliver effective care.

The premises met people's needs and they were able to access different areas of the home freely.

Is the service caring?

Good

The service was caring.

People were supported by staff that treated them with kindness, respect and compassion.

Staff had a good understanding of the people they cared for and supported them in decisions about how they liked to live their lives.

People were supported by staff who respected their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People were supported with end of life care. Preferences and choices were respected by staff but not fully recorded in their care plans.

People were supported by staff that used person centred approaches to deliver the care and support they required.

People were supported by staff that recognised and responded to their changing needs.

People were supported to access the community and take part in activities within the home.

A complaints procedure was in place. Relatives, professionals and people told us they felt able to raise concerns with staff and/or the management.

Resident and relatives meetings took place which provided an opportunity for people to feedback and be involved in changes.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality monitoring systems were in place however these were ineffective and not completed accurately.

Records were not always completed accurately or checked by management.

The management team promoted inclusion and encouraged an open working environment.

Staff received feedback from the management and felt recognised for their work.

The home was led by a management team that was approachable and respected by people, relatives and staff.

The home was continuously working to learn and improve the delivery of care to people.

The Cedars Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection site visit took place on 22 May and was unannounced. The inspection continued on the 23 May 2018 and was announced. The inspection was carried out by two inspectors on day one and one inspector and a specialist advisor on day two. The specialist adviser had clinical experience and expertise in nursing.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We contacted the local authority quality assurance team and safeguarding team to obtain their views about the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with five people who used the service, three relatives, one friend and a health professional. We had a telephone conversation with one health professional. We met with six staff, the clinical manager and deputy manager.

We spoke with the registered manager and systems manager. We reviewed 14 people's care files, policies, risk assessments, health and safety records, consent to care and treatment, quality audits and the 2017 resident and relative's survey results. We observed staff interactions with people and a meal time. We looked at four staff files, the recruitment process, complaints, training and supervision records.

We walked around the building and observed care practice and interaction between care staff and people who live there. We used the Short Observational Framework for Inspection (SOFI) at meal times. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We asked the registered manager and systems manager to send us information after the visit. This included policies and the staff training record. They agreed to submit this by Friday 25 May 2018 and did so via email.

Requires Improvement

Is the service safe?

Our findings

People who lived at The Cedars Nursing Home did not always receive safe care and treatment.

The home had not implemented safe systems and processes to ensure people received their medicines both prescribed and non-prescribed on time and in line with the providers medicine policy. On day two of our inspection the morning medicine round was not completed until 11.30am. Times of time critical medicines for example, Parkinson's and antibiotics were not recorded on people's medicine administration record (MAR) sheets. This meant that staff could not be sure that people were receiving their medicines on time and appropriate time gaps were given in-between doses. The registered manager told us they would put a system in place.

Medicines were not always stored safely. On day one of our inspection whilst reviewing a person's care and support file we found a white medicine capsule inside a plastic wallet. This meant that someone had potentially gone without this medicine. We brought this to the attention of the registered and clinical managers who told us they did not know how this could have happened and would investigate it. On day two of our inspection we found that people's names had been written on insulin but not dated with date of opening which meant that nurses could not be sure when insulin would expire. The registered manager said they would review this with the clinical manager.

A number of people needed their drinks thickened to reduce the risk of them choking. These drinks were thickened using a thickening powder. On day two of our inspection we found thickening powder left out in areas of the home and unlocked in people's bedrooms. This put people at risk of harm by having unsupervised access to the powder. The National Reporting and Learning System (NRLS) database has identified patient safety incidents where harm has been caused by the accidental swallowing of the powder, when it had not been properly stored out of reach. The registered manager told us that they would remove it from communal areas and lock it away in people who required its rooms.

Some people's risks had not been fully assessed or measures recorded to ensure the delivery of safe care and treatment. One person had recently moved into the home and their care plan had not been completed. The person had been assessed as high risk of falls but clear measures were not reflected in their plan to mitigate these risks. Catheter care procedures were not in place for people who used these to ensure the correct positioning and frequency of changes. This meant that people were at risk of infrequent changes. The registered manager told us they would put a procedure in place.

