Cedar Court Care Ltd

Cedar Court Nursing Home

Inspection report

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Date of inspection visit:
16 January 2018

Date of publication:
08 February 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

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

Cedar Court Nursing Home accommodates 25 people in one adapted building. At the time of our unannounced inspection there were 17 older people, some of whom were living with dementia, living at the service.

This inspection took place on the 16 January 2018 and was unannounced. At the last comprehensive inspection on 13 January 2017 we rated the service as requires improvement. At this inspection the necessary improvements had been made and we rated the service as good.

Why the service is rated good.

The Care Quality Commission (CQC) records showed that the service had a registered manager. 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.

Staff had an understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Staff knew how to report any suspicions of harm and poor care practice. Information and guidance about how to report concerns, together with relevant contact telephone numbers were available as a prompt for staff to refer to.

People were assisted to take their medication as prescribed. Processes were in place and followed by staff members to ensure that infection prevention and control was promoted and the risk of cross contamination was reduced as far as possible.

There were building adaptations in place to help people with limited mobility. This meant that people could access all of the services internal areas and the garden.

Staff assisted people in a caring, patient and respectful way. People's privacy and dignity was maintained and promoted by the staff members supporting them.

People and their relatives were given the opportunity to be involved in the setting up and review of their individual support and care plans. Staff encouraged people to take part in activities and maintain links with the local community to promote social inclusion. People's friends and family were encouraged by staff to

visit the service and were made to feel welcome.

People were supported by staff to have enough to eat and drink. People were assisted to access a range of external health care professionals and were supported by staff to maintain their health and well-being.

People were supported by staff and external health care professionals, when required, at the end of their life, to have a comfortable and as dignified a death as possible.

People had individualised care and support plans in place which documented their needs. These plans informed and prompted staff on how a person would like their care and support to be given, in line with external health care professional guidance.

Individual risks to people were identified and monitored by staff. Plans were put into place to minimise people's risks as far as possible to allow them to live as safe and independent a life as practicable.

The registered manager had a recruitment process in place and staff were only employed within the service after all essential safety checks had been suitably completed. Staff were trained to be able to provide care which met people's individual needs. The standard of staff members' work performance was reviewed by the registered manager through supervisions and appraisals. This meant that the staff felt supported to carry out their role.

Compliments about the care and support provided had been received and the positive feedback shared with staff. Complaints were investigated and action taken to make any necessary improvements and to resolve to the complainants satisfaction wherever possible.

The registered manager sought feedback about the quality of the service provided from people, their relatives, visiting health and social care professionals, and staff. There was an on-going quality monitoring process in place to identify areas of improvement needed within the service.

Records showed that the CQC was informed of incidents that the provider was legally obliged to notify us of.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Systems were in place to protect people from harm or poor care.

Risks to people were assessed and monitored to make sure that people remained safe.

There was a sufficient number of staff to meet people's assessed needs and recruitment checks were in place to make sure staff were of good character.

Processes were in place to ensure that people's medication was safely managed.

Is the service effective?

Good

The service was effective.

People's needs and choices were assessed and staff supported people in line with legislation.

Staff were supported with training, supervisions, and appraisals to make sure they were delivering effective care.

Guidance was followed to make sure that people had enough to eat and drink and people were supported with a healthy and nutritional diet.

Staff worked within and across organisations to deliver effective care and support. People were assisted to have access to external healthcare services when needed.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect when assisted by staff and were supported to be involved in making decisions about their care and support needs.

Staff promoted and maintained people's privacy and dignity at

all times.

People's visitors to the service were made to feel welcome by staff.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and staff used this information to deliver personalised care to people that met their needs.

Activities were in place for people to take part in. To promote social inclusion, people were supported to maintain links with the local community.

People's concerns and complaints were listened to and acted upon to reduce the risk of recurrence and improve the standard of care provided at the service.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in place running the service day-to-day with support from staff.

Staff were clear about the high standard of care and support they were expected to deliver. Quality monitoring was in place to oversee this and make any necessary improvements.

People and their relatives were encouraged to be involved in the running of the service and feedback on the quality of care provided.

