Willerfoss Homes

Cedarfoss House

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?	Outstanding

Overall summary

This inspection took place on 28 January 2015 and was unannounced. We previously visited the service on 29 November 2013 and found that the registered provider met the regulations that we assessed.

The service is registered to provide personal care and accommodation for 18 people with a learning disability. The home is located in Withernsea, a seaside town in the East Riding of Yorkshire. It is close to local amenities and the sea front. Most people have a single bedroom and some bedrooms have en-suite facilities.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC); they had been registered since 6 December 2012. 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.

Summary of findings

People told us that they felt safe living at the home. Staff had completed training on safeguarding adults from abuse and were able to describe to us the action they would take if they had concerns about someone's safety. They said that they were confident all staff would recognise and report any incidents or allegations of abuse.

We observed good interactions between people who lived at the home and staff on the day of the inspection. People told us that staff were caring and compassionate and this was supported by the relatives and health / social care professionals who we spoke with.

People who used the service, relatives and health care professionals told us that staff were effective and skilled. Staff told us that they were happy with the training provided for them, and that they could request additional training if they felt they needed it.

People were supported to make their own decisions and when they were not able to do so, meetings were held to ensure that decisions were made in the person's best interests. If it was considered that people were being deprived of their liberty, the correct documentation was in place to confirm this had been authorised.

Medicines were administered safely by staff and the arrangements for ordering, storage and recording were robust.

We saw that there were sufficient numbers of staff on duty to meet the needs of people who lived at the home. New staff had been employed following the home's recruitment and selection policies to ensure that only people considered suitable to work with vulnerable people had been employed.

People's nutritional needs had been assessed and people told us that they were satisfied with the meals provided by the home. People were supported appropriately by staff to eat and drink safely and their special diets were catered for.

There were systems in place to seek feedback from people who lived at the home, relatives, health and social care professionals and staff. People's comments and complaints were responded to appropriately.

People who lived at the home, relatives and staff told us that the home was well managed. The quality audits undertaken by the registered manager were designed to identify any areas of concern or areas that were unsafe, and there were systems in place to ensure that lessons were learned from any issues identified.

Summary of findings

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 care provided was safe.

The arrangements in place for the management of medicines were robust and staff had received the appropriate training.

Staff displayed a good understanding of the different types of abuse and were able to explain the action they would take if they observed an incident of abuse or became aware of an abusive situation.

We found that there were sufficient numbers of staff employed to ensure that the needs of the people who lived at the home could be met. Recruitment practices were robust and ensured only those people considered suitable to work with vulnerable people were employed.

The premises were being maintained in a way that ensured the safety of people who lived, worked or visited the home.

Is the service effective?

Good

Staff provided effective care.

People were supported to make decisions about their care and best interest meetings were arranged when people needed support with decision making. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Staff told us that they completed training that equipped them with the skills they needed to carry out their role and this was supported by the records we saw and the other people we spoke with.

People's nutritional needs were assessed and met, and people's special diets were catered for. We saw that staff provided appropriate support for people who needed help to eat and drink.

People had access to health care professionals when required. Advice given by health care professionals was followed by staff to ensure that people's health care needs were fully met.

Is the service caring?

Good

Staff at the home were caring.

People who lived at the home and their relatives told us that staff were caring and we observed positive interactions between people who lived at the home and staff on the day of the inspection.

It was clear that people's individual needs were understood by staff.

We saw that people's privacy and dignity was respected by staff and that people were encouraged to be as independent as possible.

Summary of findings

Is the service responsive?

Good 

The service was responsive to people's needs.

People's care plans recorded information about their previous lifestyle and the people who were important to them. Their preferences and wishes for care were recorded and these were known by staff.

People told us they were able to take part in their chosen activities and people who were able were supported to attend day centres or make visits to relatives.

There was a complaints procedure in place and people told us that they were confident that any comments or complaints they made would be listened to.

Is the service well-led?

Outstanding 

The home was well led.

There was a registered manager in post at the time of the inspection.

The registered manager carried out a variety of quality audits to monitor that the systems in place at the home were being followed by staff to ensure the safety and well-being of people who lived and worked at the home. It was evident that any issues identified were dealt with and that lessons were learned that led to improvements in the service.

There were sufficient opportunities for people who lived at the home, relatives, staff and health / social care professionals to express their views about the quality of the service provided.