Each person's optimum fluid intake had been assessed and hourly monitoring and intake charts were in place. However; fluid charts were not always completed fully and handover sheets did not record that fluid level intake had been handed over to staff on different shifts. This meant that people were at potential risk of dehydration. One person's intake had been assessed as 1275ml. We found that between 20 and 23 May 2018 their total intake over these four days only amounted to 1435ml. There was no record that this person's intake had been increasingly low or handed over to staff. During our inspection we observed people being supported to drink and drinks made readily available to them. The registered manager told us they would review people's optimum fluid intakes were handed over.

We checked eight people's pressure mattress settings and found that three were not set according to the people's weight. For example, one person weighed 45.5kg and their mattress was set at 75kg. Another person weighed 44.3kg and their mattress was set at 60kg. Although at the time of our inspection no one had a pressure ulcer this increased the risk of pressure ulcers occurring. The registered manager told us they would review all settings and ensure they were set correctly.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were administered insulin using pens that were not in line with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The term 'safer sharp' means medical sharps that incorporate features or mechanisms to prevent or minimise the risk of accidental injury. The registered manager told us that the pharmacist had informed them that the safety needles for insulin pens were not on the local formulary therefore they were unable to prescribe them.

People, relatives and staff told us that The Cedars Nursing Home was a safe place to live. A person told us, "I feel as safe as I did at home". Another person said, "I am happy living here". A relative told us, "This is a very safe home. I go home feeling confident my loved one is in safe hands". A friend said, "It's a safe home. There are always staff around. My friend would not be safe at home anymore". Staff described the service as safe and told us there were safe systems in place. A staff member told us, "This is a safe home. Staff are all driven by making sure people are happy and measures are in place. Risk assessments are in care files and we ask visitors for identification".

We observed staff competently using a hoist and sling, engaging with the person throughout ensuring their safety and comfort. This was in line with the persons moving and assisting plan.

There were enough staff on duty to meet people's needs. The deputy and clinical manager told us they used a dependency tool to ensure there were sufficient numbers of staff to deliver safe care to people. They explained that the tool assessed people's needs and levels of dependency and calculated the numbers of staff hours required. A person said, "I think there are enough staff. If I want anything and I can't get it, they get it for me". A staff member told us, "I think there are enough staff and communication is good". Another staff member said, "I feel there are enough staff. We have enough time to deliver care and spend time with people". A professional told us, "My observations have been positive. There appears to be enough staff". A relative said, "There always seems to be a lot of staff. We come at different times of the day. Never concerned". The service also employed cleaning, kitchen, and maintenance staff to help ensure the service ran effectively.

The service had a suitable recruitment procedure. Recruitment checks were in place and demonstrated that people employed had satisfactory skills and knowledge needed to care for people. All staff files contained appropriate checks, such as references and a Disclosure and Barring Service (DBS) check. The DBS checks people's criminal record history and their suitability to work with vulnerable people.

Staff were clear on their responsibilities in regards infection control and keeping people safe. All areas of the home were kept clean to minimise the risks of the spread of infection. There were ample hand washing facilities and staff had access to Personal Protective Equipment (PPE) which we observed being used correctly. Staff were able to discuss their responsibilities in relation to infection control and hygiene. We found that an infection control audit was completed and up to date. A relative told us, "It's always very clean. Never any odours. My loved ones room is kept very clean and tidy".

There were effective arrangements in place for reviewing and investigating safeguarding incidents. The local authority told us the registered manager worked effectively with them. On day one of our inspection we observed a staff member speaking to a person inappropriately. We fed this back to the registered manager and raised it with the local safeguarding team. The registered manager recorded this and took appropriate action to address this concern in line with their local policy and procedure. The management team told us they were open to learning and shared this with staff via handovers, meetings and in the communication book. A professional told us, "I have no safeguarding concerns. The service is very open to learning". A relative said, "I have no safeguarding concerns here and feel confident the management would act on any in a timely manner".

