Caring Homes Healthcare Group Limited

Cedar House Nursing and Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

This inspection was unannounced and took place on 26 and 30 November 2015.

Cedar House Nursing and Residential Home is a service that provides accommodation and care for up to 26 older people, some of whom may be living with dementia. On the day of the inspection, there were a total of 19 people living at the home.

There was not a registered manager employed at the home. The home has been without a registered manager since December 2014. However, there was a manager in place who had sent in an application to register with the Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

During our last inspection in May 2015, we found that the care provided to people was good. However, since that date we had received a number of concerns regarding the quality of the care that was being provided to people. We therefore conducted this comprehensive inspection in response to those concerns.

We found that risks to people's safety were not managed well. The provider's procedures for reporting accidents and incidents that people had experienced had not always been followed. Therefore, these incidents had not been fully investigated by the provider or action taken to reduce the risk of people having the accident or incident again. The assessment of some risks to people's safety had not been assessed. This placed people at risk of harm.

Some areas of the home and equipment that people used were not clean which increased the risk of the spread of infection. Staff had not always had the required checks to make sure they were safe to work in care and referrals had not always been made to the local authority safeguarding team when appropriate to do so.

Most staff were kind, caring and showed compassion for the people they provided care for. However, there were occasions when some people's dignity had been compromised and they had not been treated with respect.

People's care needs and preferences had been assessed. However, some people's care records did not provide sufficient information for staff on how to meet these needs and preferences. Changes in people's care needs were not always identified in a timely manner. This had resulted in some people not receiving care when they needed it and some people had not been referred to other healthcare professionals when it had been appropriate to do so.

People had access to plenty of food and drink to meet their needs. People received their medicines when

they needed them and had access to activities to complement their hobbies and interests. People were asked for their consent before the staff provided them with care.

Some staff were not clear about how people needed to be supported in line with the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards. Therefore there was a risk that these people's rights may not be protected. However, we did not see anyone being deprived of their liberty on the day of the inspection.

The provider had failed to ensure they had effective quality assurance systems in place to monitor the quality and safety of the service provided to the people who lived at Cedar House Nursing and Residential Home. Therefore, people were at risk of receiving poor care and of being exposed to harm.

There were five breaches of the Health and Social Care Act 2008, Regulated Activities (2014) and you can see what action we have told the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's safety had not always been assessed or actions taken to reduce the risks of people experiencing harm.

Some areas of the home and equipment that people used were not clean. This increased the risk of the spread of infection.

Checks on new staff before they started working at the home were not robust, increasing the risk that unsuitable staff could be employed.

The current systems in place to protect people from the risk of abuse were not effective. Referrals had not always been made to the local authority safeguarding team when it was appropriate to do so.

There were enough staff to meet people's needs and people received their medicines when they needed them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not understand their legal obligations on how to support people who could not consent to their own care and treatment.

People were not always supported by the staff to maintain their health.

Staff had received training to provide people with care but not all them had had their competency formally assessed to make sure they could meet people's specific care needs.

People had a choice of food and drink and they received enough to meet their needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some staff were kind and compassionate but on occasions, people's dignity was compromised and they were not always treated with respect.

People and their relatives where required, were involved in making decisions about their care.

People were supported with their spiritual or religious needs.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's individual needs and preferences had been assessed. However, there was not always clear or accurate information in place to guide staff on what care people required.

The provider was not always responsive to people's changing needs.

Staff supported people to access activities to complement their hobbies and interests and to enhance their wellbeing.

The provider had a system in place to investigate and deal with complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were a lack of effective systems in place to monitor the quality and safety of the service provided.

Action was not always taken in a timely manner to protect people from risks to their safety.

Staff felt supported in their role and were able to raise concerns which were listened to and dealt with by the manager.

Cedar House Nursing and Residential 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 took place on 26 and 30 November 2015 and was unannounced. The inspection team consisted of two inspectors, an inspection manager and a specialist advisor who was a nurse by profession.

Before the inspection we reviewed information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us and additional information we had requested from the local authority safeguarding and quality assurance teams.

