Anchor Carehomes Limited

The Cedars

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 9 November 2016 and was unannounced. The Cedars is a residential home for up to 42 people who have a variety of support needs, such as older people and people with dementia. There were 36 people living at the service at the time of the inspection.

There was a Registered Manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we identified a breach 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.

Not all staff were caring and people were not always treated with dignity and respect. People's choices were not always respected, their dignity was not always maintained and we observed a person who was not able to speak to their relatives at a time that suited them.

All safeguarding allegations should be reported to the local safeguarding authority however we found an instance of one allegation that had not been reported. Other safeguarding incidents had been correctly reported to the local safeguarding authority.

Although we saw examples of staff using correct moving and handling techniques we did observe one example of poor practice and also an example of a person being hoisted in an undignified manner. A visiting professional told us they had seen other instances of this whilst they had been visiting.

PRN protocols were not always in place for people that had medicine that was to be taken 'when required' and some people were not getting their medicine as prescribed. Medicines were stored in line with guidance.

There were sufficient numbers of staff to support people however a proportion of staff were not permanent and were supplied by an agency. These agency staff members did not always know people's needs which could have put people at risk.

The principles of the Mental Capacity Act 2005 (MCA) had not always been followed. Assessments had not always been carried out to help determine if people the staff felt did not have capacity were still able to make decisions and what type of decisions. Evidence of Lasting Power of Attorney (LPOA) had not been consistently sought and those who did have an LPOA did not always have the correct one in place regarding health and welfare for people who lacked capacity.

We saw examples of poor moving and handling practice and poor practice in relation to supporting people with dementia such a things not being explained to people. This meant the training had not always been effective in helping staff support people.

Care plans were not always personalised and did not always contain full information about people and their preferences. Staff did not always know people well and did not know their individual needs, as many staff were from an agency and not permanent employees. This put some people at risk of not having their needs met or not having their preferences catered for.

Poor practice had not been identified in relation to dignity and respect, moving and handling and safeguarding. Audits were in place and had identified areas for improvement. Some improvements had been followed through however some still needed to be completed.

People were starting to access the community and partake in hobbies.

People had access to other health professionals in order to maintain their health and wellbeing.

People were supported to have food and drinks of their choice that were appropriate for their needs.

Staff felt supported and had supervisions and most felt they could approach the manager or the provider. Safe recruitment practices were in place and staff had appropriate checks prior to starting work to ensure they were suitable to work with people who used the service.

Staff and relatives knew who the manager was and felt able to go to them with queries. The manager had also been submitting notifications about the service, which they are required to do.

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.

Peoples' medicines were not always safely managed and people did not always have their medicine as prescribed.

There was on instance of a safeguarding allegation not being reported.

There were sufficient staff to support peoples' needs however many staff were agency staff and did not know people.

Safe recruitment practices were followed to ensure appropriate staff were working with people who used the service.

Is the service effective?

Requires Improvement

The service was not effective.

Staff had not been trained sufficiently to support people effectively.

The service was not always effective.

The principles of the Mental Capacity Act 2005 were not always being followed. Capacity assessments were not always carried out where needed and Lasting Power of Attorney's were not always checked.

Staff had not been trained sufficiently to support people effectively.

People had adequate amounts of food and their preferences were catered for.

People had access to health care services and were supported by staff where required.

Is the service caring?

Requires Improvement

The service was not always caring.

Privacy and dignity was not always respected.

Some staff did not know people well and did not always treat people in a caring manner or respect choices.

Some staff did offer some choice and checked people were comfortable.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always have personalised care plans or their preferences catered for.

The service had a complaints policy, and people knew how to complain. However not all complainants were satisfied with the responses.

People were supported to undertake some activities of their choice.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Some concerns relating to moving and handling and safeguarding had not been identified.

Other quality monitoring systems were in place to ensure the home was being managed appropriately.

Some staff felt supported by the manager and relatives had confidence in them.

The Cedars

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 9 November 2016 and was unannounced. The inspection was carried out by two inspectors.

We looked at information we held about the service including statutory notifications submitted. Statutory notifications include information about important events which the provider is required to send us by law. We also asked commissioners and Healthwatch if they had any information they wanted to share with us about the service. Healthwatch is an organisation that gathers information from people and relatives who use services and provides feedback to commissioners and regulators (like the CQC) about those services.