Staff were able to tell us how they would recognise signs of abuse and who they would report these concerns to. This included the management team and external agencies such as CQC, the local authority or police. We observed that the home displayed posters regarding reporting abuse in the reception area and staff room. A staff member told us, "Changes in behaviour, unexplained or un recorded marks, flinching may be signs of abuse. I would report this to management or CQC and social services. I have done my safeguarding training".

Staff understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and report these internally and externally as necessary. Staff told us if they had concerns the registered manager would listen and take suitable action. Accident and incident records were all recorded and analysed by the deputy and registered manager and actions taken as necessary. These had included seeking medical assistance and specialist advice. Lessons were learned and shared amongst the staff team and measures put in place to reduce the likelihood of reoccurrence. A staff member told us, "If I witnessed an incident I would report it. The nurse would assess it; call 111 or 999 for advice or further support. It is then recorded and any body maps completed".

Equipment owned or used by the registered provider, such as specialist chairs, adapted wheelchairs and hoists were suitably maintained. Systems were in place to ensure equipment was regularly serviced and repaired as necessary. All electrical equipment had been tested to ensure its effective operation.

Good

Is the service effective?

Our findings

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.

Staff were aware of the Mental Capacity Act and worked within the principles of this. Consent to people's care was sought. For example we observed people being asked before being given support to eat and medicines being administered. However records did not always capture that outcomes of decisions were in people's best interests. For example, the use of tilt and space chairs for people which restricted movement, the administration of the 'when required' (PRN) medicines for example; rectal diazepam and for another person had moved bedrooms.

People can only be deprived of their liberty to receive care and treatment when it is in their best interests and legally authorised under the MCA. Applications had been made for people who required Deprivation of Liberty Safeguards (DoLS) and were pending assessment by the local authority.

Staff told us that they felt supported and received appropriate training and supervisions to enable them to fulfil their roles. A staff member told us, "I get enough training here. If we have additional training requests they are accepted and provided. I requested awareness training in toileting the other week and it was provided the next day". Another staff member said, "I receive regular training and supervision here. I recently did a moving and assisting refresher and some feeding training. This helped me have a better understanding of soft diets". Another staff member told us, "I have regular supervisions with my supervisor. They are a good opportunity to talk, check we are ok and discuss people we support. It is nice to have this support".

The Cedars Nursing Home provided staff with regular training which related to their roles and responsibilities. Staff were knowledgeable about people's needs, preferences and choices. A staff member told us, "Training is good here". Training records confirmed that staff had received training in topics such as health and safety, moving and assisting, infection control and prevention and first aid. We noted that staff were also offered training specific to the people they supported for example; nutrition and dementia awareness. Nurses had received additional clinical training which included; syringe drivers, wound care and verification of death. A relative told us, "Staff appear competent in their roles and are always professional".

Nursing staff were aware of their responsibilities to re-validate with their professional body, the Nursing and Midwifery Council. Nurse re-validation is a requirement of qualified nurses. This process ensures they provide evidence of how they meet their professional responsibilities to practice safely and remain up to date. The registered manager was supporting clinical staff to achieve this through reflective learning and development sessions arranged at the home and external training and events.

There was a clear induction programme for new staff to follow which included shadow shifts and practical competency checks in line with the care certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. A staff member who was on induction during the inspection said, "This is a really good induction so far. I like to be doing a job where I can spend time with people and make a difference. Staff are supportive. I have been working with them and shadowed them". We met with the staff member who led new staff inductions at the home. They told us that they arrange new staff paperwork and show them around the home and complete the first few shadow shifts with new staff. They said that they deliver moving and assisting training and check competencies. The staff member said, "New staff had probation meetings with the clinical manager which I feed into".

People's needs and choices were assessed and care, treatment and support was provided to achieve effective outcomes. Care records held completed pre admission assessments which formed the foundation of basic information sheets and care plan details. There were actions under each outcome of care which detailed how staff should support people to achieve their agreed goals and outcomes. As people's health and care needs changed ways of supporting them were reviewed.