Cedarfoss House

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.

The inspection took place on 28 January 2015 and was unannounced. The inspection team consisted of an Adult Social Care (ASC) inspector.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider, information we had received from the local authority who commissioned a service from the home and information from health and social care professionals. The registered provider submitted a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

Prior to the inspection we spoke with a social care professional and three health care professionals to ask for their opinion about the service provided by the home, and contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they had with the home. On the day of the inspection we spoke with three people who lived at the home, two members of staff and the deputy manager. We also spoke with two relatives following the inspection day.

We looked at communal areas of the home and also spent time looking at records, which included the care records for two people who lived at the home, staff records and records relating to the management of the home.

Good

Is the service safe?

Our findings

We spoke with three people who lived at the home and chatted to others. We asked them if they felt safe and they all told us that they did.

We saw that care plans included risk assessments and management plans for any areas that had been identified as posing some level of risk. One person had a risk assessment in place that advised staff how to manage their anxieties about receiving personal care, and two staff always assisted with this task to ensure the person's and their own safety. People who had epilepsy had specific management plans in place. One person's care plan included the statement, "I am familiar with some dangers in the home. For example, I know when the wet floor sign is out that the floor is dangerous and wet." We saw that risk assessments were in place for topics such as falls and trips, smoking, use of the shower chair, financial abuse, choking, baking activities, managing unmet complex needs and transfers in a wheelchair. These were reviewed by staff each month.

The registered manager was not present on the day of the inspection and the staff team was being led by the deputy manager. We saw there were two care workers, a senior care worker and the deputy manager on duty, plus another care worker who worked on a one to one basis with a person who lived at the home from 9.00 – 12.00 am. There were two ancillary staff on duty; a cook and a domestic assistant. This meant that care staff were able to concentrate on supporting the people who lived at the home. We checked the staff rotas and saw that staffing levels had been consistently maintained and any vacant shifts had been covered by existing staff. Staff who we spoke with confirmed that the staffing levels were consistently maintained although one person said that some shifts were 'hectic' as it was difficult to anticipate what would happen each day. A health care professional told us that staff were always available to speak with them when they visited the home.

There were safeguarding policies and procedures in place and the registered manager submitted alerts to the local authority as required. We spoke with the local authority safeguarding adult's team and they told us they currently had no concerns about the home. The registered manager also submitted notifications to the Care Quality Commission about any incidents or allegations of abuse.

Staff who we spoke with told us that they had undertaken training on safeguarding adults from abuse. They were able to describe different types of abuse, and were able to tell us what action they would take if they observed an incident of abuse or became aware of an allegation. Staff told us they felt all of their colleagues would recognise inappropriate practice and report it to a senior member of staff. The training record stated that all staff had completed training on safeguarding adults from abuse. The registered manager and deputy manager were due to attend the training being provided by the local authority to explain the new thresholds in respect of reporting safeguarding incidents or allegations.

There had only been one new employee recruited during the previous year. We checked their recruitment records and saw that the application recorded the person's employment history, the names of two employment referees and a declaration that they did not have a criminal conviction. Prior to the person commencing work at the home, checks had been undertaken to ensure that they were suitable to work with vulnerable people, such as references, a Disclosure and Barring Service (DBS) first check and a DBS check. We saw that a thorough interview had taken place that including recording verbal questions and responses, and a series of written questions. The deputy manager told us that they viewed people's existing training certificates so that they could measure their training achievements and needs, but people were still expected to undertake further training at the home.

The medication trolley was fastened to the wall and stored in an enclosed area of the dining room. A holder for disposable gloves was positioned above the trolley so they were easily accessible.

The temperature of the dining room was taken routinely to ensure that medication was stored at the correct temperature. There was no medication fridge; the deputy manager told us that they only held a small amount of medicine that needed to be stored in a fridge. The top shelf of the kitchen fridge was only used for medication and daily temperatures were taken. These checks ensured that medication was stored at the correct temperature. Creams were stored in a separate cupboard and we saw that the pharmacy provided a body chart to advise staff where on the person's body the cream should be applied.

Medication was supplied in blister packs that recorded the person's name and the name of the tablet. The blister

Good

Is the service safe?

packs were colour coded to identify the times that the medication needed to be administered. The medication administration record (MAR) charts were also colour coded to coincide with the blister packs; this reduced the risk of errors occurring. We saw that the pharmacy supplied a separate blister pack for one person who regularly went to stay with relatives so that there was one blister pack to use at the home and another to be used when the person was living away from the home. Again, this reduced the risk of errors occurring.