During the inspection, we spoke with six people living at Cedar House, three visiting relatives, four care staff, an agency care worker, a nurse, the cook, two members of the domestic staff, the manager and the regional director of the provider. Some people were not able to communicate their views to us and therefore, we observed how care and support was provided to some of these people. To do this, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The records we looked at included seven people's care records, five people's medicine records and other records relating to people's care, four staff recruitment files and staff training records. We also looked at maintenance records in respect of the premises and equipment and records relating to how the provider monitored the quality of the service. We asked the manager to send us some further information after our visit and this was received promptly.

Inadequate

Is the service safe?

Our findings

Prior to the inspection, we had received concerns from the local authority safeguarding team that people were not being protected from the risk of avoidable harm. We found that some risks to people's safety were not always being managed effectively and that the provider had not put in place actions to mitigate these risks.

One person who had been admitted to the home for respite care had initially been assessed by the local authority as having a history of falls. This risk had not been assessed by the manager when the person moved into the home. There was no clear guidance in place for staff to follow regarding how to mitigate this risk. This person subsequently had a fall. However, no reassessment of this risk had taken place after this fall and no actions had been implemented to reduce this risk. We noted that the person had gone on to have a number of falls, one of which had resulted in a serious injury. Some of these falls had not been reported as an incident by the staff, which was in breach of the provider's policy. We also found that the provider had failed to refer this person to the relevant medical professionals following a fall when they indicated they were pain.

Another person had been assessed by the staff as being at a high risk of falling out of their chair. The guidance in place for staff to reduce this risk was for this person to be under 'close supervision at all times'. No specific timescales in relation to this had been recorded so it was unclear how often the person was to be supervised. We saw that this person was left on their own for periods up to 15 minutes during the inspection. It had been recorded within the daily care records that they had fallen out of their wheelchair in November 2015. This incident had not been reported in line with the provider's policy and therefore, not investigated.

This person had previously seen a speech and language therapist (SALT) as they had experienced difficulty swallowing their food. They were on a specialist diet for this and had been discharged by the SALT. However, the SALT had left the staff with clear instructions that should the person experience any incident of choking or coughing, that they should be referred back to them immediately. We saw within this person's daily care records that there had been incidents in November 2015 where the person was recorded as having choked or coughed when eating their food. They had not been referred back to SALT until 20 days after the first incident occurred. Due to our concerns regarding this, we referred this matter to the local authority safeguarding team.

One person had been assessed by an occupational therapist (OT) on 14 November 2015 in relation to the support they needed from the staff to be moved safely. The OT had advised that the sling that was being used to support this person was not appropriate as it was too big and therefore, posed a risk to their safely. We found that the incorrect sling was still being used on the day of our inspection, some 12 days later. We reported this to the manager who was not aware of this. They confirmed after our visit that a new sling had been ordered for this person.

Another person had a portable heater within their room. It had not been assessed whether it was safe for

this person to have this heater within their room. The manager agreed to carry this out as a matter of urgency. After our visit we were informed that this risk had been assessed.

Risk assessments were in place in respect of people's skin care. However, for one person who was at high risk of developing a pressure ulcer, this risk had not been assessed monthly in line with the provider's policy. The risk had last been assessed on 19 October 2015. For another person, we saw that the risk assessment had been completed incorrectly. The total score had indicated that the person was at high risk when in fact, they were at very high risk.

There were lockable cabinets within people's rooms where prescribed creams and items such as fluid thickener were stored. We saw that these cabinets were not always locked and where they were, the keys had been left in the lock. This presented a risk to people who may not understand what the thickener or creams were for and therefore could use then inappropriately.

We found that a nurse who was employed by the provider was subject to a number of conditions regarding their practice that had been set by their regulating healthcare body. These conditions stated that this nurse had to have a more senior member of their profession on the premises whenever they were on duty. This had not been adhered to and we saw that this nurse worked without senior supervision on a number of night shifts which was a possible risk to people's safety. The regional director of the provider advised us that it was the provider's policy not to employ any nurses who had conditions attached to their professional registration. The regional director took immediate action during the inspection regarding this matter.