We were told that changes relating to people's care, treatment and support were discussed within daily care staff handovers. We found that each person was discussed and a summary of their day given during handovers. This included any changes, concerns or observations. These meetings also gave all staff an opportunity to seek further advice and ask any questions before starting their shift.

People were supported to maintain a healthy diet. A person told us, "Food is excellent, no complaints. My favourite is roast". Another person said, "The food is not bad, it's edible. They do nice desserts". Another person said, "I can have drinks whenever I want to throughout the day and evening". A relative told us, "My loved one is asked food choices. The staff appear to know their preferences. The food looks lovely" A friend said, "Very good food. Always looks appetising and smells good. It is also always presented nicely. My friend can choose to eat where they like in the home".

We observed that menu choices were displayed visually in the communal dining area. There was a choice of two options. People and staff told us that alternative options were also available upon request. People's dietary needs were assessed and understood by care and kitchen staff. Care plans included an admission services form which detailed people's food and drink preferences.

We observed people eating and found that there was a relaxed atmosphere. Food looked appetising, was plentiful and overall it appeared to be a pleasurable experience. Tables were nicely laid and drinks were available to people. People requiring assistance were helped in a manner which respected dignity and appeared to demonstrate knowledge of individual dietary and food consistency needs. People choose whether to have their meals in their own rooms or the communal dining room.

The kitchen had been awarded a five star food standards rating and all kitchen staff had received food hygiene training.

People had access to health care services as and when needed. Health professional visits were recorded in people's care files which detailed the reason for the visit and outcome. A health professional said, "Staff are prepared for my visits and have paperwork ready" Recent health visits included; A psychiatrist, district nurse, GP, out of hours GP, and a chiropodist.

People told us they liked the physical environment. The house was split across two levels and had been adapted to ensure people could access different areas of the home safely and as independently as possible.

There was a working lift in place providing access to both floors. There was clear signage to indicate shared lounges and bathrooms. There was access to secure, outdoor spaces with seating and planting that provided a pleasant environment and a quiet lounge on the first floor. A person said, "I go down to the lounge occasionally when I want to". A relative said, "We have had family parties in this quiet lounge. We celebrated an anniversary here and a birthday. The whole family came. It was lovely".

Good

Is the service caring?

Our findings

People, professionals and their relatives told us staff were kind and caring. One person told us, "Staff are excellent, I can't fault them". Another person said, "Staff are nice" People were treated with respect; staff knocked on people's doors before entering and did not share personal information about people inappropriately. One person told us, "Carers are very nice". A relative told us, "The staff are amazing. My loved one is respected as an individual". A friend told us, "Staff respect my friend and see them as a person. Their choices are respected. Staff back off if my friend refuses something and go back again later". A staff member said, "We respect people's dignity and privacy by making sure we know their preferences, closing doors and using dignity towels". Bedrooms were personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. A relative said, "It is lovely here, it's personalised, homely and has a nice atmosphere".

People who were able to talk to us about their view of the service told us they were happy with the care they received and believed it was a safe environment. Comments from people and their relatives included. "The level of care is great; they [staff] go out their way". "From what I have seen I am impressed with the level of care". "I am really happy here; it's like home from home". "We are happy with our loved ones care".

People's cultural and spiritual needs were respected. A local minister and catholic priest regularly attended the home and others were able to express their spirituality in a way that suited them. Staff encouraged people to receive visitors in a way that reflected their own wishes and cultural norms, including time spent in privacy. A relative told us, "My loved one stays in their room now, they don't like mixing. This is respected and staff visit them".

People were supported to maintain contacts with friends and family. This included visits from and to relatives and friends and regular telephone calls. There was a quiet lounge so people were able to meet privately with visitors in an area other than their bedrooms. A relative told us, "I am made very welcome here and can visit anytime. Staff don't mind when I come". Staff were aware of who was important to the people living there including family, friends and other people at the service.