Cedar Court 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 took place on 16 January 2018 and was unannounced. The inspection was carried out by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at all the information we held about the service. This included the provider information return (PIR) which was submitted to the Care Quality Commission on 8 December 2017. This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

We also looked at information we held about the service and the provider. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. Before the inspection we asked for information from a fire safety officer; representatives of a local authority contracts monitoring team and safeguarding team; a health professional that visited the service and Health watch. This helped us with planning this inspection.

During the inspection we spoke with four people who used the service and three relatives. We also spoke with a registered manager/ director, another director of the service; a nurse; the kitchen manager/ care worker; deputy manager; one senior care worker and two care workers. We also spoke with a house-keeper and the activities co-ordinator.

We observed staff who were supporting people to help us understand the experience of people who could not talk with us. We looked at three people's care records and records in relation to the management of the service; management of staff; management of utilities; and the management of people's medicines. We also looked at compliments and complaints received; staff training records; and three staff recruitment files.

Good

Is the service safe?

Our findings

Staff received training on how to safeguard people from avoidable harm and poor care. They confirmed to us that they would be confident to whistle-blow. (This is a process where staff can report any poor standards of care if they ever became aware of this). Staff verified to us that they would report concerns in line with their training. A staff member told us, "I don't have concerns about safeguarding. I would report them to the [registered] manager and it would get dealt with." Another staff member said, "There is a good culture, [safeguarding] issues would get addressed." Staff explained to us that they would report poor care and suspicions of harm both internally to management and to external agencies. Information and guidance about how to report concerns were available for staff to refer to if needed. This showed that there was a process in place to reduce the risk of poor care practice.

People's support and care plans were stored securely and contained enough information for staff to deliver safe care. Risks to people had been identified when they first came to the service and as staff got to know them and their individual requirements. These risks were assessed to provide individual prompts and guidance for staff to assist people and reduce the risk of harm. In general, the majority of people living at the service were unable to tell us how they had been involved in the management of their risk assessments, care decisions, and review of these. However a relative confirmed that they felt involved in decisions around their family members care. They said, "The [registered] manager is lovely and nothing is too much trouble. He is trying to find a bigger mattress for [family member]. He always speaks and checks everything is okay."

Technology was used to support people to receive safe, care and support. We saw that there were care call bells and lifelines (personal alarms worn around a person's neck) in place for people to summon staff when needed. We also noted that sensory mat technology was used to inform staff when a person, assessed to be at risk of falls, was up and attempting to walk. Closed Circuit Television (CCTV) cameras were also in communal areas of the service and a staff member told us that they were used to promote people living at the service and staff's safety. This demonstrated to us that technology was used in the service to support people where needed.

Records relating to checks on the service's utility systems and building maintenance showed that checks were in place to make sure people were, as far as possible, cared for in a place that was safe to live in, visit and work in. People also had emergency evacuation risk assessments in place to assist them to evacuate safely in the event of an emergency such as a fire.

The registered manager used a dependency tool to establish staffing levels based on people's care and support needs. They then added in a supernumerary (additional) staff member who could step in and help deliver care and support if needed. People and their relatives had positive opinions over the number of staff available. One relative told us, "I have no concerns about staffing." Another relative said that staff responded promptly when their family member pushed the call bell. Observations during this inspection showed that there was enough staff to meet people's needs. This meant that staff were busy, but supported people in an unhurried manner.

Checks were carried out on new staff members by the registered manager to confirm that they were appropriate to work with people and of good character. Staff told us that these checks were in place before they could start work at the service. This showed us that there was a process in place to make sure that staff were deemed satisfactory and suitable to work with the people they supported.

The provider had an electronic recording system in place to promote the safe management of people's prescribed medication. If a person had not received their medication this was also flagged up to the nurse via the electronic system as an additional safety check. A random spot check of medication showed us that the running balance corresponded with the amount in stock. This demonstrated to us that accurate records were maintained.

Medication was stored securely, at the correct temperature and disposed of safely. Records showed that medication had been administered as prescribed. A person confirmed to us that the nurses, "Always check carefully [when giving medication], especially if the dose has changed." This meant that the provider had systems in place to ensure that people's medication was managed safely.

