Cedar Grange Ltd

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Inspection report

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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

This unannounced inspection was conducted on 16 and 17 January 2017.

Cedar Grange is a residential care home that provides accommodation and personal care to a maximum of 26 people living with dementia. The home is situated in Southport near to the town centre. The facilities are provided over two floors with a passenger lift for easy access to the upper floor. All communal areas are on the ground floor including lounges, an activities room and toilets. There is a large conservatory at the back of the home which serves as the dining room. At the time of the inspection 24 people were living at the service.

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

During a previous inspection in November 2015 concerns were identified relating to the Mental capacity Act 2005 (MCA) and in particular to the assessment of people's capacity to make decisions. We made a recommendation. At this inspection we checked people's care records for evidence that capacity was being assessed on a decision-specific basis in accordance with the MCA. We saw that improvements had been made to capacity assessments and they were no longer generic.

At the previous inspection we identified concerns relating to the submission of notifications to the Commission and the display of the ratings from an earlier inspection. At this inspection we looked at recent incidents and spoke with the registered manager regarding these matters. We saw that notifications had been submitted as required and that the ratings from the previous inspection were displayed.

People and their relatives told us that they felt the service provided at Cedar Grange was safe. We saw that staff were vigilant in monitoring safety and acting to protect people from harm.

Risk was appropriately assessed and recorded in care files. We saw examples of risk being regularly reviewed in conjunction with care plans and with the involvement of people, relatives and care staff.

Because of the design and layout of the building and the vulnerability of the people living at Cedar Grange, we were concerned about the effectiveness of emergency evacuation procedures. The instructions were clear, but did not indicate exactly where it was safe to move people to within the building in the event of a fire. We spoke with the registered manager and maintenance manager about this and they provided an updated set of instructions with greater detail within 24 hours.

Staff were recruited following safe procedures and deployed in sufficient numbers to provide safe, effective care.

Medicines were stored and administered in accordance with best practice guidance. Where issues had been identified through audits, they had been addressed appropriately.

The staff that we spoke with were positive about the training that was made available to them. We saw from the training matrix that staff had access to a wide range of training course which gave them the skills and knowledge to meet people's needs.

We observed the lunchtime experience, looked at the menus and spoke with a chef at the service. Lunch was served in a well presented dining room and consisted of two sittings. People who required assistance were seated first so that staff could attend to their needs.

People were supported to maintain their health through regular contact with community-based healthcare professionals. The service had daily input from district nurses and GP's and made use of a 'Telemed' service which gave access to healthcare professionals for consultation over a secure internet connection.

Cedar Grange had been adapted to meet the needs of people living with dementia. The service had a reminiscence room, music room and other dementia-friendly facilities. However, some areas of the building were better suited to meeting the needs of people living with dementia than others.

People told us that the staff were caring and attentive and over the course of the inspection we saw that this was the case. We saw and heard that staff knew people well and spoke to them in a gentle and caring manner.

For the majority of the inspection we saw that the provision of care was not task-led, but it was clear that at certain times of the day, for example, meal-times, staff had less time to sit and talk to people or engage with them.

People's right to privacy and dignity were respected by staff through the provision of care and the choices that they were offered. Personal care was given discretely in locked bathrooms or bedrooms.

The majority of people at Cedar Grange were living with dementia which made it more difficult to involve them in the assessment and planning of care. To ensure that their views and preferences were considered, the service met with each person and their relative on a regular basis to review care needs. Staff also completed monthly reviews of care to ensure that people's needs were being met.

People were supported to stay active and follow interests through a programme of structured activities. Social events were open to relatives and sometimes used as an opportunity to gather feedback. Posters were used in conjunction with an activities board to promote events and photographs were displayed to aid memory and discussion.

The procedure for making a complaint was displayed in the service and the people that we spoke with were clear about who they should speak to.

The service had good links to the local community and was part of networks which helped improve quality. For example, the service was represented at the Dementia Provider Forum where developments in practice and issues of concern were debated.

The service had an extensive set of policies and procedures containing important information and guidance for staff. We noted that the review of these policies was not consistent and that some contained out of date

information.