On both days of the inspection there was a calm and welcoming atmosphere in the home, punctuated with moments of singing, music and laughter. We observed staff interacting with people in a caring and compassionate manner. For example, during lunch staff were patient and attentive as they supported people. They demonstrated a concern for people's well-being and were gentle and encouraging. A person's friend told us, "Staff are caring and compassionate. For example, they [staff] hold my friends hand and give them a hug which means a lot and makes them smile".

People were encouraged to be independent and individuality was respected. We observed a staff member encouraging a person to walk freely to another room. The staff member was reassuring, patient and did not rush the person. A person told us, "They [staff] help me to wash and dress. They are so good to me and that's all there is to it". A relative said, "The staff do make an effort to get to know the residents". A staff member told us, "I encourage people to do things for themselves like, wash, dress and brush their own hair and teeth".

People were encouraged to make decisions about their care, for example what they wished to wear, what they wanted to eat and how they wanted to spend their time. A staff member told us, "I talk to people and show them options to aid choice and decision making". People appeared well cared for and staff supported them with their personal appearance.

The home had received a number of compliments and thank yous. We read one which said, "To you all with love and for the respect and care my loved one received". We read another which read, "Thank you to all of you hardworking staff at The Cedars. You made [name's] last few months as comfortable as it possibly could be".

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Staff were able to tell us how they put people in the centre of their care and involved them and / or their relatives in the planning of their care and treatment. The clinical manager told us, "We now do reviews which include families, people (if they are able and choose to), staff from different departments and professionals whenever possible. These allow us to gather and share more information including any changes in preferences, hobbies and interests". They went on to say, "We used to review them with people in their rooms and with families over the phone. These meetings are now more meaningful than before; they are more interactive and person centred." Outcomes from recent meetings included understanding one person's past love of fishing. Now they received a monthly fishing magazine and the home had purchased videos of fishing. Another person loved babies. The home had purchased a doll which had had a positive impact on the person allowing them to cradle and care for the doll.

Staff had access to people's care files and responded to people's changing needs. A professional told us, "I look for flexibility and person centred care, staff know their people well and respond positively if needs change". A relative told us, "They [staff] call me and update me if there are any changes or concerns. For example, last week my loved one was unwell. They arranged a GP visit, antibiotics were prescribed and now they are better". A person told us that the staff had given them tablets recently for a chest infection. The person said, "The staff noticed it before it took hold, they called the doctor and they came to see me". "I am now on my second lot of tablets".

Activities coordinators were employed and worked across the home. They had a good understanding of people's social needs and what people's hobbies and interests were. One activities coordinator told us, "We tend to do themes each month and decorate the communal lounge. This month it was the Royal Wedding and next month is a celebration of Dorset". On our arrival to The Cedars Nursing home we found that the lounge area was decorated in royal wedding photos, bunting and on the far wall a person's wedding dress from 1951 and memos written by people to the Royal couple. One memo read, "May god shine on you", another read, "Make sure you know each other's wages!". We were told by people, staff and relatives that the day had been enjoyed.

The activities coordinator said, "Other activities we do include; arts and crafts, cake baking and external visitors come in too like local schools, birds of prey and a pianist". We observed that art work made by people was displayed throughout the home giving it a personal touch. Monthly programmes were created and weekly timetables printed out and given to each person at the start of every week. A person said, "They [staff] offer to include me in the activities. The activity staff are very good. A relative told us, "My loved one likes music and gentle interaction. They like being in the communal area". A professional said, "What I like about here is that people have time in the lounge and can participate in activities".

The service arranged for a memory box to be delivered every other Tuesday. These boxes were filled with past time memories to engage people in conversation and allow them to reminisce.

People were provided with opportunities to feedback to the service. Resident and relative meetings took place. A relative said, "Relative meetings take place and if I lived closer I would attend these". The registered and clinical manager told us that they welcomed complaints and saw these as a positive way of improving the service. The service had a complaints system in place; this captured the nature of complaints and steps taken to resolve these. We noted that three complaints had been raised since January 2018 and found that the service had taken actions to address these, respond to people concerned and learn from them. We noted that one visitor had raised a concern that it had taken several minutes for staff to answer the door. In response to this the home had purchased two portable door bells which were located on both floors.