All staff who administered medication at the home had undertaken appropriate training and one member of staff told us that they had been observed by the registered manager to assess their competency. We observed the administration of medication and saw that this was carried out safely; the deputy manager wore a tabard that recorded "Do Not Disturb" so that they could concentrate on administering medication. The MAR chart was not signed until people had been seen to take their medication. People were provided with a drink of water so that they could swallow their medication. Liquid medication was measured carefully and the medication trolley was locked when not in use. The pharmacy had supplied an information sheet for each medicine prescribed for people who lived at the home. This enabled staff to check the reason the medication was prescribed and any possible side effects. We saw that possible side effects of medication had also been recorded in the person's care plan.

The system in place to check that the medicines prescribed by the GP were the same as those supplied by the pharmacy was robust. This included medication being 'booked in' by two staff.

One person's medication was supplied by the pharmacy in a separate blister pack and was stored as a controlled drug (CD). We checked the storage arrangements for CD's and recording in the CD book and saw that this was accurate. Two staff had signed all entries in the CD book.

We checked medication administration record (MAR) charts and saw that each person had a sheet that included their photograph, details of possible side effects of the medication prescribed for that person and any allergies. There were no gaps in recording and two staff had signed hand written entries. In addition to this, there were protocols in place for the administration of 'as and when required' (PRN) medication. The deputy manager told us that care plans recorded each person's preferred way to take their medication and we saw this on the day of the inspection.

There was an effective stock control system in place and we saw the date was recorded on liquid medication to record the date it was opened and the date it expired to ensure the medication was not used for longer than stated on the packaging. The deputy manager told us that they did not need to record dates on inhalers and eye drops, as these were only used for one month and any remaining medicine was returned to the pharmacy. We recommended that a date also be recorded on boxed medication that was held for longer than a month. We checked the records for medicines returned to the pharmacy, including CD's, and saw that these were satisfactory.

We saw that a monthly medication audit was carried out; these recorded any identified concerns and how they had been rectified. There was also a procedure in place for dealing with any medication errors.

We observed that the premises were suitable for the needs of people who lived there. The home was well maintained; there were gas safety and electrical installation certificates in place and portable appliances, bath seats and hoists had been serviced. There was a fire risk assessment in place and the fire alarm system, fire extinguishers, emergency lighting and the nurse call system had been serviced. Staff recorded any repairs needed on the 'handyman's sheet' and the handyman signed when the repair had been carried out. The handyman was also 'on call' to deal with any emergencies. There was a maintenance programme in place and this included records of regular checks of bed rails and bumpers and in-house fire alarm checks. These checks ensured that the premises were maintained in a safe condition to protect the well-being and safety of people who lived and worked at the home.

There was an emergency plan in place that included details of all of the people who lived at the home, the names of their next of kin, staff telephone numbers, the contact details for health and social care professionals, a flood plan, a copy of each person's patient passport and a copy of each person's MAR chart. This meant that this information was readily available to staff in the event of an emergency.

Good

Is the service effective?

Our findings

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected.

Discussion with the deputy manager evidenced that there was a clear understanding of the principles of the MCA and DoLS. We saw one person's care plan recorded, "I am under constant supervision and it would not be safe if I were free to leave. A DoLS application is now in process with the local authority and I will be allocated an IMCA (Independent Mental Capacity Assessor)."

Care plans included a section called "Human rights." This recorded people's ability to make decisions and choices. One care plan we saw recorded, "I make choices every day – what I would like to eat and drink, where I would like to go, what time I get up and go to bed, who I spend the day with and where I would like to go. I would need a best interest meeting to make decisions." Another person's care plan recorded, "I know what my rights are and will openly tell carers, family and others my choices and decisions." On the day of the inspection we saw that people were encouraged to make decisions. Choices were explained to them clearly, including showing them pictures (and at mealtimes, the meals on offer). We heard staff telling one person that they had received some post, and asking if they would like help to open and read the content. This evidenced that staff consulted with people and did not make decisions on their behalf without consulting them first.

