Healthcare Homes (LSC) Limited

Cedar Court Care Home

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

We carried out this unannounced inspection on 8and 12 July 2016.

Cedar Court is a purpose-built nursing home caring for up to 63 people whose care needs are associated with physical needs, mental frailty and/or dementia. At the time of our visit 62 people were using the service, most of whom lived with dementia.

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

People told us they felt safe and staff were aware of their responsibility to keep people safe. Risks to people's safety were appropriately assessed and managed.

Systems were in place to make sure people received their medicines safely. Arrangements were in place for the recording of medicines received into the home and for their storage, administration and disposal.

Staff knew what action to take if they were concerned that someone was being abused or mistreated. The provider's whistleblowing policy protected staff to make disclosures about poor staff conduct or practice, and staff confirmed the manager would take responsive action if they reported such problems.

Staff had been recruited safely to ensure they were suitable to work with vulnerable people. There were sufficient numbers of suitable staff to meet people's needs and people received their medicines as prescribed.

We found the premises were clean and tidy. There was a record of essential inspections and maintenance carried out. The service had an infection control policy and measures were in place for infection control.

Staff had a good understanding of the Mental Capacity Act 2005 and we saw people's consent was sought routinely. People were supported to make their own decisions wherever possible, and staff took steps to support people to do this. Where people were unable to make a decision, there was a best interest decision recorded within their support plan. We saw the person concerned and relevant people had been involved in making best interest decisions. This meant people were given the opportunity to participate in decision making and decisions were made in the person's best interests. The service had effectively implemented the Deprivation of Liberty Safeguards (DoLS) as required.

Records showed staff received the training they needed to keep people safe. The manager had taken action to ensure that training was kept up-to-date and future training was planned.

Staff told us they felt supported by the management and received supervision and appraisals, which helped to identify their training and development needs.

People had access to healthcare when they needed it and recommendations from healthcare professionals were implemented.

Staff prepared appropriate care plans to ensure people received safe and appropriate care and support. Each person had a personalised care plan containing information about their likes and dislikes as well as their care and support needs. The care plans were updated in line with changing needs and people and their relatives were involved in making decisions regarding their care.

People's healthcare needs were closely monitored and responded to. Staff were considerate and caring. Their knowledge of the individual choices and preferences of people enabled them to provide people with relevant care and support.

The management appreciated and acted on people's and relatives' opinions on the service, including complaints. Such information was used to implement changes and enhance the functioning of the service. People and staff had confidence in the manager as their leader and were complimentary about the positive culture within the service. There were systems and processes in place to help monitor the quality of the care people received.

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.

People were kept safe from abuse. The registered manager and staff understood their responsibilities and knew how to report any concerns.

People's risks associated with their care were managed to help ensure people's freedom was supported and maintained.

Appropriate arrangements were in place in relation to the management and administration of medicines.

Is the service effective?

Good

The service was effective.

Staff had completed training to enable them to provide people with care effectively. Staff were supervised and felt well supported by the whole team and the registered manager.

Staff understood the requirements of the Mental Capacity Act 2005 (MCA) and how this applied to their daily work.

People had access to healthcare professionals to make sure they received appropriate care and treatment.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind and who delivered care in a compassionate way.

People who use the service and their relatives said the staff were caring and treated them with dignity and respect.

People were supported to maintain important relationships and be as independent as possible.

Is the service responsive?

Good

The service was responsive.

Documentation was personalised, up-to-date and included specific information about people's backgrounds, events and persons important to people.

People's and relative's complaints were valued and investigated to help make improvements to the service.

Is the service well-led?

Good

The service was well-led.

Staff and people spoke highly of the registered manager and the way she ran the home.

Staff were supported by the registered manager and told us they felt able to have open and transparent discussions with them.

The quality of the service was monitored and there were systems in place to make necessary improvements.

Cedar Court Care 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 8 and 12 July 2016 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor in dementia care 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. In this case, the expert's area of expertise was providing care to people with dementia.