The quality and safety audits that we saw were comprehensive and demonstrated honesty and transparency when mistakes were identified. Audit processes were completed on a regular basis by managers at a local and national level and coordinated through a dedicated quality team.

The staff that we spoke with were motivated to provide safe, effective care. They told us that they understood what was expected of them and enjoyed their jobs.

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.

Risk was appropriately assessed and regularly reviewed and changes made to care plans where required.

Staff were recruited subject to appropriate checks and were deployed in sufficient numbers to meet people's needs.

Medicines were stored and administered in accordance with best practice guidelines for care homes.

Is the service effective?

Good

The service was effective.

Staff were given access to appropriate training development opportunities and were supported through regular supervision.

The service adhered to the principles of the Mental Capacity Act 2005 meaning capacity, consent sought and applications made to lawfully deprive people of their liberty.

People told us that they enjoyed the food and were offered a good choice of nutritious alternatives.

Is the service caring?

Good

The service was caring.

Staff knew people well and spoke to them in a calming and re-assuring manner.

Staff responded in an effective and timely manner when people needed care and support.

People's right to privacy and dignity were respected by staff through the provision of care and the choices that they were offered.

Is the service responsive?

Good

The service was responsive.

People were encouraged to take part in reviews of their care. Where this was not practical, relatives, staff and healthcare professionals represented them.

The procedure for making a complaint was displayed and people told us that they felt confident about the process. The number of recent complaints was small.

Is the service well-led?

Good

The service was well-led.

People spoke positively about the registered manager and the quality of communication within the service.

The service used robust quality audit processes to monitor performance and identify issues and errors.

The service was well supported by the provider through regular visits and the allocation of resources.

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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 and 17 January 2017 and was unannounced.

The inspection was conducted by two adult social care 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 checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all of this information to plan how the inspection should be conducted.

We observed care and support and spoke with people living at the home, their relatives and staff. We also spent time looking at records, including four care records, three staff files, medication administration record (MAR) sheets and other records relating to the management of the service. We contacted social care professionals who had involvement with the service to ask for their views.

Over the two days of the inspection we spoke with four people living at the home, two relatives and one visitor. We also spoke with the registered manager, a care manager, a chef, the maintenance manager and a member of the care staff. We spoke informally to other care staff throughout the inspection.

Good

Is the service safe?

Our findings

The majority of people using the service were living with dementia and experienced difficulty understanding our questions and providing an appropriate response. Those that were able to respond told us that they felt safe living at Cedar Grange. One person said, "[Safe] I should think so. I don't feel frightened at all." One relative told us, "Most definitely, yes. It's always been safe." While another commented, "Yes, they're quite attentive staff, especially of a night." We asked people and their relatives why they felt that the service was safe. One person commented, "I use the rails [on corridors] and the carers are there to help you get to where you want to go." A relative said, "[Relative] has a walker that they can use independently and seems safer here than at [previous care home]."

We saw that staff were vigilant in monitoring safety and acting to protect people from harm. For example, floors that had been mopped were cordoned-off and clear signage displayed to warn people of the danger. The home had hand-rails on all corridors so that people could steady themselves as they moved around the building.

The staff that we spoke with had completed training in adult safeguarding and knew what action to take if they suspected that a person was being abused or neglected. Each staff member told us that they would not hesitate to raise a concern and was able to explain how they could report outside of the service if necessary.

Risk was appropriately assessed and recorded in care files. We saw examples of risk being regularly reviewed in conjunction with care plans and with the involvement of people, relatives and care staff. In one example, a pressure mat had been placed outside of a person's room to alert staff to them leaving the room at night. Their room was adjacent to a staircase meaning that staff would have a limited time to respond if the alarm sounded. We spoke with the registered manager about this who explained that the mat was previously placed beside the person's bed, but they had developed a behaviour which meant that they 'fiddled' with the mat making it inoperative. The mat was moved to a position outside of the door to ensure that it was not tampered with. The risk assessment indicated that the person was not at a high risk of falls. The registered manager said that they would review the risk assessment and associated care plan to ensure that they continued to offer the safest care. Risk assessments were also undertaken and reviewed in relation to; moving and handling, nutrition, skin integrity and behaviours.