We saw that there was information displayed on the manager's office to inform staff about the importance of best interest meetings. We saw the record of one best interest meeting that had been attended by the person concerned and other relevant people. This was to make a decision about surgery and the decision was made that it was not in the person's best interests for the surgery to go ahead.

There was no overall training record for the full staff group but we checked the individual training records and identified that all staff had completed training on safeguarding adults from abuse and most staff (apart from four) had completed training on MCA / DoLS. The registered manager told us that all staff had completed training on moving and handling but three staff were due to have refresher training. We also saw that all staff had completed induction training and most staff had completed a National Vocational Qualification (NVQ) or equivalent at Level 2 or 3.

We checked the individual training records for two members of staff. These recorded that the mandatory training courses for staff were food hygiene, infection control, safeguarding adult's from abuse, fire safety, first aid, moving and handling, health and safety and medication. Non-mandatory courses were listed as leadership, dementia, autism, nutrition and diabetes, oral hygiene, epilepsy, challenging behaviour, MCA and DoLS, oral hygiene and managing complex needs. Both staff files that we checked included a training progress report that recorded a meeting between the registered manager and the member of staff to discuss training achievements and needs.

We saw the induction training records for a new member of staff. These showed that induction training took place over several days and had been overseen by the deputy manager. Topics covered included care planning, responsible risk taking, complaints, infection control, equality and diversity, safeguarding adults from abuse and moving and handling. The deputy manager told us that staff would not be involved in moving and handling tasks before they had completed appropriate training. Moving and handling training was provided by a training company used by the organisation. The new member of staff had supervision with the registered manager when they were new in post. Topics discussed included roles and expectations, care plans and the home's induction programme.

Staff told us that they received appropriate training to help them carry out their roles effectively. One staff member told us that they had refresher training on most topics every three years and that they had completed training on first aid, food hygiene, safeguarding adults from abuse and moving and handling. They said that they could ask for extra training if they felt they needed it. Another member of staff told us, "The stoma nurse recently came to show all staff how to manage this type of care" and that they could always request refresher training. They said that one member of staff had requested extra training on how to use the hoist and that was going to be arranged.

Good

Is the service effective?

We saw that the systems in place to ensure that staff were aware of people's up to date care needs were robust. One sheet was used to record each handover meeting and every person's name was printed on the sheet. It included details of any medication changes, appointments, the staff on duty, what time people went to bed and if they had a shower or bath. Both senior staff signed the handover sheet to record that they had passed over the keys to the home and medication storage cabinets to their colleague. At the end / beginning of each shift the senior care workers met to transfer information from one shift to the next. The senior care worker then met with the staff team for that shift to share the information with them. At this stage staff were allocated their tasks for the day that were in addition to supporting people who lived at the home. This ensured that all staff were clear about people's up to date needs and who would be doing what during the shift. Staff told us that they looked back over the handover sheets if they had been absent from work for any length of time.

There was a record of any contact people had with health care professionals, for example, GP's and district nurses. This included the date, the reason for the visit / contact and the outcome. We saw advice received from health care professionals had been incorporated into care plans. One person's care plan included a physiotherapy programme that had been produced by the Community Team for Learning Disability (CTLD) and it had been laminated and placed in the person's care plan. The care plan had been updated to record, "Physio. programme from CTLD to be followed three times a day." This care plan also included guidelines for the safe use of this person's walking frame that had been produced by CTLD. Details of hospital appointments and the outcome of tests / examinations were also retained with people's care records.

The health care professionals who we spoke with told us that staff asked for advice and made appropriate referrals to the team. One health care professional told us that staff ensured people at the home had an annual health check and that they were referred to appropriate health care professionals when needed. They said that staff kept records of any seizures people had and always had appropriate information prepared for reviews of the persons condition.

We asked people who lived at the home if the GP visited them when they were poorly and they said that they did. One relative told us that staff were very good at keeping in touch. They said, "If they ring a GP or if (my relative) is not well, they always let me know."

People had patient passports in place; these are documents that people can take to hospital appointments and admissions with them when they are unable to verbally communicate their needs to hospital staff. They include details of the person's physical and emotional health care needs. The registered manager told us that people also took a summary of their care plan to hospital appointments and admissions. This meant that hospital staff would have access to information about the person's individual needs.