We saw that the fire officer had visited the home in August 2015. They advised in their report to the home following their investigation, that the staff needed to be trained on how to use a piece of equipment to ensure they could evacuate people from the upper floors of the home safely in the event of a fire. However, this training had not taken place and had not been booked. Therefore there was a risk that staff would not know how to evacuate people safely from the upper floors of the building in these circumstances.

Some risks in relation to the safety of the premises had not been assessed in line with legislation. Although we saw that fire doors were kept closed and that the emergency exits were well sign posted and kept clear, the fire risk assessment had not been reviewed in line with the Regulatory Reform (Fire Safety) Order 2005. We also found that the emergency alarm system within the conservatory when activated, was not very loud. A staff member told us that they could not hear the alarm when they were in people's rooms providing them with care. Therefore there could be a delay in staff assisting colleagues within this area in the event of an emergency. The regional director advised us that this had been raised as an issue and that an upgrade to the alarm was required. However, she was unaware of what action had been taken with regards to this and agreed to check with the provider's head office in relation to this issue.

This was a breach of Regulation 12, (1), (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Prior to the inspection, we received some concerns that the home was not clean and that infection control processes were not being followed.

We observed that some people's rooms and the equipment that was used to support them to move were not all clean. We checked six people's rooms and found that three mattresses that were on their beds were unclean. One person's bed frame was unclean with dried food and dust. Two people's pillow cases were stained. All of these beds had been made by the staff. There was debris on the floors within four of these rooms and under the beds. Shelving within some rooms were dusty. One person's commode and two hoists

that were used to support people to move were also unclean. The toilet within the communal shower room was unclean as was a further communal toilet in the home. We also saw that the nurse did not wash her hands when applying eye drops to people. This is poor practice and placed the person at risk of infection.

This was a breach of Regulation 12, (1) and (2), (h) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Although we found issues with cleanliness within some people's rooms and some of the communal facilities, other communal areas such as the conservatory and lounges were clean. The laundry area and the kitchen were also clean. The home had recently been awarded the top mark by the local authority environmental team for their standards of food hygiene. Each person who needed to use a hoist to move had their own sling. This is good practice and we saw that these were clean and had been washed regularly.

We looked at the recruitment files of four staff members to check whether the required steps had been taken by the provider to make sure they were safe to work within care. Two of the staff files showed that the required checks had been made. There was a concern about another staff member's conduct in their previous employment. The manager told us that they had assessed this risk and were happy that the staff member was safe to work at Cedar House, although this assessment had not been documented. For another staff member, two references had been received regarding their conduct in their previous job that was within care but neither of these were from their previous employer at the time of their employment at Cedar House. The manager of Cedar House had managed the person previously at another care home. They had provided the staff member with a written reference at the time of their recruitment to Cedar House. This is a conflict of interest as no independent view of the staff members conduct during their previous employment had been sought. This staff member had conditions attached to their practice as a health care professional. This had not been explored by the manager at the time of their recruitment even though the information had been received by the provider's human resources department.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The people we spoke with told us that they felt safe living at Cedar House. One person when asked if they were safe told us, "Oh crumbs yes." Another person said, "Yes, I am safe here."

Staff had received training in safeguarding adults and were able to demonstrate to us that they understood what constituted certain types of abuse such as physical or verbal abuse. However, we saw that it had been recorded in one person's care record that they had an unexplained bruise on their arm. This had not been investigated by the provider and had not been brought to the attention of the local authority safeguarding team. We referred this matter to them after our visit. Therefore improvements were required to the provider's existing systems to ensure that people were protected from the risk of abuse.

The people we spoke with told us they felt there were enough staff to assist them when they required support. However, some people said that staff did not always have time to sit and chat with them, which they enjoyed. One person said, "Yes, they help me when I need help." Another person told us, "They occasionally pop in and have a natter with me but this is not very often. I would like to chat to the staff more but they are so busy."

All of the staff we spoke with told us there were enough staff to meet people's individual needs and preferences. They told us that this had improved recently and that agency staff were used to cover shifts when needed. We observed this to be the case on the day of the inspection. However, we noted that an extra member of agency staff had been requested to work in the afternoon who had not been on the original rota.

The regional director of the provider and a manager from another of the provider's home was also on the premises at the time of the inspection and were observed to provide people with some assistance with their care. Due to this, it was not possible for us to conclude whether there were always sufficient staff available to meet people's needs and preferences.