The service was clean and we saw that soap and hot water was available for staff, people and their visitors to use to wash their hands. A relative confirmed to us that, "It's always clean and tidy." Staff were knowledgeable about their role in preventing the spread of infection. A member of staff told us that they had enough cleaning equipment and personal protective equipment (PPE) available to use. They talked us through how they cleaned different areas of the service using different cloths, and different colour mops and buckets to maintain good infection prevention and control practices. This showed us that procedures were in place to reduce the risk of infection and cross contamination.

Records showed that there was monitoring of any accident and/or incidents that had occurred, such as a person falling. The registered manager told us that the numbers of incidents were low and as such, there were no clear patterns (reasons) currently for the falls. For example, a pattern could be that people fall at certain times of the day. The registered manager said that they were looking into developing and improving the review of any accidents and incidents that occurred with the service. This was so that the risk of recurrence could be reduced where practicable.

Good

Is the service effective?

Our findings

External health and social care professionals visited the service. This included weekly visits by the local GP and visits to the service by district nurses, a foot health practitioner and people's social workers. These professionals worked with the registered manager, nurses and staff to help them support and promote people's well-being in line with legislation, such as medication updates, and good practice guidance. This was reflected within people's care records looked at. The registered manager also told us that they attended a lot of forums (meetings) to keep up-to-date with legislation. A visiting health care professional confirmed to us that staff seemed more organised during their recent visits. They also said that staff were, "Friendly and helpful." This showed us that staff worked with external health and social care professionals to try to make sure people's needs were in line with up-to-date guidance.

People were assessed for and used equipment to promote their skin integrity and mobility. Observations showed that staff offered reassurance and encouragement to people when they were using this equipment.

Staff completed training to ensure that they had the right skills, experience and knowledge to provide the individual care and support people needed. Training included, safeguarding adults; moving and handling; dementia awareness; basic life support; fluids and nutrition; mental capacity act 2005 (MCA) and deprivation of liberty safeguards (DoLS); equality and diversity; fire awareness; food safety and infection control prevention and control. A relative told us, "Staff are brilliant…staff work well together…I would recommend this home to anyone." This showed us that were processes in place to make sure that staff were given training to help them provide effective care and support.

Staff were supported through supervisions and appraisals. A staff member said, "I am supervised by senior staff, I have had a couple [been in post four months] since I have been here." Another staff member confirmed to us, "I am supervised two monthly." When new to the service staff had an induction period. This included training and shadowing a more experienced member of staff. A staff member told us, "The induction included manual handling training, a tour of the building and I shadowed [another staff member] for two weeks." This was until staff were deemed competent and confident by the registered manager to provide care.

Observations showed that people were supported by staff with their meals and drinks when needed. This was done by staff in a patient and supportive manner. Adapted cutlery, plates and cups were also used to support and promote people's independence. People were offered condiments and extra servings of the meal. Staff told us that currently no one at the service had a special diet due to cultural or religious needs. However, they confirmed that they would adapt the menus to meet these needs. People's individual dietary needs, such as softened or pureed food for people at risk of poor swallowing were catered for. A staff member said, "We ask people about their favourite food and plan these into the menu. We have recently included more fish." A relative said, "My [family member] always likes to have [named cereal] before bedtime, I told staff and they now make sure he has it every night when he wants it." Another relative confirmed to us that, "The food is lovely." We observed that snacks and drinks were available to people

throughout the day to promote people's food and fluid intake and requirements. This showed us that people were encouraged by staff to eat and drink sufficient amounts.

The service worked with external organisations to ensure that the best possible quality of service was provided. For example, working with the local authority commissioning team meant that the overall quality of the service was monitored.

People were supported to attend health care appointments at the service and when required, outside of the service. Records showed that staff at the service had requested input from and followed advice from external health care professionals. We saw an example of where a person's behaviour had been discussed with their GP, a district nurse and their social worker. As a result of these discussions the person's care and support plans had been updated and behaviour charts instigated to monitor their increased anxiety. We also noted that people were also supported by input from district nurses, speech and language therapists and a foot health practitioner, when needed. This showed us that people's health and well-being needs were monitored and acted upon.