We saw that care plans included a nutritional assessment and recorded the person's special dietary needs. The deputy manager told us that two people who lived at the home had been referred to a dietician. Neither had been prescribed food supplements. One person was described as "Very slight" and the dietician had advised that they should eat full fat foods. A third person had recently been discharged from hospital and staff had been advised that they needed to be on an enriched (full fat) diet. There was a food intake chart in place to monitor this person's food intake. When we discussed these people with staff it was clear that they were aware of their needs and we saw that people received the special diets they required.

There were risk assessments in place to record any difficulties with eating or drinking. This included the risks for people who had been diagnosed with diabetes, the risks associated with false teeth and the risk of choking. Some people had eating and drinking plans in place that had been produced by the Speech and Language Therapy service (SALT) and this included information to be followed on 'good' days and 'bad' days, and indicators for staff that might mean the person was having difficulty with eating and drinking.

People were weighed as part of nutritional screening. We saw that some people were weighed monthly and others were weighed weekly; the deputy manager told us that this would be when recommended by a dietician or when the person had a sudden change in weight.

People's specific dietary requirements and preferences were known to staff, including the cook. There was a list in

Good

Is the service effective?

the kitchen that recorded people's special dietary needs and their likes and dislikes. The cook spoke to people each day to describe the choices on the menu for the next day and there was a choice of meal at each mealtime. Care staff told us that, if people were not able to make a choice, the cook would speak to them about people's preferences so that a choice could be made in the person's best interests. The three people who we spoke with told us that meals at the home were good and that they could choose what they liked. We overheard one person who lived at the home talking to staff about how they enjoyed curry and usually had this on Thursday or Friday nights. Two people told us that their drinks of tea or coffee were sometimes not hot enough; we discussed this with the deputy manager and they assured us that this would be addressed.

We saw staff assisted people to eat their meals and noted that this was unhurried and carried out with a caring approach. We heard one person say that they did not want their cold drink and a hot drink was quickly made. At the end of the meal, people were asked if they preferred tea of coffee. We pointed out to the deputy manager that one person ate their meal very slowly and that it might be cold before they finished it. They acknowledged this and said they would ensure the meal was always warm enough for the person to enjoy.

The home had achieved a rating of 5 following a food hygiene inspection; this is the highest score available.

Good

Is the service caring?

Our findings

We asked the three people who we spoke with if they felt staff really cared about them and if staff were kind to them. They all said that the staff were kind and helpful and really cared about them. A health care professional told us, "Although the building is not purpose built, the staff are warm and caring and staff turnover is low." A relative who we spoke with told us, "The staff are 'spot on'. They are compassionate and look after the residents well. They have good rapport with people who live at the home." Another relative told us, "Staff seem the right kind of people to do the job – they really care."

We observed that people who lived at the home looked appropriately dressed in clothes that they had chosen to wear; their hair was tidy, men were clean shaven (if that is what they had chosen) and they looked cared for. People told us about the relationships they had with their family and friends and it was evident that staff helped people to maintain these relationships, including people spending time at the home of their relatives.

We observed that all staff engaged in positive relationships with people who lived at the home. It was clear from the conversations overheard that staff knew the people who lived at the home very well.

We saw that care plans included information about each person's specific support needs, and information about a person's life history and family relationships. This helped staff to understand the person and provide more individualised care. All care plans were reviewed and updated each month. In addition to this, more in-depth reviews of care plans were carried out annually, sometimes with involvement from Social Services. We saw that care plans recorded any changes to a person's care needs on separate sheets, but then this information was incorporated into care plans. This included information about changes to medication, referrals to health care professionals and contact made with people's relatives or care managers.

The deputy manager told us that they were in the process of introducing a new style of care plan that they thought would provide more effective records of the person's care needs and the actual care or support provided. We saw the new documentation and noted it included a document called, "About Me" that would record individualised information about the person's care and support needs.

We saw that people's privacy and dignity was maintained. People were asked discreetly about their needs for personal care and if they required pain relief medication. Care plans recorded how people should be involved in their care to promote their independence. One person's care plan recorded, "Encourage (name) to take an active part in their personal hygiene where possible. Pass (name) the flannel and ask them to wash their face and body. Even a bit is an achievement and this will boost (name's) self esteem."

The deputy manager told us that the home had previously used the services of an advocate who would assist people with decision making but they had retired. They acknowledged that they needed to locate alternative advocacy services so they could inform people about the support that was available. There was evidence that an Independent Mental Capacity Advocate (IMCA) had been requested for one person.