The number of staff required was calculated based on people's individual needs. We checked the staff rotas for 14 days from 14 November 2015 to make sure that people received the required amount of care as stated on the provider's dependency tool. We found that all of the shifts were covered. However, we did see that some day staff were on occasions, asked to continue to work on the night shift after they had completed work during the day. We advised the manager that this was not safe practice for either the staff or the people who lived in the home. The manager agreed to stop this practice.

There were a total of four nurses and nine care staff employed by the provider. A number of nurses and care staff had left the home since July 2015. The provider had been successful in recruiting new staff to fill some of these vacancies, although three care staff and two nursing staff vacancies remained. In response to this, a nurse from another of the provider's care homes was providing support and covering some shifts. All other shifts were being filled by agency staff. The manager told us that their plan was to reduce the number of agency staff being used once new permanent staff were recruited.

Prior to the inspection, we received concerns that people's medicines were not being managed safely. However, we found that this was not the case.

All of the medicine records that we checked indicated that people had received their medicines when they needed them. Oral medicines were stored securely so that they could not be tampered with or removed. The nurses had received training in how to give people their medicines and their competency to do this safely had been regularly assessed.

There was clear guidance in place for staff to help them give people their medicines safely. This included information about allergies people had. A photograph of each person was also available to help staff make sure they were giving the correct person their medicines. There was guidance for staff on how and when to give people 'as and when required' medicines.

We observed the nurse giving people's their medicines. They explained to people what their medicine was and why they needed to take it. They also made sure that the person had taken their medicine before signing the records to indicate that it had been given. This is good practice.

Requires Improvement

Is the service effective?

Our findings

The staff and provider told us that there were some people who lived at the home who lacked capacity to make decisions about their own care. Therefore, the provider had to work within the principles of the MCA. The 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 are called the Deprivation of Liberty Safeguards.

People told us that the staff gained their consent before performing a task. We observed this on the day of the inspection. For example, people were asked if they wanted a meal or drink or whether they wanted their medicines. One staff member asked a person if it was okay to move their chair closer to the table whilst they were eating their lunch. Staff also asked people for their consent before they supported them to move.

The staff we spoke with had a basic understanding of how to support people to make decisions for themselves where they lacked capacity to do so. Some staff were able to explain to us how they assisted people to choose the clothes they wanted to wear or the food they wanted to eat. However, none of them were able to demonstrate to us that they clearly understood what steps they needed to take when taking decisions on behalf of people in their best interests or how the MCA and DoLS impacted on their daily care practice. Also, none of them had a clear understanding of DoLS even though they had received training within the subject recently. Therefore improvements within the staffs knowledge regarding this subject are needed to reduce the risk that people's rights are not protected.

The manager had assessed whether anyone living at the home required a DoLS. They had recently made some applications to the local authority for authorisation to deprive some people of their liberty in their best interests. Until these had been assessed by the local authority, the provider was keeping the deprivation of liberty under review and seeking to find the least restrictive way of providing these people with care.

The manager told us that the GP visited when required. Other healthcare professionals such as district nurses, chiropodists, opticians and occupational therapists also visited to provide people with the care they needed. However, we found that on occasions the expertise of healthcare professionals had not always been sought in a timely manner. One relative told us how their family member had missed a recent dental appointment as a taxi had not been booked. On another occasion, a GP was not contacted when a person had experienced a fall that had resulted in a serious injury and another person had not been referred to a speech and language therapist in a timely manner. We have therefore concluded that improvements are required to ensure that people receive support with their health when they need it.

All of the staff we spoke with told us they felt they had received enough training to meet people's individual needs. They said they had received training in a number of different areas such as assisting people to move,

infection control, food hygiene and fire safety. They had also recently completed training in how to assist people if they had swallowing difficulties and further training regarding this subject was being sought from a swallowing specialist. The manager confirmed that staff had recently received training in dementia. The nurse who was working on the day of the inspection told us that they had received training in venepuncture, catheterisation, using a syringe driver and end of life care. The training was delivered either face to face or by e-learning via a computer.