We spoke with two people who use the service, two relatives, five members of staff that supported people, the manager, the area manager and two professionals that have contact with the people who use the service. We also made observations in communal areas. We reviewed the care plans and other care records (such as medication records) for eight people who use the service and looked at management records such as quality audits. We looked at recruitment files and training records for three members of staff.

Requires Improvement

Is the service safe?

Our findings

Some medicine is applied or taken as and when required, called 'PRN medicine'. Protocols should be in place for staff to follow so they can identify when a person should take their medicine and what the guidance is around taking that particular PRN medicine. Although some were in place, there were not always protocols available to help staff identify when a person may need or not need their PRN medicine or information was missing from the protocols that were in place. People who are not able to communicate if they are in pain would need a personalised PRN protocol to help staff identify when they need to have their medicine and these were not always in place. There was an instance of someone refusing their PRN medicine for a period of 24 days. Another person had a medicine listed on their MAR chart that did not state it was a PRN medicine however the MAR chart had been completed as if it was a PRN medicine. The recording by members of staff showed the person had not had 'not required' the medicine for 19 days. These had not been identified through audits or checks as a person's medicine should be reviewed to check whether the medicine was still required or whether a PRN protocol was required to help staff identify when people required their PRN medicine. This meant there was a risk of some people not always getting their PRN medicines when they needed them and their symptoms persisting.

One person had a medicine patch that was applied to their skin. The instructions stated it should not be applied in the same place on the skin within 14 days. The records did not record the time the patch was replaced and it documented that the patch was sometimes being applied in the same place within a 14 day period. This could result in unnecessary side effects. For instance, if you apply some patches in the same area, this can cause thinning of the skin and leave the person susceptible to damage in that area. One relative we spoke with also told us that they had found their relative's medicine in their bedroom when they have visited on more than one occasion, "I have found medicines on the floor and down the side of my relative's chair." Other people's MAR charts did have information about when medicines were administered and were fully completed by staff. We saw that medicines were stored safely in line with guidance. This meant that although some people were receiving their medicines and this was being documented, we could not be sure that everyone was receiving their medicines as prescribed.

People were weighed regularly in order to check they remained healthy and were not unintentionally losing weight. We saw examples of people being weighed and their weight remained stable. However, one person had been losing weight and although they had been weighed monthly, this weight loss had not been identified and documented as acted upon in the care file. This meant the person could have been at risk of continuing to lose weight and become unwell or of an underlying health issue not being identified.

There was an allegation by a person that a member of staff had not supported a person appropriately when moving and handling them and the staff member had raised their voice to them. Action taken by a staff member to resolve the situation was documented but these had not been reported to the local safeguarding authority. All safeguarding incidents must be reported to the local safeguarding authority to investigate and one of these had not been. Staff we spoke with were able to identify abuse and they knew how to report it. We saw evidence of other safeguarding incidents which had been reported in the correct

way. However, incidents may have continued to occur due to the local safeguarding authority not always being made aware of incidents as they were not reported.

Some people needed extra support to help them mobilise, we saw one example of a person being assisted from a sitting down to a standing position by two members of staff. One of the members of staff helped the person by putting their hand under the person's arm. This is not an appropriate technique as it can cause injury to the person however on this occasion the person did not come to harm. One professional we spoke to said, "Their moving and handling could be better, I have seen some under arm lifts." Risk assessments and plans were in place for staff to follow to help people with their mobility. For example, one person's care plan stated that they needed an alarm sensor so that staff knew when the person was getting up so they could go and help them. We saw that this person did have the alarm in place so staff could be alerted when they stood up and they could go and support them to walk. We saw examples of when people had started walking, but they did not take their frame with them and staff quickly intervened and gave them their frames and encouraged them to walk with them. We saw that some people needed support to help maintain their skin integrity and plans were in place to assist them. For example, two people needed to sit on special cushions and we observed them sitting in these in the communal areas. This meant that plans were in place for staff to follow however the correct techniques were not always used, which could cause harm to people.