Prior to our inspection, we reviewed information we held about the service. This included any information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During the inspection we spoke with six people who were using the service; however, only one person was able to give us verbal feedback. We also talked to six family members. We spoke with the registered manager, the deputy manager, the activities co-ordinator, the registered nurse, two care staff members, the dignity champion, maintenance staff, the housekeeper and kitchen staff.

Some people could not convey what they thought about the home because they were unable to communicate verbally. Therefore we used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care in order to understand the experience of people who could not talk to us. We observed how people were supported at lunch and watched how staff interacted with them at that time.

We reviewed care plans for six people, four staff files, training records and records relating to the management of the service such as audits, policies and procedures.

Good

Is the service safe?

Our findings

People felt safe at the service as they knew there was always support when they needed it. One person stated, "I feel safe here; you have good locks on the doors and the staff look after you". A relative told us, "My (person)is very safe. The security is good and the staff are good too."

We spoke with staff about what actions may need to be taken to ensure people were protected from abuse. They were aware that incidents of potential abuse or neglect should be reported to the local authority. A member of staff told us, "Abuse can be physical, financial or institutional. There are different signs of abuse: bruises, body language, a person becomes frightened. There is a change in normal behaviour". Staff told us they would report any concerns to the registered manager and take further action if needed. One member of staff said, "I can report abuse to the manager or to the Care Quality Commission (CQC)". The registered manager knew their responsibilities to report concerns to the correct authority in a timely way. Staff explained how they knew people well and would be aware if a person was distressed or worried about something.

Risks were appropriately managed. For example, when one person's health had deteriorated, a range of risk assessments had been produced. These risk assessments covered the areas of mobility, communication, manual handling and personal hygiene. Risk assessments were in place to help identify risk factors specific to each person, such as manual handling, falls, specific nutrition needs or fragile skin integrity. This helped to provide staff with information on how to manage and minimise these risks and provide people's care safely. All risk assessments were reviewed monthly or, if circumstances changed, even more often.

A thorough recruitment policy and procedure was in place. We looked at the recruitment records for staff and saw that they had been recruited safely. Records included application forms (including employment histories, with any gaps explained), interview records, references, proof of identity and evidence of a Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals. This helps employers make safer recruiting decisions and employ only suitable people who can work with children and vulnerable adults.

People and relatives told us there were enough staff to meet their needs. A relative told us, "One of the reasons of moving [person] here was the fact that they have more staff at night time". We noted agency staff were employed to cover shifts at times. This was recorded clearly in the rota. We were told by the registered manager that where possible the same agency nurses worked at the home to maintain the consistency of care.

During our visit we saw staff administering people's medicines in a patient and relaxed manner, whilst also following safe procedures. Staff recorded times at which people took their medicines and documented a reason if a person did not take their medicine. We saw that medicines were stored securely in locked trolleys and kept at appropriate temperatures. There was a robust system in place to manage the ordering and disposal of medicines and all relevant staff told us they had been made aware of these system. Medicines administration training was provided to staff as well as regular checks of their competency and knowledge.

People were protected from the spread of an infection. All the departments: care staff, housekeeping, catering and maintenance staff contributed to preventing such occurrences. The kitchen staff ensured the kitchen remained clean and free from potential cross infection. They adhered to food safety standards and ensured the food was prepared safely. They wore appropriate protective clothing, food was kept at appropriate temperatures and other staff had limited access to the kitchen.

Housekeeping staff followed the colour coding system for their cleaning equipment. As a result, the spread of a potential infection was reduced because, for example, toilet cleaning equipment was not used for cleaning bedrooms and communal areas. Care staff and nurses wore protective plastic gloves and aprons when delivering personal care so as to reduce the risks of cross contamination. We observed that staff washed their hands and used hand cleansing products before performing various tasks.

The service took appropriate action to reduce potential risks relating to Legionella disease. Staff reported any maintenance requirements and these were resolved in a timely manner.

Good

Is the service effective?

Our findings

People received care from staff who had received various kinds of training, such as dementia care, safeguarding or moving and handling equipment, in order to meet their specific needs. One of the relatives told us, "The carers have certainly all skills and knowledge to take care about people".