The building was currently undergoing a refurbishment and the number of people who lived there was limited so as to cause as little disruption to people as possible. A relative told us, "They [directors] have made a lot of improvements to the environment." The service was an adapted building and adaptations had been made to the building and communal gardens. This was to enable people to be able to access all areas of the service. The floor was one level and handrails ran the length of the corridors to aid and assist people with limited mobility. Observations showed that people had access to the garden. These again were on one level and paved in areas and with pathways for easier access and people were able to spend time enjoying them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had undertaken training in MCA and DoLS and were able to demonstrate an understanding to us. Staff supported people with their decision making and choices. A staff member told us that, "Three people have authorised DoLS. We involved family and health care professionals in best interest decisions." Another staff member said, "The MCA protects people who don't have [mental] capacity. People had a DoLS so we can support them in their best interests." Applications had been made to the local authority supervisory body for people who had been assessed as lacking mental capacity and needed legal restrictions (for example a person not being allowed to go out on their own as this would put them in danger) in place to aid with their safety. This showed that people would not have their freedom restricted in an unlawful manner.

Good

Is the service caring?

Our findings

People using the service and their relative had positive opinions about the care and support provided by the staff. One person said, "The staff are very friendly." Another person told us that Cedar Court Nursing Home, "Felt like home." A relative said, "I think it is a fantastic place."

Staff knew and respected the people they were caring for. They were able to demonstrate to us that they knew peoples histories, preferences and any wishes they had. This also meant that staff had knowledge on how to promote and support people's independence. Records documented and prompted staff on what people were able to do for themselves and what staff were to support them with. A staff member said, "We encourage people to wash themselves as far as possible." Staff knowledge also included distraction techniques known to work for people who were at risk of becoming anxious. We saw that staff supported people in a kind way that included respecting that the person required some time to themselves which helped reduce the worries for the person who was becoming anxious.

Observations showed that staff respected people's choices and asked permission before supporting them. Advocacy information was available on request for people if they needed to be supported with making decisions. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

People were not able to tell us that they were involved in the setting up, review and agreement of their care and support plans. However, a relative told us about the good communication with staff. They said, "The night staff are really good and if there is a problem with my [family member] they ring me up." A satisfaction survey undertaken with people's relatives showed that the majority of them felt involved in their family members care plans. To help promote relatives involvement with this, care planning was also on the agenda for discussion during a recent (January 2018) relatives meeting. This showed us that staff endeavoured to involve people's relatives in decisions about their family members care.

Records showed and people told us that feedback was sought from people living at the service, their relatives and visitors and visiting health and social care professionals to express their views and engage with the service. This was captured via newsletters, satisfaction questionnaires or during meetings. Feedback from these questionnaires were mainly positive with a few areas of improvement suggested which had been actioned or were on-going. Newsletters were also used as a way of communicating to people and their relatives updates and news about the service and any up and coming events. This meant that the registered manager used different ways to engage people and their relatives with the running of the service.

People's privacy and dignity was promoted and maintained by staff. People were seen to be clean and tidy and were dressed in clothes appropriate for the temperature of the service. We saw that conversations about care were held in private and that when a staff member wanted to go into a person's room, they either knocked on their door and/or announced themselves before going in. A relative told us about their family member, who liked to eat in their own room, with assistance from staff. They said, "If I am not there, I know that staff will feed [family member] carefully, respecting his dignity." This demonstrated to us that staff

respected and promoted people's privacy and dignity.

People were encouraged by staff to personalise their rooms to make them feel more homely. A relative told us, "[The staff] agreed on a light room [for family member] with the bed position so that he could see the garden and people going past in the corridor. The TV position was moved to suit, [staff] also put up his pictures and ornaments where he could see them." This demonstrated to us that staff understood that people should be encouraged to have as much choice and control of their lives to promote their well-being.

Visitors were encouraged and made very welcome at the service by staff. Staff were seen to make people's visitors feel welcome and chatted to them to update them about their family members' care and welfare.

Good

Is the service responsive?

Our findings

Care and support plans and risk assessments recorded people's daily living needs, care and support requirements and health needs. These had been developed in conjunction with the person, their relatives, legal representative and advocates where appropriate, prior to them moving into the service. This care record was in place to guide staff on how they could meet the person's individual needs. The care record also acted as information for staff on how each person wished to be assisted, including their likes and dislikes, interests and any personal preferences. Reviews of these records were then carried out to make sure that these were up-to-date and reflected people's current requirements. For example, detailed guidance was available to staff in response to a person who had complex behavioural needs and staff demonstrated to us that they were familiar with this information. A staff member confirmed to us that, "Staff are given time to read care plans over a period of time." This showed us that staff were able to get to know the people they were supporting.