The manager confirmed that the training of the agency staff was checked by her and we saw that records had been kept in relation to this. The manager also told us that the agency staff had been trained by the agency in how to assist people who were at risk of choking or who had swallowing difficulties.

The manager told us that they had assessed the nurses competency recently in relation to the administration of medicines. We saw evidence of this and that any issues identified had been followed up with the nurses. The manager said that the care staff's competency to perform their role was assessed informally through regular observations but that there was no programme in place to formally assess this.

The provider told us that new staff had an induction period where they shadowed more experienced staff and where they completed their training. They added that new staff members were not allowed to provide care to people independently until they were competent to do so. One of the new staff members we spoke with confirmed this although this had not been formally documented within the staff member's records. Therefore there was no documentary evidence to show that this had taken place.

Staff told us they felt they had enough supervision to enable them to provide effective care and that they supported each other day to day. When we checked some staff supervision records, we found that no formal supervision had been carried out between April and September 2015. Formal supervision is important as it gives staff an opportunity to discuss their performance and development needs. Two staff had not had any formal supervision for a year. Not all staff had received an annual appraisal. One staff member who had conditions attached to their practice had not received the required level of supervision or development. We spoke with the manager about this. They told us they were aware that some staff had not received as much formal supervision as they should have. They told us that she had recently completed formal supervision with the nursing staff and that there was a plan in place to provide other staff with regular formal supervision.

We received mixed views from people regarding the food they were offered. Two people felt that the food was very good. However, two people said that the quality of the food was variable. We spoke to the manager about this. They told us that they were aware of people's thoughts about food and that in response to this, they had involved people in the design of the recent menu choices. They advised that there were plans in place to survey people shortly regarding their thoughts on the quality of the food served.

People told us they had a choice of food and were offered alternatives if there was nothing on the menu that they liked. One person added that they were regularly offered snacks throughout the day and we saw staff giving people a snack of strawberry mousse in the morning.

The food was freshly prepared by the cook who had a good understanding of people's individual likes and dislikes and whether they required a specialist diet. We saw that where people required a specific diet that this was catered for. This included diets for people who were vegetarian, who were living with diabetes or who required a soft or pureed diet on the advice of a speech and language therapist. Where people had been assessed as requiring their food to be fortified with extra calories, we saw that this was being given.

People were observed to have access to a choice of drink throughout the day including cold drinks or tea and coffee. People who were in their rooms were able to reach their drinks and those who required assistance to eat and drink received this. We have therefore concluded that people had enough food and drink to meet their needs.

Requires Improvement

Is the service caring?

Our findings

On occasions, we observed that people's dignity was compromised or that some staff did not act in a caring and respectful manner.

One person was observed discussing an issue with a nurse. They were unhappy about their medicines. This quickly escalated into an argument that was conducted in front of other residents and the staff. The nurse made no attempt to calm the situation or take the person to a private area to discuss the matter confidentially. Eventually the manager intervened and calmed the situation. We heard the nurse discussing the altercation with another member of staff later during the day in full view of other residents which was not appropriate or respectful.

During the lunchtime meal, we observed one person become distressed. One member of staff was not sure what to do. Another staff member came to assist but told them, "She is ok, just leave her." The person remained distressed. This was noticed by a different staff member who then intervened and suggested pushing the person nearer to the table so they could access their meal more easily. This was done with the person's permission which resolved their distress and they happily continued to eat their meal.

On another occasion, we saw one person who was sitting in a wheelchair in a communal toilet. They were alone so we asked them why this was. They said that they wanted to use the toilet but had been left by the staff member. The person told us that the staff had not returned in time to support this person with their personal care needs.

A wardrobe in one person's room contained broken draws and shelving. It was observed to be leaning over to one side. Although it was secured to the wall so it would not fall over, this did not respect the person's right to functional furniture. We pointed this out to the regional director who agreed to order a new wardrobe for the person immediately.

Some people's beds had been made by the staff where their mattresses were not clean. Two people's pillow cases were stained and had not been changed.

We have therefore concluded that people were not always treated with dignity and respect.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

However, all of the people we spoke with told us that the staff were kind and caring. One person said, "The staff are very good, very accommodating and very friendly." Another person told is, "The staff are good but they never stay (at the home)." A relative told us, "They (the staff) are all alike, so friendly, I want to stay here."