There were sufficient staff to meet the needs of the people at the home. The manager explained to us that they used a dependency tool to decide how many staff to have working which is updated weekly, or as required. One relative we spoke with said, "There are plenty of carers." However many of the staff were not permanent employees, but temporary agency staff. Another relative we spoke with said, "There are staffing issues as a lot of staff have left." A professional we spoke with said, "A lot of the staff have left." One member of staff told us, "There is a lot of agency, some of them don't seem to want to work. The experienced staff and senior care workers try their best." Agency staff were not always aware of people's needs. For example, we observed a member of agency staff offering food to a person that was not appropriate for their needs and a permanent member of staff had to correct them. This meant people could have been put at risk as agency staff did not know people well and did not always know their needs.

The service followed safe recruitment practices. Staff files we viewed included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with people who used the service. Agency staff had also been checked for their suitability to work. This meant that people were supported by staff who were suitable to work with the people who use the service.

There were checks in place in relation to fire safety and audits in relation to infection control. There was also a risk assessment and plans in place in the event of an emergency such as a fire, and people had personal plans to help them evacuate the building if it was necessary.

Requires Improvement

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. A person who has Lasting Power Of Attorney (LPOA) for health and welfare has the legal right to make decisions and sign agreement on behalf of someone who has lost their capacity to make their own decisions. A person who has LPOA for financial decisions cannot make decisions regarding health and welfare.

We saw evidence that LPOA had been considered by the service and saw evidence of LPOAs in people's files. However, some of these LPOAs were for financial decisions yet the representative was making decisions regarding the person's health and welfare. In some instances, copies or evidence that a LPOA was in place were not available so it could not be verified whether representatives had the right to make decisions on people's behalf. This meant people were not always protected as people who may not have had the legal right to make decisions had been.

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). In order for staff to know whether a person no longer has their capacity and whether a DoLS referral is appropriate, a mental capacity assessment should be carried out to help them determine the type of decisions a person can make. We checked whether the service was working within the principles of the MCA. Multiple referrals had been made, however one referral did not include the details of a restriction that was being applied to a person so it could not then be assessed by the DoLS team. Also, people did not always have capacity assessments in place therefore it was not possible to determine how the service established that a DoLS referral was required. This meant that although some appropriate applications had been made, one person was not being protected as some of the restrictions placed on them had not been included and approved and not all people who had a DoLS in place had been assessed sufficiently.

We saw people were offered choices throughout the day, such as where they would like to spend their time and what food they would like to eat and drink. However, choices were not always respected such as whether they wanted to wear an apron to protect their clothes from food or whether they wanted salt on their food. This meant people's rights were not consistently protected because the staff had not consistently offered choices or respected people's choices.

Staff told us they had the training they needed when they started working at the home, and were supported to refresh their training. However, the training was not always effective as we observed and were told by a visiting professional that poor moving and handling techniques were sometimes used. This meant some training had not been effective as staff had used some inappropriate techniques to support people. One

relative we spoke with said, "Staff seem to have a lack of understanding of dementia." We also observed on occasion where staff did not fully explain things to people which can help people with dementia to understand things more easily, for example, what they were having to eat. This meant people were cared for by staff who did not always have sufficient training to support them effectively. Since our inspection an action plan has been submitted by the service detailing how staff will be supported to re-train.

Staff told us they had supervisions and we saw these documented. One member of staff said, "I have a supervision with the deputy." Another member of staff said, "In supervisions we go over how I work, if I have any problems and discuss training needs" and they went on to say "I find them useful, it's good to get good feedback too." Another member of staff said, "The manager is supportive when they need to be." This meant staff felt supported in their role to effectively care for people.

We saw that health professionals had been involved with people's care when necessary. One member of staff told us, "The district nurses come in and we can let them know if anything changes." For example, we saw documented that GPs had visited regularly, district nurses and that paramedics had been called when necessary. People's swallowing ability been assessed by a Speech and Language Therapist and the guidance was being followed by staff. If someone had a fall, then a referral had been made to the Occupational Therapist in order to try and prevent a further fall occurring. We also saw visiting professionals whilst we were present in the service and the staff had requested a GP to visit due to a person not feeling well. This meant people were being supported to access other health professionals to help maintain their wellbeing.