The registered manager told us in the Provider Information Return (PIR) that two people had a Do Not Attempt Resuscitation (DNAR) in place and the DNAR form we saw had been completed correctly. We noted that this was placed in the file amongst other documents and the deputy manager acknowledged that it would be more easily identified by staff if it were placed at the front of the care plan. We saw that there was information displayed in the manager's office to inform staff about the importance of DNAR forms.

Good

Is the service responsive?

Our findings

We were told that three people who lived at the home attended a local day centre. When they arrived back from the day centre they told us what they had been doing, that they had enjoyed their day and that they had friends at the day centre. People had a weekly activity programme in their care plan that included details of any regular days out and visits to the home of their relatives as well as activities they took part in at the home. We saw that there was a large board in the dining room that gave details of the weekly menu and the activities available each day; these were displayed in both words and pictures.

We saw a variety of activities taking place on the day of the inspection and that these were tailored to the person's individual interests and skills. We also saw that staff had time to sit and chat to people who did not want to take part in activities.

We saw in care plans that people's needs had been assessed when they were first admitted to the home, that care plans had been developed to record people's individual needs and that care plans were regularly reviewed and updated accordingly. We noted that care plans included information about a person's previous lifestyle, their hobbies and interests and people who were important to them. One person's care plan recorded, "I like boats and clocks and I collect these. I also like postcards and reading history books." We overheard conversations between people who lived at the home and staff and it was clear that staff knew people well, including their likes and dislikes and their individual preferences for care. A health care professional told us, "Staff are knowledgeable about the people who live at the home."

We saw that care plans included information about people's individual ways of communicating and how staff would be able to understand the person's needs when they were not able to verbalise these. One person's care plan recorded, "If my head is in my hands, I either want to be left alone or something is bothering me. If I am waving my hands, I am angry." There was also a description of specific words and phrases the person used and what they meant. On the day of the inspection we observed that staff were skilled in understanding people's individual needs, including their body language, their facial expressions and their gestures.

We checked the complaints log and saw that the most recent formal complaint had been received in March 2013. All of the people we spoke with told us that they felt able to tell staff if they had any problems or concerns and that staff would try to help them. One relative told us that they would not hesitate to raise concerns, and another said, "I would not have a problem with raising a concern. Staff will send me a letter or telephone me if there is anything remotely wrong. I have no complaints at all."

People who lived at the home told us that they had meetings. We saw the minutes of 'residents' meetings that had been held in September, October, November and December 2014. These evidenced that people had been asked about trips out and about menus / menu choices. People were asked if they had any complaints and at the meeting in September 2014 they were told that a satisfaction survey was due to be given to them. In October 2014 people were told about staff absences due to holidays or sickness so that they were aware of why some staff were not at work. We saw that the minutes of meetings were in both written and symbol format.

We looked at the surveys sent to people who lived at the home and saw that they included symbols to help people understand the questions. The responses had been analysed and the report stated, "Surveys showed that people have involvement in devising care plans and have their choices respected."

Outstanding ☆

Is the service well-led?

Our findings

We found the atmosphere at the home to be friendly and welcoming, and this was supported by the people who lived at the home, health and social care professionals and relatives who we spoke with. Everyone said the culture in the home was open, transparent and very friendly and staff told us that they cared about the people who lived at the home and created a family environment. A social care professional told us, "The registered manager and deputy manager are always friendly and helpful and have an excellent knowledge of residents needs. The home has improved greatly over the past few years and the residents I visit always appear happy and content."

The Willerfoss Homes Quality Assurance (QA) framework was displayed in the manager's office. We saw that there was a monthly checklist for QA audits and this recorded the audits to be carried out each month. An audit of infection control had been carried out in August 2014, a medication audit had been carried out in October 2014 and a kitchen audit had been carried out in October 2014. Audits planned for January 2015 were staff supervision and infection control. Audit forms recorded any actions that needed to be taken following the audit to improve the service that people received and the health, welfare and safety of people who used the service and staff. We asked the deputy manager how any issues identified during audits were shared with staff. She told us that issues would be recorded in the 'seniors book' and learning from incidents would be shared at staff meetings. She said that any issues identified were dealt with in an open and transparent way.

The registered manager and deputy manager told us that they had introduced a new care planning format as they had identified that improvements could be made to current care plans to ensure that information held about people was recorded in a way that staff would find more accessible. We did not identify any concerns with the current care plans but this showed that managers were continually striving to improve the service.