All new staff had undertaken induction training which had included the completion of mandatory training in relevant areas and completed a probationary period. Newly employed staff members shadowed more experienced staff for two weeks and had their competencies assessed. For example, in how to operate the mechanical lifting equipment. The induction programme was linked to "Skills for Care". This meant care workers were trained to nationally recognised Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. We were told the period of shadowing could be extended if necessary. A member of staff told us, "Induction included basic training and shadowing until you feel you are happy to not shadow anymore". We were told by the registered manager and it was confirmed by staff that they received training in communication methods as a part of the Care Certificate standards.

Further training was also available to care workers in various forms and areas, such as end of life care and completing national care qualifications. A member of staff told us, "I requested (national care qualifications) training and I am already doing it". A member of maintenance staff said, "I had asked for Legionella training and it was provided to me". Legionnaires' disease is caused by Legionella bacteria infecting lungs. It's usually caught by breathing in small droplets of contaminated water.

Records showed and staff had received regular supervision sessions and this staff confirmed this while talking to us. Supervision sessions enabled staff to discuss their personal development objectives and goals. We also saw records confirming that staff had received annual appraisals of their individual performance and had an opportunity to review their personal development and progress. A member of staff told us, "We get supervisions every three months and yearly appraisals. In a supervision I talk about how I'm feeling, how I'm doing and how to improve my work. In our appraisals we discuss our performance, training and development plans for future".

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.

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. We noted that care plans contained information about people's mental state and cognition. Some people were unable to give their verbal consent in some areas of their care. Records showed that in such cases the person's next of kin and health professionals were involved to ensure decisions were made in the person's best interest. People who had

the capacity but were unable to express their consent verbally used alternative methods of communication. For example, some of them used objects of reference while others preferred pictures or written language due to their hearing impairment.

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).

The registered manager had made applications to the local authority when people had needed to be deprived of their liberty for their own safety. We saw that any conditions were being met and staff were providing care in the least restrictive way. Staff had received training regarding the MCA and DoLS and demonstrated an understanding of the principles of the MCA and how it applied to their work. A member of staff told us, "People have ability to make decision unless questionable. If the person lacks capacity the decision must be undertaken in the least restrictive way in a best interest for the person". Another member of staff explained how they involved people in making day-to-day decisions, "Most of our residents give yes/no answers so we give them choices. We still consider their capabilities. We show them pictures and photos to help them to make choices".

People's needs relating to nutrition and hydration were monitored when required to ensure people ate sufficient amounts of food and drank enough fluids. One of the relatives commented on the food offered to people, "She has a good choice of menu. They have three main courses to choose from and a choice of puddings. Her favourite meal is a roast and at night she always has water by her bed". One person said, "Food is very good, really, when you think they're doing it for so many people. We get a good choice and they let us pick on the same day what we want. I eat almost anything and at night I have my water and I can always get a biscuit".

When there were concerns about a person's health or well-being, immediate action was taken, such as contacting the person's GP or seeking guidance from professionals such as speech and language therapists (SALT) or a dietician. People were supported to maintain good health by accessing health care services and obtaining advice from their GP, chiropodist and optician. One person told us, "GP comes around once a week and she's very good. We also have an optician come in once a year. I have my own dentist and I have my own chiropodist".

The interior of the service premises was dementia-friendly. For example, carpets were free of any patterns that might cause confusion. All toilet doors were painted yellow so that people knew where the toilets were both in their rooms and in the communal areas. Each floor of the building had been designed with regard to people's conditions and needs. The design allowed people to walk through the corridors and return to the main communal rooms without being faced with 'dead ends', which could be frustrating for people with dementia. There were also different decoration patterns to suit people's tastes. For example, one place in the building reminded a garden. There were lights of different colours on tree branches and sounds of birds singing were played from a CD. In another part of the building there was a seaside corner decorated in sea-related patterns where people could hear soothing sounds of the sea. It provided people with sensory stimulation but also helped them relax and evoke their memories.

Good

Is the service caring?

Our findings

People using the service and their relatives spoke very positively about staff and the care they received. A relative told us, "They do treat him with kindness and respect and with dignity and they always knock on his door before they come into his room. If they are doing anything to him, they always have the door closed". Another relative said, "Oh yes, they treat her with kindness and dignity since she's been here and they treat her with TLC".