People were supported to maintain their nutritional intake. We saw staff offering drinks throughout the day, and were supported to make a decision if they were unsure what they wanted to drink and offered an alternative when they did not like their drink. We saw there was a choice of food from the menu and we observed staff offering people different foods at lunch time. One person we spoke with told us, "I can choose my food. I've had bacon for my breakfast." We spoke with the chef who told us, "I can try different meals for the residents and I can change things if they don't like them", they also went on to say, "I get a handover each day if someone's dietary needs change." We observed people at lunch time having food appropriate for their dietary needs, such as having pureed food rather than solid food and this was presented in an appetising way. This meant people were offered a choice of food and had food and drink appropriate to their needs.

Requires Improvement

Is the service caring?

Our findings

We observed staff not treating people in a dignified manner. For example we witnessed a person being hoisted and their undergarments were on show in a communal room. This could have caused the person to be embarrassed as there were other people in the room with them. We heard staff speaking loudly in front of other people about a person needing support with eating. This could have made the person feel demeaned. The staff member had no consideration for how their lack of discretion regarding the person's support needs could have made the person feel. We saw staff put food on the table in front of people and they did not interact with the person or explain what the food was. Some people needed extra support to help them understand what they were eating and to encourage them eat. We also saw one staff member that was supporting a person to eat their breakfast and there was limited interaction. One relative we spoke with said, "Some staff treat my relative with dignity and respect but there are some staff I don't know." This meant people were not helped to retain their dignity and were not always treated with respect.

We saw that staff did not always respect people's choices. We observed a member of staff asking a person if they wanted to wear an apron to protect their clothing whilst they ate and they responded that they did not want to wear it. However the member of staff put it on them anyway and said, "You need it sweetie." This could have made the person feel upset or angry as they were asked for their choice but this was disregarded by the member of staff. We also observed a member of agency staff put salt on a person's food without asking the person if they wanted it or not. The member of staff did not respect the person's right to make a choice about whether they wanted salt or not. This meant people were not always given a choice and that their choices were not always respected.

One person had requested to use the phone to call a relative. However staff did not act upon this request for several hours and when the person did use the phone, it was in a communal area and the person found it difficult to hear what their relative at the end on the phone was saying and had to end the conversation. The person could have been upset due to them wanting to speak to their loved one sooner and frustrated when they were unable to hear them as there was noise around them. This meant the person did not get to speak to their relative at the time they originally wanted to and were not given the privacy and appropriate space to have a conversation.

This issue demonstrated a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we observed some undignified practice, we did also see some caring interactions. For example, staff were observed talking to a person sitting in their chair and went and got a cushion for them. Staff were also regularly checking whether people wanted fresh drinks. Whilst some staff were treating people with dignity and respect, this was not consistent practice across the service.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us that staff did not always know the people who lived in the home very well. One relative we spoke with said, "The agency staff don't know my relative, it is different staff every time." A relative also said, "It is frightening, they need regular staff to get to know my relative." Due to the amount of agency staff being used, staff did not know the people very well if they had not worked in the home before. We observed a member of staff feeding someone, however their care plan stated that they should be encouraged to eat themselves with a knife and fork, but this was not done. We were told by a member of staff that they encouraged other staff to show people food on plates so they could make a more informed decision, however we observed staff not doing this. One relative also told us that their loved one had an item they like to keep close to them, but frequently they would visit and it would not be with them or not the correct item. This meant the person could become agitated. We found that people were not always supported by staff who knew their individual needs.

It was also not clear if people had always been asked for their input into the care file. For example, we saw some people had a Do Not Attempt Resuscitation document (DNAR) and it had not always been documented whether the person (or appropriate representative) had been asked for their opinion and whether they wanted a DNAR in place. Other documents such as life history were left uncompleted and people's preferences and how they liked to be supported were not always detailed, although we did see some detailed examples. One relative we spoke with said, "I'm not sure if my relative has had a care plan written." This meant people may not have always been supported in a way that matched their preferences.

Resident's meetings were held, however one relative we spoke with said, "There are meetings but I raise things [complaints] each day" and they went on to say that, "Nothing is following through." Another relative also told us, "Complaints that have been made to staff members have not always been followed up." Examples of complaints are that soiled bedding has been left in people's rooms. There was a complaints policy in place and it was available for visitors to access. We saw that complaints had been documented and responses sent. However, one relative said, "I am not happy with the complaint responses and have had to complain many times." Another relative we spoke with said, "I've got no concerns so far but could ask a manager." This meant that people knew how to complain, the service was responding to complaints however complainants were not always satisfied with the responses.