We saw many good examples of staff being kind, caring and compassionate to people. For example, some staff were seen to speak to people in a polite manner, sitting next to them and talking to them quietly when

assisting them to eat and drink. Staff explained to people clearly what they were doing before they assisted them to move with a hoist. They made sure that the person was safe and comfortable during this process. Some staff took the time to say goodbye to people when they had finished their shift.

Before people moved into the home an assessment of their needs was completed in conjunction with themselves and/or their relative. People and relatives had a choice of how often they wanted their care needs to be discussed and we saw that these regularly took place. One relative told us they felt fully involved in making decisions about their family member's care.

People told us they had a choice about how they wanted to spend their day and we saw that they could make decisions about this which the staff respected. Some people choose to remain in their rooms whilst others resided within the communal areas. People were able to eat their food in their rooms, the conservatory, dining room or lounge. The staff we spoke with were clear about the importance of enabling people to make choices about their daily lives. However, we did see that advocacy services were not always offered to people where it may be appropriate. We brought this to the manager's attention who agreed to explore the possibility of promoting the use of advocacy within the home.

Residents and relatives meetings had recently re-commenced with the first meeting having been held on the day after the first day of our visit. The manager told us that people and their relatives were asked for their opinion on the care they received during these meetings, with a view to improve the care they received. The manager also advised that they were trying to increase the attendance to these meetings and that letters were to be sent to relatives shortly regarding future meetings.

People were supported to continue with their religious faith. Representatives from various faiths visited the home regularly. The provider's policy regarding this issue had clear guidance for staff to help them support people of many different faiths.

Requires Improvement

Is the service responsive?

Our findings

People's care needs had been assessed but there were not always care plans in place to provide staff with clear guidance on what care that person required. We also found that some of the information within people's care records was contradictory or inaccurate and did not reflect their current care needs. Therefore, there was a risk that people could receive inappropriate care. This risk was increased due to the number of agency care staff that the home used. This was because agency staff may not be familiar with people's individual needs, meaning that accurate information within people's care records is important.

One person who had been admitted for respite care had their needs assessed. However, there were no care plans in place to guide staff on how to meet these needs. In another person's care record, there were three different documents in relation to their nutritional needs. It was stated within two of the records that the person may require thickener in their drink if they coughed or choked when drinking. Two of the documents quoted the required amount of thickener was two scoops and the other stated 1.5 scoops. The correct figure as directed by the speech and language therapist was 1.5 scoops. In another person's care record it stated that they had a catheter in place but the nurse told us that their continence needs had changed and that this was no longer the case. The person's needs in relation to continence were therefore incorrectly reflected within the care record.

Information recorded within people's care records demonstrated that the provider was not always responsive to people's changing needs. Therefore, appropriate action had not been taken to address these changes.

A review of one person's needs in relation to falls stated that they had not fallen in the previous month. There was a record in their daily care notes that contradicted this which stated that they had fallen out of their wheelchair. A review of the same person's nutritional care stated that they had not had any episodes of choking that month whilst eating or drinking. Again, records within the daily care notes contradicted this where it stated that they had experienced some episodes of coughing and choking whilst eating. During a conversation with one person, they told us that they had not been able to participate in outings for some time. This was due to a condition they experienced when travelling. No action had been taken in response to this until it was raised at a resident/relative meeting on the day after our inspection. The manager had then agreed to explore this with the person to see if they could assist them with this.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The people we spoke with and their visiting relatives told us that their preferences or those of their family member were met and were respected. Staff also told us they were able to meet people's individual preferences in respect of how they wanted to receive their care. They explained how some people liked to be up early in the morning and that they catered for this. However, on the day of the inspection we saw that only male carers had been scheduled to work in the afternoon. Although most people we spoke to were happy with this, one person did tell us, "You get used to it." We mentioned this to the manager at the beginning of the inspection and they requested a further female agency staff member to work during the

afternoon shift. We saw that this was the only day within the two weeks prior to our inspection that only male carers had been scheduled to work. The manager agreed to take this into account when allocating shifts to staff in the future.