During our visit we saw individual and group activities taking place, this included a sing-along to popular music that both people and staff took part in with great enthusiasm. A person told us that they, "Like bands for the 60's and 70's as they remind me of times when the children were growing up." People said how staff took time to sit and talk to them and that they appreciated this one-on-one time. One person confirmed to us that, "[Staff] often sit and talk with me." We also saw on display the results of people's art and craft sessions, proudly displayed on the communal noticeboard. External entertainment also took place at the service on a regular basis for people who wished to attend to enjoy. This showed us that various activities took place at the service for people to take part in should they wish to do so.

People were supported to access and maintain links with the local community. These included one-to-one outings with a staff member or a family member / visitor or a group outing, supported by staff. A staff member told us that, "We try and make sure different people get the opportunity to go out." During this inspection we observed people being taken out into the local area by family members. This showed us that people were encouraged to maintain their links with the local community.

We saw that the service received compliments and thank you cards from relatives and visitors of people who had used the service. Compliments were used to identify to staff what worked well and were on display in the communal area of the service for people to read. Records showed that the service had received some complaints since the last inspection. We saw that these complaints had been investigated and resolved where possible or the investigation was still on-going. Where any action had been taken to try to reduce the risk of recurrence, this had been fed back to the complainant.

A relative told us that they knew how to make a complaint but had not needed to do so. They confirmed to us that they felt that any complaints raised with the management of the service would be listened to, and resolved where possible. They confirmed to us that, "Nothing is too much trouble."

Cedar Court Nursing Home is a care home that also provides nursing care. The nurse told us that to support people approaching the end of their life; they would work with the person and their family to make sure that

they met their wishes, including their preferred place of death. They also told us that they worked with external health care professionals, when it became clear that people's health condition had changed or deteriorated. External health care professionals that staff worked with during this time included doctors and specialist end-of–life nurses. The nurse also gave us an example of how they supported the families during this time and how they would promote a quiet and calm atmosphere around the person. A staff member would also be made available to sit with a person, when family was not available to give comfort. This was to enable staff to support people to have the most comfortable, dignified, and pain free a death as possible.

Care records documented people's end of life wishes, including a wish to not be resuscitated, cultural and religious wishes; funeral arrangements and preferences. This showed us that there were procedures in place for staff at the service to promote and respect people's individual end of life wishes.

Good

Is the service well-led?

Our findings

The Care Quality Commission (CQC) records showed that there was a registered manager in place, who was supported by a deputy manager, nurses, care staff and ancillary staff members. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 rating from the last CQC inspection that was carried out on 13 January 2017 was displayed in a communal area for people, their visitors and staff to refer to and on the provider's website. Records showed that the CQC was informed of incidents that the provider was legally obliged to notify them of. This showed us that the registered manager was aware of their responsibilities in reporting notifiable events to the CQC when required.

Staff told us that there was a clear expectation, by the registered manager, for them to deliver high quality care and support. To make sure staff felt valued and to promote and maintain staff morale, staff members could be nominated as recognition for their work each month. A staff member said that, the services values was a, "Dedication to care." Our observations showed that people and their relatives knew the registered manager and the staff well and that communication was good. Staff made very positive comments about the registered manager. One staff member said, "I feel supported. Management is good." Another staff member told us, "I feel supported one hundred percent." A third staff member said, "The [registered] manager is here a lot and there is good communication [to support staff]."

Quality monitoring audits were carried out to ensure organisational oversight was in place. These audits looked at all areas of the service. The results of these audits were positive and at the time of this inspection did not identify any concerns.

Questionnaires were sent out for people, their visitors/family, staff and visiting health and social care professionals to engage with the service and feedback their views. Records showed that responses were positive. Any areas for improvement were noted and where possible acted upon.

The registered manager told us how they worked in partnership with, took advice from, and shared information with key organisations to provide good care to people living at the service. This included working together with the local GP, social workers and nurses who specialise in end-of-life care and support.