Any accidents or incidents had been recorded correctly and we noted that the accidents we saw recorded in care plans had been notified to the Care Quality Commission as required. The accident report form recorded the action that needed to be taken by staff, for example, was first aid required, were the emergency services required, was a falls assessment carried out and was a risk assessment required? There was also a section headed "Lessons Learned." We saw the accident and incident analysis that was carried out by the registered manager each month.

Staff described the registered manager as "A strong manager" and said that she listened and they felt any issues could be discussed with her. They said that the manager would keep information confidential when this was appropriate.

One health care professional told us, "I rate Cedarfoss highly. The crucial thing in my experience in residential homes is always the quality of the on-site leadership and I can only praise the manager. She asks for help appropriately and supports her staff well. She has facilitated my providing specific training to the whole staff group around the specific needs of a client. In that particular case I was very pleased with how staff attitudes changed and how the environment was modified to accommodate the lady's needs." This evidenced that the registered manager actively sought the advice of health care professionals to make improvements to the experiences of people who lived at the home.

The registered manager has recently introduced a "Reflective account diary" where they intended to record any learning from accidents, incidents, complaints / comments, safeguarding or whistle blowing. It was planned that this would be used to feed back information to staff, determine any needs for additional staff training and to highlight ways to improve the service. This showed that the manager understood reflective practice and how positive changes could be made to the service as a result of learning from incidents at the home.

We saw that a 'family' survey had been distributed during 2014 and that, although only a small number of responses had been received, these were analysed by the registered manager. The report recorded, "Positive responses – people feel the home communicates well with them." A survey was also distributed to health and social care professionals. There was only one response but this was very positive. The person recorded, "Lovely home."

Staff meetings were held; we saw the minutes of a senior staff meeting held in January 2015 and a notice that informed senior staff that they were expected to attend. The topics discussed included the new care plans, use of mobile telephones, safeguarding adults from abuse (all

Is the service well-led?

staff confirmed that they received training), the new staff supervision format and updated information about people who lived at the home. Staff were asked if they had any issues they wished to discuss.

A full staff meeting was held in October 2014. Topics included the new Care Bill, the key lines of enquiry (KLOEs) produced by the Care Quality Commission, privacy and dignity, keeping care plans up to date and DoLS applications. We noted that staff were asked for feedback on recent training they had attended. Staff were asked if they had any issues they would like to discuss.

Both members of staff who we spoke with confirmed that they attended staff meetings and these were a 'two way' process; information was shared with them but they got the opportunity to ask questions, raise concerns and make suggestions for improvement.

Senior staff confirmed that they had been given a section of the KLOE document to read and that they were going to discuss these at future senior meetings, and be questioned by the registered manager. This was to help them understand the standard they were expected to be working to and how the home would be measured in future inspections.

The deputy manager told us that staff had supervision meetings; these are meetings that take place between a member of staff and a more senior member of staff to give them the opportunity to talk about their training needs, any concerns they have about the people they are supporting and how they are carrying out their role. Staff who we spoke with confirmed that they attended supervision meetings and we saw the supervision plan for the year was on the office wall. Staff told us that they felt well supported and that the registered manager and deputy manager listened to their concerns. They said that the service "Always learned from their mistakes." Staff told us that they also had appraisals twice a year. One member of staff said, "We are always asked if we are happy in the job and we are asked if we would like more training."

We asked the registered manager if they had considered introducing 'champions' amongst the staff group for topics such as dementia and dignity and they said that this was planned for the near future. This would create a system within the home where one member of staff had responsibility for collating information about a specific topic and sharing good practice with their colleagues.

Whilst we were at the home we heard the deputy manager discussing the care of someone who was due to be transferred from hospital back to the home. There had been some difficulties arranging this due to the person's condition and access to their bedroom, but it was clear that staff had considered all aspects of this persons care and what would be in their best interests. There had been discussions with all health and social care professionals involved to ensure that this discharge could take place, and all of the equipment needed to ensure that the person received safe and appropriate care had been obtained.

When there had been a change in a person's care needs, we saw that the appropriate people had been informed. This included their family and friends, and any health or social care professionals involved in the person's care. This ensured that all of the relevant people were kept up to date about the person's general health and well-being.