Because of the design and layout of the building and the vulnerability of the people living at Cedar Grange, we were concerned about the effectiveness of emergency evacuation procedures. We looked at the service's fire records including instructions for staff to complete horizontal evacuation. Horizontal evacuation is a process of moving people to safer places within a building in the event of a fire. The instructions did not indicate exactly where it was safe to move people to within the building. We spoke with the registered manager and maintenance manager about this and they provided an updated set of instructions with greater detail within 24 hours. All other documentation and processes relating to fire risk had been completed and regularly reviewed. For example, the fire risk assessment was completed by an external specialist and safety equipment had been regularly checked and serviced.

Other safety checks were completed on a regular basis including; water temperatures, portable appliance testing (PAT) and the nurse-call system. The service also had a contingency plan which detailed the location of gas and electric isolation points and gave staff clear instruction on how to respond to a range of emergency situations.

Accident and incidents were recorded in appropriate detail using a standard document. However, this made subsequent analysis of accidents and incidents difficult because there was no consolidated record available to look for patterns or triggers. We discussed this with the registered manager who said that they would liaise with senior managers to see if a spreadsheet could be developed to aid this process.

The service deployed five direct care staff on each daytime shift, plus an apprentice, ancillary and domestic staff and a manager. On the first day of the inspection we saw that some people were left without access to a carer for prolonged periods. We checked the staff rotas and spoke with staff and identified that there were sufficient numbers of staff on duty to meet people's needs as identified in their care plans. However, the assessment of people's dependency had not been recently reviewed and we were concerned that people's needs had changed. For example, three people were being cared for in bed and others required two staff to provide support with moving and handling. The registered manager said that they would review people's dependency assessments to ensure that staffing numbers remained adequate to provide safe, effective care. On day two of the inspection we noted a marked improvement in the availability of staff and the level of engagement with people using the service. The staffing numbers were the same as those on day one, but the staff were more visible within the shared areas of the service. None of the relatives or staff that we spoke with expressed concern over staffing levels.

The staff records that we viewed indicated that staff were recruited subject to the appropriate checks being completed. Records included; an application form, photo I.D., two references and a Criminal Records Bureaux (CRB) or Disclosure and Barring Service (DBS) check. CRB and DBS checks are used to establish if potential staff are suited to working with vulnerable adults. Staff were required to complete an annual statement confirming that their CRB/DBS status had not changed.

We looked at the service's procedures for the storage and administration of medicines. Medicines were stored in a locked trolley which was in turn kept in a locked room. The temperature of the room was regularly monitored to ensure that medicines were not damaged by excessive temperatures. A specialist refrigerator was used to store medicines where appropriate. The operating temperature of the fridge was monitored to ensure that it remained within a safe range.

We checked medicine administration record (MAR) sheets for three people. On one sheet we identified two missing signatures for a laxative. The care manager said that they would check if the medicine had been administered and the circumstances regarding the missed signatures as soon as the staff member concerned was next on duty. We were told subsequently that the member of staff had confirmed that the medicine had been administered, but not signed for. All other records were completed as required. We saw from medicines audits that other issues and errors had been identified by the provider and appropriate action had been taken to improve practice.

The service had PRN (as required) protocols in place for people who required medicines, for example, for pain relief or anxiety. The protocols were sufficiently detailed to inform staff of the circumstances under which the medicines should be administered. No one living at Cedar Grange was having medicines administered covertly (hidden in food or drink and administered in their best-interests) but the care manager was able to explain the circumstances under which this could be done safely with involvement from the GP and pharmacist. The service had the facility to store controlled drugs (CD). CD's are medicines

which have additional controls in place because of their potential for misuse. However, none of the people currently living at the service was prescribed CD's.

Good

Is the service effective?

Our findings

During a previous inspection in November 2015 concerns were identified relating to the Mental capacity Act 2005 (MCA) and in particular to the assessment of people's capacity to make decisions. We made a recommendation.

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

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

At this inspection we checked people's care records for evidence that capacity was being assessed on a decision-specific basis in accordance with the MCA. We saw that improvements had been made to capacity assessments and they were no longer generic. People's capacity had been assessed in relation to the provision of care, use of bedrails and other restrictions on people's liberty. Each had been assessed to effectively balance independence and safety. Applications to deprive people of their liberty had been made to the local authority and a record maintained of authorisations received.