We received mixed reviews from people regarding the support they received to maintain their hobbies and interests. One person told us, "I am happy doing my puzzles." Another person said they were happy with their own company in their room. A further person said, "The activities are ok if you call putting a pea in a cup fulfilling."

The home employed an activities co-ordinator who worked for five days per week at the home. We explored with them how they supported people to take part in activities that were meaningful to them. They confirmed that this was being developed. There were a number of activities that were on offer each day. On the day of our inspection, people participated in a quiz which they were seen to enjoy. The activities co-ordinator had a folder for each person who lived at the home. This contained details of their life history and their likes, dislikes, hobbies and interests. They told us that they were using this information to develop programmes for individual people. They gave us some good examples of where people had been supported with activities that meant something to them.

One person was supported to maintain their interest in painting. The home had sourced someone to come from outside the home to help the person with this. The activities co-ordinator had made a scrap book for one person about where they used to live and used this for reminiscence. Another person ordered a magazine that was of specialised interest to them and the staff spent time going through this with them.

We saw that people's birthdays were treated as a special occasion and that other occasions such as St Andrews day and Christmas were celebrated. A singer regularly attended the home and a local expert who talked to people about birds and plants. People were able to go on outings. A recent one had been to the library in Norwich and to the Theatre Royal. Other outings to the coast and garden centres had also taken place. The home had a minibus to enable them to do this. However, it could only accommodate four wheelchairs so people had to take it in turns going on the outings. Some people were not happy about this. The manager was aware of this and was looking for ways to improve this so people were able to attend outings when they wished to.

The people we spoke with told us that they did not have any complaints about the care they received. Both written and verbal complaints were recorded by the registered manager. Records showed that these had been fully investigated and that feedback had been given to the person who raised the concern. We were therefore satisfied that people's complaints were investigated and responded to effectively.

Requires Improvement

Is the service well-led?

Our findings

There were a lack of effective systems in place to monitor the quality and safety of the care that was being provided to people. This placed them at risk of receiving poor care and exposed them to harm.

The provider required that a number of audits be performed monthly and quarterly to assess the quality and safety of the care that people received. These audits assessed areas such as infection control, care records, medicines and the kitchen. We noted that although the manager had recently conducted these audits in November 2015, they had last been completed in July 2015. Therefore they had not been completed in line with the provider's policy and the home had not been monitored effectively for a number of months.

We saw that action plans had been put in place following the recent audits that had been conducted by the manager and we saw that some improvements had been made. For example, a recent audit of the kitchen had identified that the oven needed to be cleaned and this had been completed. However, some of these audits had not identified a number of the issues that we identified during the inspection. The recent audit of infection control and cleanliness stated that the practices in place were 'satisfactory' but we found that some people's rooms and equipment they used were unclean.

These audits had also not picked up that some care plans within people's care records contained inaccurate or contradictory information. They had not identified that the monthly reviews that had been conducted by the nurses had not picked up crucial information about people's changing needs. Therefore, this audit was not effective.

The manager told us that they informally checked on the competency of staff's care practice. Although some of the nurses practice had been formally assessed, none of the care staff's practice had. We saw the nurse used poor infection control practice when applying eye drops to one person's eyes.

We found that the recruitment checks in place were not robust enough to make sure that the staff employed were safe to work within care. The manager had not read the information supplied to them regarding one member of staff who had conditions applied to their practice. This had therefore not been identified at the time this staff member was employed and contravened the provider's policy on recruitment.

A number of incidents and accidents had occurred that had not been correctly reported in line with the provider's policy and therefore not investigated. This was despite the manager telling staff on a number of occasions, including in team meetings, the importance of following the provider's policy ensuring that all accidents and incidents were recorded. Due to this failure in reporting and recording accidents and incidents, one person had experienced harm and there were significant risks to others' safety.

No analysis of incidents and accidents had taken place at the time of the inspection although there were plans for these to commence shortly. As no analysis had taken place, the manager had not been able to identify if the failure to record incidents and accidents was widespread or down to just a few individual staff members. Therefore, any action required to correct this had not been taken. It also meant that any patterns

in relation to these incidents could not be identified and acted upon. No learning from complaints had taken place. We found that three complaints had been in relation to the cleanliness of people's rooms but we found this still to be an issue.