The service had appointed a dignity champion from the staff group. A dignity champion is someone who is knowledgeable about the need for people to be treated with dignity and respect. They act as a role model for their colleagues. The dignity champion told us, "I'm part of dignity council and the dignity champion. I work out and promote best practice".

We observed that staff respected people's dignity and privacy. Staff knocked on people's doors before entering their rooms. They also ensured that curtains were pulled and doors were closed while they provided people with personal care. We saw that care staff took time to talk to people to make them feel supported and comfortable at the service. For example, we observed care staff talk to one person and then give them assistance with a drink and a snack. They talked to the person about their past and where they had lived. The person appeared to be happy to have a friendly chat with staff.

During the Short Observational Framework for Inspection (SOFI) we saw staff assisting people with their meals. People were offered food options by staff who talked to them or used gestures and other prompts to ensure people understood them and could make their choices. We observed staff assisting people with eating and drinking in a calm and caring manner. Staff worked well as a team; there was frequent communication among staff members who shared all information needed to ensure people's needs were met.

People and their relatives were involved in preparing and, if necessary, amending people's care plans. One of the relatives told us, "Yes I have seen it and we review it once a year and we did it a couple of weeks ago". People's personal history and preferences were listed and their preferred names were noted at the front of each plan. Care workers used people's preferred names in a respectful manner.

People's care plans described ways in which people should be supported to promote their independence. During the inspection, we observed care workers provide prompt assistance but also encourage and prompted people to build and retain their independence. For example, people were encouraged to choose what they wanted to do and where they wanted to go throughout the day. A person told us, "I'm encouraged to keep my independence as I can eat independently and yes, the staff here also know my needs". When asked how the service supported people to maintain their independence, a relative said, "Yes, they do encourage his independence making sure he feeds himself and they put up on a board for him what day it is and they make sure he can walk around and he has no restrictions going into the garden and he takes his own laundry to the laundry room". A staff member told us, "I encourage people to do simple things like

buttering toast or making drinks. I let them wash themselves if they can".

People were able to receive visitors at any time and they could talk to their guests in the privacy of their own rooms. One person told us, "My cousins come and see me and they can come in anytime they like and go when they like". A relative stated, "I can come and go as and when I like and there's no restrictions on when I go".

Staff were discreet and respected people's confidentiality. We saw that records containing people's personal information were kept in the main office which was locked so that only authorised persons could enter the room. People knew where their information was and they were able to access it with the assistance of staff. Some personal information was stored within a password protected computer. A member of staff told us, "We keep documents locked away. Information on computers is password protected. We check people's identifications".

Good

Is the service responsive?

Our findings

People and relatives spoke positively about the service and the care people were receiving. A person using the service expressed their satisfaction with the service, "I am happy here, the staff are very friendly." One relative told us, "I just asked my mum having her clothes changed and they done it straight away".

The service provided people with care that was individualised and person-centred. Prior to moving into the service, people underwent a pre-assessment review to identify their needs and to ensure these needs could be fully met at the service. Care plans were in place to give staff guidance on how to support people with their identified needs in such areas as personal care, medicines management, communication, nutrition and mobility. Staff were provided with information which detailed what was important to each person, described their life history, daily routine and the activities they enjoyed. Staff members told us that care plans were a good resource in terms of obtaining sufficient information to provide effective care.

Care plans were reviewed monthly by staff and were updated as soon as people's needs changed. For example, when a person's health had deteriorated, their care plan had been updated to reflect the person's current needs and ways to address those needs. Staff told us and records confirmed that there was a handover meeting after each shift and daily records of people's progress were completed every day. When asked, staff were able to tell us about people's personal and individual needs.

Records showed there were regular formal review meetings with people using the service and relatives. At these meetings people's care was discussed and reviewed to ensure people's needs were being met effectively.