Relatives, people and staff we spoke with all said that they would feel able to raise any concerns they may have. A person told us, "I would tell someone if I was not happy about anything". A relative said, "I have no concerns or complaints. If I did I would raise these with the staff and nurses. I am confident they would act quickly". A friend told us, "So far no complaints, worries or concerns. I am happy I can go home knowing my friend is well cared for".

The registered manager told us that the home had an end of life care accreditation. People were supported with end of life care and some preferences were recognised, recorded and respected. However, we noted that one person enjoyed catholic hymns but this had not been captured in their end of life plan. The registered manager told us that this would be discussed with the person and added if they wished. A relative told us that their loved one had recently passed away at the home. They said, "What really impressed me was the deputy manager, outstanding and compassionate. They offered time to me if I wanted it. My loved ones wishes were met for example, they played their preferred music, and was kept clean and changed".

Requires Improvement

Is the service well-led?

Our findings

When we completed our previous inspection in June 2017 we found concerns relating to good governance. Quality monitoring systems were in place but were not effective nor were they always completed accurately.

We reviewed the current audit processes The Cedars Nursing Home were using and found that the audits remained ineffective and inaccurately completed. For example, care plan audits did not cover capacity assessments or best interest decisions. This meant that gaps we found were not identified or actions taken to improve these in line with the MCA. The care plan audits asked the auditor to confirm if all care plans had original signatures of the person, advocate or next of kin (NOK) and stated if the answer was no action must be taken. All audits confirmed that these were in place but none of the care plans we reviewed had been signed or actions recorded to rectify these. This demonstrated that the audit was not effective or being completed accurately.

Mattress audit tools had been completed incorrectly and ticks placed in the wrong boxes for seven people. These audits identified that there were breaches in the integrity of mattress covers, fastening devises were broken, mattresses were soiled and they had offensive odours. However, each of the audits were recorded as passing and being compliant. We checked these mattresses and found that they were clean and unbroken. We discussed the audit findings with the management who had not identified the errors but told us that they think the auditor must have misread the questions. This demonstrated that records were not completed accurately.

We reviewed people's personal care charts and found that there were gaps in recording. The charts had a variety of key codes indicating personal care tasks such as, bath, bed bath, body wash, hair wash and shave. We noted that mouth care, teeth cleaning and denture cleaning had not been recorded as being completed for the people's records we reviewed in March, April or May 2018. Through conversations and observations with people we did not find that mouths were dry or teeth were dirty. The management told us that they had not identified these recording gaps and that they were in the process of reviewing the daily recording paperwork.

Mental Capacity Act records were not completed accurately and there were areas of care and equipment which had not been assessed or best interest decisions recorded in line with the Mental Capacity Act 2005 (MCA). These included the use of tilt and space chairs for people which restricted movement, the administration of medicines prescribed as required (PRN). A professional told us, "I am concerned that there is no best interest paperwork in place for [names] tilt and space chair. We have identified there are gaps in MCA recording and paperwork here and have raised it with the management who have acknowledged it". The registered manager told us they would arrange a Multi Disciplinary Team (MDT) meeting to review these.

We read one person's capacity assessment and best interest decision for the delivery of personal care. It referred to the person as the wrong gender five times. Another best interest decision completed for a person in relation to their medicines referred to the person as the wrong name twice in the same document.

A person's capacity assessments for medicine and personal care had been recorded as completed on 26 April 2018 at 2.30pm by a registered nurse. The person had been identified as not having capacity however no best interest decisions were recorded in the persons care file. Another capacity assessment for a person had recorded the person as both having and not having capacity to consent to the delivery of personal care in line with their care plan.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a registered manager in post. 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 registered manager told us that they were reviewing the quality monitoring systems that the home was using and had purchased a new on line programme which would be rolled out in the next few months. Following our inspection the registered manager sent us an initial action plan detailing some of the concerns we had fed back to them. This demonstrated a positive reactive approach to wanting to improve the service.