It was evident that there had been a lack of communication between the staff and the manager about incidents or accidents that people had experienced. There were also a number of different records that staff had to complete in relation to people's care. There was no clear oversight of these different records which meant there was a risk that issues in relation to people's care could be missed. This meant that the manager was not always aware of actions that needed to be taken to ensure that people received the care that they needed or to keep them safe.

Improvements to the quality of care and to reduce the risks to people's safety had not always been taken in a timely fashion. Recommendations in relation to staff training from the fire officer had not been implemented, an upgrade to the alarm in the conservatory had not been completed and one person's wardrobe that had been broken for sometime, had not been replaced.

We were provided with evidence that a survey of staff opinions on the care that was provided and their working conditions was conducted in September 2015. Staff had made some positive comments but there were also areas that staff felt could be improved. An action plan regarding these areas of improvement had not been compiled and we were not advised of any improvements that were being made in response to this feedback.

This was a breach of Regulation 17 1, 2 (a), (b), (c), (d), (e) and (f) of the HSCA 2008 (Regulated Activities) 2014.

The regional director for the provider had been made aware of a number of these issues prior to us finding them at the inspection. In response, they had requested an experienced registered manager from another of their homes to provide support to the manager of Cedar House. This registered manager was present on the day of our inspection. Also, new systems had been implemented to improve the communication between the manager and the staff and to improve the manager's overview of what was happening within the home. The manager was in the process of reviewing the care that people were receiving to make sure it was safe. The staff were reminded in a meeting that was held each day of the importance of reporting any changes in people's needs or concerns about their safety. It was too early for us to evaluate whether these revised systems would be effective at improving the quality and safety of the care that people receive.

Cedar House has been without a registered manager since December 2014. After the last registered manager retired, a temporary manager was in place from December 2014 to July 2015. This manager then left to manage another or the provider's homes and a new manager was appointed. The home has therefore not had consistent leadership in place since December 2014.

In the main, people were satisfied with the care they received at Cedar House. One person described the care as, "Excellent, first class." Another person when asked what it was like living in the home said it was, "Alright." A further person told us, "It's ok." A relative said, "Yes, I am happy with the care given to [family member] here."

The staff we spoke with told us they felt supported by the manager and were happy to raise any concerns without fear of recriminations. They said that the manager listened to them and acted on any concerns they raised. Staff told us that their morale was good and that it had improved recently with the recruitment of more staff to the home.

The manager and the provider were in the process of making a number of improvements at the home. The provider had recognised the difficulty that the manager had experienced in recruiting staff so they had reviewed the staff's pay structure. The provider was also actively looking to recruit nursing staff from overseas and the manager had planned an open day within the local area in the new year to try to recruit further staff.

The dependency tool that was used to calculate how many staff were needed to provide people with care had been changed. This was because the provider felt that it gave a more accurate picture of the care that people required.

The manager was passionate about providing people with person-centred care and was looking to improve this within the home. The staff we spoke with had a good understanding of person-centred care and were aware of the importance of providing people with choice. The manager told us that they had plans to provide the staff with further training within this subject and to help them interact effectively with people who were unable to communicate verbally.

A new survey was being sent out to the people who lived in the home, relatives and healthcare professionals to enable the manager to carry out any improvement in relation to their feedback.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment was not always designed with a view to ensuring that service users needs are met. Regulation 9 (3) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10 (1).

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 Risks to people's safety had not always been assessed and actions were not always taken to mitigate any identified risks. Regulation 12 (1) (2) (a) and (b). Some areas of the service and equipment that people used were unclean, increasing the risk of the spread of infection. Regulation 12 (1), (2) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Not all of the required checks had been completed when the provider employed new staff to the service. Regulation 19(1)(a) (b) (2) and (4).

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 17 HSCA RA Regulations 2014 Good governance There were a lack of effective systems in place to monitor the quality of the service provided and some records in relation to people's care were inaccurate. Regulation 17 (1) (2) (a) (b) (c) (d) and (f).

The enforcement action we took:

The provider must meet this Regulation by the 1 February 2016.