There was a wide choice of activities offered to people, ranging from visits of entertainers to daily activities people could attend in the house. These activities included games, quizzes, listening to music and gardening. Activities were reviewed and feedback was sought from people to see what they preferred most. We saw people sat in the communal areas listening to music and reading newspapers. Others stayed in their bedrooms, watching television, reading or being visited by their relatives. One person commented on how they were able to pursue their hobbies, "We have a library come in once a fortnight and I like to play dominoes. The activities lady is very good and sometimes she comes into my room." A relative told us, "He likes exercising and dominos."

People said they knew how to complain if they were not satisfied with the quality of care. One person stated, "I've never had to make a complaint but if I needed to I would go and see the manager". Another person said, "No, never made a complaint but if I did I would go to the manager". One of the relatives told us, "I have never complained but I did have an issue about washing and I spoke to the manager". The matter was addressed and resolved by the registered manager.

There were records of people's concerns and evidence showed the service had responded to these concerns in line with procedures. There had been 18 complaints since the service had been registered with us in May 2015. People's concerns and complaints were monitored and appropriately investigated. Furthermore, this

information was used as a basis for actions aimed to enhance the service. We also saw letters of appreciation. Relatives wrote in their comments that they were grateful and thankful as people at the service were well looked after and safe, and could rely on staff's constant support. One of the relatives wrote, "From the very first time I set foot in Cedar Court I was welcomed".

Good

Is the service well-led?

Our findings

The people we spoke with and their relatives felt the culture of the home was open and transparent. One person told us, "I get to speak to the manager and yes, she does a good job". A relative remarked, "I think the culture here is set by the manager and I can get to speak to her when I like which is very good". A member of staff said, "We show openness and there is nothing to hide".

Staff were positive about the home and described their team as friendly and supportive. There was a relaxed and friendly atmosphere in the home and staff told us they were happy to work there. They also said they were satisfied with the way the home was run. Staff told us they considered the management to be accessible and supportive. A member of staff told us, "The manager is very nice. I can talk to her about anything work or personal". Another member of staff said, "I feel assertive. We receive good support from the manager. We work well as a team and we are pro-active".

There was a clear management structure which included the registered manager and a deputy manager. They were supported by an area manager who visited the home once a month.

The registered manager had a good knowledge of all people living at the home. They were familiar with each person's individual needs. We spoke with the deputy manager and they were also very knowledgeable about people and the staff team they supported. They both had a clear understanding of their roles. Staff told us they had clearly defined roles and responsibilities and worked as part of a team.

The manager had helped to develop a learning environment for staff by appointing champions. Staff were appointed to lead on and be a point of reference for other staff in specialist areas such as infection control, tissue viability, dignity, falls prevention and safeguarding. Where necessary, these staff received specialist training in their area and were able to share their knowledge and advice with other staff members. Staff were empowered to develop their skills and knowledge and therefore contribute to improving the quality of the service by supporting their less experienced colleagues.

People told us there were regular meetings for people and their families. One person explained how their feedback was sought, "We have a residents' meeting here and I go to them. It gives me opportunity to put our point across. And then we get a newsletter once a month". One of the relatives told us, "Yes, I've been to the residents meeting and I can if I want to put my point of view across".

The registered manager explained that these meetings were held regularly and agreed actions were followed through. For example, we saw an action plan following a recent relatives' meeting. The registered manager was acting on feedback indicating that the catering had needed improvement as the service had not provided enough choices of evening meals. The registered manager was in the process of implementing the changes highlighted at the meeting.

We saw evidence of regular staff meetings. The recent meetings included topics such as audits, accuracy in documentation, changes in procedures and maintenance issues. The action plans were created to address

issues highlighted during staff meetings. For example, all registered nurses had to check medicines administration records at the end of each shift.

The provider had a schedule of audits which checked on practice in relation to a variety of topics such as management of medicines, infection control and dignity in care. Relevant action plans were attached to audits when areas for development had been identified by the audit. For example, one audit had showed that people and their relatives had not been sufficiently involved in developing people's care plans. Initially, the care plans had lacked information about people's life histories, their goals or achievements. This issue had also been addressed and we saw evidence that feedback had been obtained from people and their relatives. The information gathered had been incorporated into the care plans. As a result, the care plans became more person-centred, improving the quality of care.