People told us that staff had the skills and knowledge to provide, safe, effective care. One person said, "I can't find any fault." While a relative told us, "Always very happy with the staff." They gave us an example where staff agreed to provide specialist support at mealtimes which allowed their family member to be discharged from hospital.

The staff that we spoke with were positive about the training that was made available to them. We saw from the training matrix that staff had access to a wide range of training course which gave them the skills and knowledge to meet people's needs. Each of the courses had been completed or refreshed within the last 18 months. Topics included; First aid, moving and handling, administration of medicines, communication and dementia. New staff were inducted in accordance with the principles of the Care Certificate. The Care Certificate requires staff to complete a programme of training before being assessed as competent by a senior colleague. We saw evidence of workbooks and records which indicated the progress made towards completion.

Some staff had been supported to access specialist qualifications at level two and above. In one case this had led to two promotions within the service. The person was studying for a management qualification to aid their professional development. Staff also told us that they were well supported by the provider through regular supervisions and appraisals. We saw from records that supervisions had been completed on a regular basis throughout 2016.

People told us that they enjoyed the food at Cedar Grange and had a choice of meals at each sitting. One person said, "It's perfect. You get a choice, yes, and there's more than enough." A relative told us, "[Family member] is a fussy eater but they manage to get them to eat. Sometimes if [family member] is a bit 'off', they'll give them a rice pudding because they know they'll always eat that."

We observed the lunchtime experience, looked the menus and spoke with a chef at the service. Lunch was served in a well presented dining room and consisted of two sittings. People who required assistance were seated first so that staff could attend to their needs. Some people were given soft or pureed foods because of their health conditions. The chef was clear about which person needed which food and how it should be prepared. Some people also required that their drinks were thickened to aid safe swallowing.

It took time for people to be seated and served for the second sitting because of their restricted mobility, but each person that we spoke with said that they were enjoying their lunch. We saw that people were not rushed in eating their meals and that drinks were readily available. The service also had an additional kitchen/diner where people could sit or prepare drinks throughout the day. The menu offered a good choice of nutritious meals and changed weekly. People had access to adapted cutlery and crockery so they could eat and drink independently.

People were supported to maintain their health through regular contact with community-based healthcare professionals. The service had daily input from district nurses and GP's and made use of a 'Telemed' service which gave access to healthcare professionals for consultation over a secure internet connection. We saw from records that people also accessed; dentists, opticians and speech and language therapy. The care records that we saw clearly indicated that people's healthcare was well managed. For example, one person had recently been referred to a dietician due to their weight loss. The same person had also been referred for specialist advice in relation to a deterioration in their skin integrity.

Cedar Grange had been adapted to meet the needs of people living with dementia. The service had a reminiscence room, music room and other dementia-friendly facilities. For example, rummage boxes and tactile decorations. Bedroom doors featured photographs and familiar objects to help people identify their own room. However, some areas of the building were more suited to the needs of people living with dementia than others. We spoke with the registered manager about the differences and improvements that could be made. They told us that they had taken specialist advice on décor and facilities, but accepted that people experience dementia in different ways and may not be as comfortable in some areas of the building as others. For example, one corridor was decorated in bright colours with flowers painted on the walls. It also featured plastic flowers for people to remove from frames on the wall. This provided a stimulating environment for some people, but one relative reported that their family member was distressed by some of the features. Other features like high-contrast door frames and toilet seats were not evident. These are features that tend to help people living with advance dementia to orientate themselves. The registered manager said that they would consider developments and adjustments to the environment as part of the service's refurbishment programme.

Good

Is the service caring?

Our findings

People told us that the staff were caring and attentive. One person said, "If they see someone struggling, they always help." While another person commented, "I think they're nice." When asked if staff were caring in their approach a visitor told us, "Oh yes, they look after the people very well: doing their hair or trimming it, doing their nails and such."