People were supported to partake in activities and hobbies by the staff team. We saw that some people with dementia reacted well to looking after a doll, one person would walk up and down the corridor with the doll in a pram and another would sit cradling a doll. We also saw people in the afternoon having their nails painted by staff and a person having a magazine read to them and others sitting talking to staff. There was also a computer tablet available for people to use and we saw it documented in one person's notes that they had been playing on it. People were accessing the community and we saw documented that people had been to the pub for lunch and local garden attractions. There were also singers and entertainers that visited the home. This meant people were supported to engage in hobbies that interested them.

Requires Improvement

Is the service well-led?

Our findings

We found that a safeguarding incident had not been reported to the local safeguarding authority. This incident had not been identified as safeguarding through audits or by staff reporting it. Care plan audits were being completed and had identified omissions and the action they planned to take, however upon checking the files that had been audited, the action had not always been completed. For example, one person needed a mental capacity assessment completed and more information and detail was needed in the person's life history however when we checked these had not been rectified. However we saw other examples where an issue had been identified, action documented and upon checking the file it had been rectified. Whilst we were present, two members of staff from another home owned by the same provider were auditing files, updating information and transferring it onto new paperwork and it was explained to us that this was a 'work in progress'. The service was aiming to improve its documentation however the information was not yet always available for permanent and agency staff to follow. This meant that although care plan audits were in place, they had not always identified issues that needed to be reported and when omissions had been identified, they had not always been rectified.

We saw documented that people were either refusing or not always having their medicine because it was 'not required' for long periods of time. This had not been identified though audits and it had not been checked whether people still required their medicine or whether it was due to some PRN protocols not always being in place or not being detailed enough for staff to identify if medicine was required. There were also instances where some medicine was not being applied in line with guidance and this had also not been identified through checks. Other medicine audits were also in place. For example, we saw evidence that a medicine stock check had been carried out and through this an error had been identified. The action to reduce the likelihood of another error occurring had been documented and the action taken to protect the person involved was also recorded. This meant that whilst some checks were in place and had found and remedied issues, not all concerns had been identified.

We observed poor practice by staff during our inspection which meant people were not always treated with dignity and respect. It was also observed on one occasion during the inspection that an inappropriate technique was used and another instance of a person being hoisted in an undignified manner. This was also reported by a visiting professional as happening before. However, we observed the manager working with staff to improve their skills. For example, we saw the manager help a staff member reposition their hand when supporting a person to mobilise. We also observed the manager encouraging a member of staff to put a bowl of food closer to a person so they could clearly see what they were being supported to eat. We gave feedback at the inspection about this issue and since then the area manager sent us an action plan which detailed how they were going to improve moving and handling techniques in the home and support staff to re-train. This meant that although poor techniques were observed on one occasion whilst we were present, the home had taken immediate action to resolve this.

When people had fallen in the home, there were audits to identify any trends in when or where people were falling in order to try and prevent people from falling again. Other audits also included how many people

living in the home needed support with their skin integrity and how competent the staff were in relation to skin integrity care. This had identified some staff needed further training. The service had an action plan in place which had identified areas for improvement, including some areas we had identified during our inspection, their timescale for rectification and what action was required. This meant the provider and manager had an overview of where improvements were required and had made plans to develop the effectiveness of the care being offered to people. The manager had also notified CQC about significant events that they are required to notify us of by law.

Relatives and staff knew who the manager was. One relative we spoke with said, "The new manager is trying, they follow things through" and went on to say, "I believe in the new manager and I hope they get support from the company." Most staff told us they felt supported by the manager and felt they were approachable, one member of staff, "I would go to the manager if I needed to." Another member of staff we spoke with said, "I don't know the new manager yet but the area manager is approachable." A member of staff we spoke with said, "It's [the service] is getting better." The area manager was also present and involved in helping the manager settle into their role. This meant staff were supported in their role to care for people effectively and the manager was supported by the provider.

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 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity were not always respected. Choices were not always respected. Some staff did not people well as they were not permanent staff. Some staff did not treat people in a caring way.