The management told us that they promoted an open door policy. The manager's office was located on the first floor at the end of a corridor. The registered manager's office was situated in an adjacent building to the home. This meant that they were not always visible to people, visitors and staff. Staff and relatives told us that they did not often see the registered manager but when they did they found them polite and welcoming. A staff member said, "The registered manager seems lovely but I don't see them a lot".

Staff, relatives and people's feedback on the deputy and clinical manager was positive. A person told us, "The manager is nice". One staff member said, "The deputy is really good. Easy to talk to. They listen to us [staff]". Another staff member told us, "The clinical manager is lovely. Very encouraging. The management promote an open door policy. They are also flexible. I was able to choose my weekend off to fit in with family time". A relative said, "The deputy manager seems extremely good. They are caring and patient. Always happy to answer my questions". Another relative told us, "The management went out of their way during my loved ones last days. The deputy spent the night at the home". The clinical manager told us, "To make a good leader you need to be a good listener and involve people and staff. It's also important to see everyone equally and lead by example. This is what I believe I do".

The provider had an equality and diversity policy in place. The recruitment process was open and equal to all. The registered manager told us that they would make adaptations for staff in relation to cultural beliefs. For example, uniforms, flexible shifts to allow for prayer times, food and holidays. Other adaptations the service had made included staff who were pregnant and those with a disability.

The service worked in partnership with other agencies to provide good care and treatment to people. Professionals fed back that they felt information was listened to and shared with staff. A health professional said, "The home works well in partnership with us. They prioritise visits and understand the ethos of dementia". The registered manager told us they had a good relationship with the local GP surgery and that they had recently arranged for the local district nurses to come to the home weekly to visit people identified as requiring their support.

The manager understood the requirements of duty of candour that is, their duty to be honest and open about any accident or incident that had caused, or placed a person at risk of harm. They fulfilled these obligations where necessary through contact with families and people. A relative member said, "The home is transparent and hold their hand up when things go wrong whilst learning from this and sharing it with us and their staff".

People, relatives and staff told us that they felt engaged and involved in the service. A relative said, "The home is really supportive. I feel I can raise ideas and am involved in improvements. I can't think of any examples now though". We found that surveys had been submitted to people, families, staff and stakeholders in 2017. The home had compiled the results of these, analysed the feedback and made changes in response. For example, the home had created you said we did or are doing posters. Some findings included; families and friends weren't routinely asked if they wanted to attend meetings regarding their loved ones. Families and friends are now directly invited to review meetings and can attend any resident meetings. Staff were not clear on their responsibilities. Staff have now been briefed by supervisee's on their role and responsibilities.

Staff meetings took place regularly. A staff member told us, "Staff meetings usually take place monthly and are for all staff. They are a good opportunity to get together and raise any concerns we may have. Management use these to share learning, changes and improvements with us. They are also good for us to raise ideas and suggestions. The management always listen to these and acknowledge them".

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely, securely stored or correctly recorded. Risks had not always been assessed for everyone who was living in the home and catheter care procedures were not in place. Pressure mattress settings were not always set at people's weight meaning some people were at risk of pressure ulcers.

The enforcement action we took:

The registered person must undertake audits, at The Cedars Nursing Home. These audits must examine the quality and accuracy of all service users' support plans and risk assessments associated with their health and care needs. Audits must also examine the management of medicines and medical devices. A report must be submitted to the Care Quality Commission by the last Friday of each calendar month, setting out the action taken or to be taken, and by when, as a result of these audits.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality monitoring systems were in place however these were ineffective and not completed accurately. Records were not always completed accurately or checked by management.

The enforcement action we took:

The registered person must undertake audits, at The Cedars Nursing Home. These audits must examine the quality and accuracy of all service users' support plans and risk assessments associated with their health and care needs. Audits must also examine the management of medicines and medical devices. A report must be submitted to the Care Quality Commission by the last Friday of each calendar month, setting out the action taken or to be taken, and by when, as a result of these audits.