On the first day of this inspection we were concerned that there was a limited staff presence in lounges which meant that people's needs may not have been attended to. However, we saw on a number of occasions that staff remained vigilant and attended to people's needs in a caring and timely manner. For example, some people complained of feeling cold and were quickly supplied with blankets to cover their legs. The staff member took time to check if the person wanted the blanket before laying it over them.

On day two of the inspection the staff presence was more obvious and we were able to better observe the provision of care. We saw and heard that staff knew people well and spoke to them in a gentle and caring manner. For example, one member of staff asked if a person wanted to take a seat to rest as they were becoming fatigued. Somebody else was asked which magazine or newspaper they would prefer to read. While another member of staff was heard to use gentle, encouraging language in support of a person struggling to walk along the corridor. The staff that we spoke with demonstrated that they knew people's personal histories and used this to offer reassurance in conversation. The service had a mood board in one of the corridors which displayed facial expressions and emotions. We were told that this was used to help people who could not express themselves verbally.

For the majority of the inspection we saw that the provision of care was not task-led, but it was clear that at certain times of the day, for example, meal-times, staff had less time to sit and talk to people or engage with them.

Throughout the inspection we heard staff discussing the provision of care with people and encouraging them to express an opinion. Where people did not appear to understand or did not respond, staff sometimes re-phrased the question or used an object to aid understanding. For example, when a chair-based activity involving a bean-bag was suggested, the throwing of the bean-bag was demonstrated and people were asked again if they wanted to participate.

We saw that people were offered choices about meals, drinks, activities and where they sat within the service. Staff allowed people time to respond and confirm their choice, either verbally or through their actions. People were actively encouraged to be independent within the service. For example, by the provision of adapted cutlery and crockery or by staff walking with people to ensure that they were safe when walking in corridors.

People's right to privacy and dignity were respected by staff through the provision of care and the choices that they were offered. Personal care was given discretely in locked bathrooms or bedrooms. Staff were able to explain the importance of maintaining people's privacy and dignity and gave practical examples to

support their comments. For example, one member of staff said, that they did not leave people completely naked when providing personal care. They said that they covered the top or bottom half of the person while they washed the other half.

The service placed no restrictions on visitors and made them feel welcome when they attended the service. One relative said, "I come and go as suits me. They are always welcoming." While another commented, "Yes [I can visit], any time as far as I know. They will make you a cup of tea and they let us know if they've any concerns."

The service was in the process of being accredited for the Gold Standards Framework (GSF) for end of life care. The GSF helps services to achieve better quality of care, better coordination of care and better outcomes for people at the end of their lives. Services are required to complete a programme of training and development before being assessed and accredited. It was clear that staff at all levels were committed to achieving the standard and were able to explain the benefits for people living at Cedar Grange.

Good

Is the service responsive?

Our findings

The majority of people at Cedar Grange were living with dementia which made it more difficult to involve them in the assessment and planning of care. To ensure that their views and preferences were considered, the service met with each person and their relative on a regular basis to review care needs. Staff also completed monthly reviews of care to ensure that people's needs were being met.

When asked if they were involved in reviews of care one relative said, "Yes – the GP and I make all the decisions, especially regarding [family member's] medicines." While another commented, "Yes, my brother [is involved] especially." We saw that care staff were also involved in reviews of care. One member of staff told us, "I do care plans. We keywork three or four residents and review each month." We saw evidence in care records that the review of care had identified changes in need and the relevant care plans. For example, in relation to behaviours and continence. Changes in care needs had prompted reviews of risk which ensured that care continued to be provided safely. Some plans had been reviewed with input from specialist healthcare professionals.

Care records captured personal information about people's histories and preferences. For example, one person enjoyed woodwork and model cars. We were told that this was reflected in the décor of the room and the activities that they engaged in. Records included photographs and person-centred information. This helped staff to get to know each person as they arrived at Cedar Grange. Care plans were extensive and made good use of respectful, person-centred language. The service also supported people to take part in 'Sefton's Lost Voices Project.' The project made recordings of people talking about their personal histories and families to be included as part of a local archive. The information could also be used as people's dementia progressed so that staff could provide meaningful conversation.

People were supported to stay active and follow interests through a programme of structured activities. For example, a visit had been arranged to a cinema which was showing a dementia-friendly screening of a classic film. The film was being shown with low-level lighting in the auditorium and reduced sound to help people living with dementia enjoy the experience. Other activities included; a vocalist, chair-based exercise and a number of themed social events. Social events were open to relatives and sometimes used as an opportunity to gather feedback. Posters were used in conjunction with an activities board to promote events and photographs were displayed to aid memory and discussion.

People were also supported with their cultural and faith needs. A visitor told us, "I come every other Monday and another church visitor comes on the Mondays in between, to give [person] the Sacrament."

The service used a number of means to gather feedback and listen to people's views. There were resident and relative's meetings where matters of importance were discussed and a survey was issued by the provider on a regular basis. The return from the most recent survey had been poor, but the comments included were positive about each aspect of the service. The results of the surveys were analysed by the provider before being discussed at a local level.

The procedure for making a complaint was displayed in the service and the people that we spoke with were clear about who they should speak to. A relative said, "I'd see the manager or one of the floor managers. The social worker is also good and advised that I could go to him if ever any problems." Another relative told us, "We've never really had a complaint, only something that happened when [family member] first came and there have been a lot of changes since then."

We looked at the record of the most recent complaints. Two complaints had been received in October 2016. Each had been detailed and action recorded which was in accordance with the provider's policy.

Good

Is the service well-led?

Our findings

At the previous inspection we identified concerns relating to the submission of notifications to the Commission and the display of the ratings from an earlier inspection. At this inspection we looked at recent incidents and spoke with the registered manager regarding these matters. We saw that notifications had been submitted as required and that the ratings from the previous inspection were displayed.

It was clear from records and observations that the service was developed with input from people and staff. It was equally clear that the management of the service was open and approachable. This meant that staff were confident in making suggestions or questioning practice. We were told this had led to changes in staff rotas and activities. People also confirmed that the quality and flow of information was of a high standard. Regarding communication, a relative commented, "I think it's as good as I could wish for."

The service had good links to the local community and was part of networks which helped improve quality. For example, the service was represented at the Dementia Provider Forum where developments in practice and issues of concern were debated.

The registered manager was aware of the day to day issues and culture within the service and spoke positively in support of the staff team. They said, "I've got a totally open door policy. It's relaxed because it's the resident's home. I empower staff. They love their jobs." The staff that we spoke with confirmed that they enjoyed their roles and understood what was expected of them. One member of staff told us, "I absolutely love it here. It's a good team."

The service had an extensive set of policies and procedures containing important information and guidance for staff. We noted that the review of these policies was not consistent and that some contained out of date information. We discussed this with the registered manager who acknowledged the issue and confirmed that they would discuss the review of policies with senior managers.

The quality and safety audits that we saw were comprehensive and demonstrated honesty and transparency when mistakes were identified. We saw from the staff meetings records that staff had been challenged with improving the dining experience and better monitoring of fluid intake as well as being informed about changes and plans for the service. Audit processes were completed on a regular basis by managers at a local and national level and coordinated through a dedicated quality team. Topics covered included; infection control, health and safety, catering and care plans. We saw evidence that actions had been identified and completed within appropriate timescales. For example, 'sleeping care plan needs re-writing' and 'bedrails consent sent to next of kin.'

The registered manager was also responsible for another service in the locality. We spoke to them about the management of the service in their absence and were told that they alternated responsibility for each service with a deputy. Staff confirmed that they always had access to a manager including through an out of hours/on-call service. The registered manager was clear about the responsibilities of the role and the requirements in relation to their registration.

The staff that we spoke with were motivated to provide safe, effective care. They told us that they understood what was expected of them and enjoyed their jobs. One member of staff said, "I'm 100% happy in my job. I feel this home shines." The registered manager confirmed that they felt well supported by the owners and said that they regularly visited the service, "Sometimes unannounced."

There was a programme of development and refurbishment underway at Cedar Grange which demonstrated the provider's commitment to the service. For example, an adjoining property was being renovated to provide additional, improved facilities and increase the number of rooms available. The registered manager explained that the new building was not just being developed to maximise rooms, but that additional lounges and activity areas were being built to provide an improved service.