Embrace (England) Limited

Cedar Court

Inspection report

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Date of inspection visit: 22 and 23 April 2015
Date of publication: 17/12/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 22 and 23 April 2015 and was unannounced. This meant the service did not know we would be arriving to carry out the inspection.

Cedar Court provides accommodation for 68 people and is located in Seaham, County Durham. The home is divided into four units. There are two units downstairs; Byron unit accommodates up to 12 people with dementia care needs and Dalton provides 22 residential care needs. Upstairs Tempest unit has accommodation for 12 people with nursing care needs, and Seaton unit can accommodate up to 22 people with nursing and dementia care needs. The Seaton unit number also included five beds used for intermediate care and treatment. This means people leaving hospital can have a further period of care before they return to their own homes or are assessed as needing further care provision.

We last carried out a full inspection of the service in June 2013 where we found the provider was not compliant with our regulations in relation to the administration of

Summary of findings

people's medicine. We undertook a follow up inspection in December 2013 and found the provider had made improvements and people were safely receiving their medicines.

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. We found the service had a registered manager in post.

During our inspection we found the registered manager had a refurbishment plan in place to improve people's environment.

We saw the provider had checks in place for gas and electric supplies to the home.

We found there were some hazards in the home where people were put at risk of trips and falls and risks associated with fire safety.

Staff told us they had received training in areas appropriate to their role. During our inspection staff were being trained in moving and handling in the building.

We found the service did not always meet people's nutrition and hydration needs.

People and their relatives told us they had mixed experiences of being involved in their care planning.

We saw people who needed glasses and hearing aids were not always supported by staff to wear them.

Relatives told us they were made to feel welcome when they came into the home.

We saw the registered manager had put in place monthly audits to monitor the quality of the service. We saw where they had found deficits actions were taken.

The registered manager had put in place staff meetings and staff supervision meetings to provide staff with support, guidance and direction.

We found people's records were not confidentially maintained.

We found a number of breaches of regulations. You can see what action we told the provider to take at the back of the full version of the report.

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?
The service was not always safe.

We looked at the safety of the premises and found the provider had carried out timely checks on gas and electrical supplies.

We found staffing levels to be unsafe on the Tempest Unit.

We found trip hazards both internally and externally.

Requires Improvement

Is the service effective?
The service was not always effective.

We found the provider was not meeting people's nutritional and hydration needs, and in particular on the Tempest Unit.

We saw the provider had in place a range of training courses to support staff and enabled them to meet people's needs.

The provider was using the Deprivation of Liberty Safeguards in the home and had applied to the appropriate authority to deprive people of their liberty.

Requires Improvement

Is the service caring?
The service was not always caring.

We observed incidences where staff did not effectively communicate with people and which left people in frustrated or excluded states.

People we spoke with said they were treated with respect and dignity and their privacy was respected.

People and their relatives told us they had mixed experiences of being involved in their care planning.

Requires Improvement

Is the service responsive?
The service was not always responsive.

The provider had in place a complaints policy. Relatives we spoke with had mixed views about how the policy was operated.

We found people who needed glasses and hearing aids were not always given to them by staff.

We saw the provider had in place an activities coordinator and activities were provided to people. However we found people on the upstairs units were provided with less stimulation.

Requires Improvement

Is the service well-led?
The service was not always well led.

Requires Improvement

Summary of findings

People told us they were made welcome in the home.

We found records were not securely stored to maintain confidentiality.

We saw the manager had put in place a number of audits to determine the quality of the service and had in place staff meetings and staff supervision meetings to support staff.

Cedar Court

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 22 and 23 April 2015 and was unannounced.

The inspection team consisted of two adult social care inspectors, a specialist advisor who had a background in nursing 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. The expert by experience on this inspection had a background in caring for older people.

Prior to the inspection we looked at notifications to the Care Quality Commission (CQC) made by the provider to notify us about events in the home. We checked with local commissioner and the Infection Prevention and Control Team to identify any concerns. No concerns were identified to us.

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.

During our inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also looked at nine people's care records and other records including four people's medicine records. We spoke with seven people who used the service, seven of their relatives and two professionals who were visiting the home at the time. We also spoke with the registered manager, the regional manager and other staff including nursing and care staff, administration and domestic staff.

Requires Improvement

Is the service safe?

Our findings

All the residents we spoke with said they felt safe in the home. One person said, "I feel very safe the staff are fantastic, I love it in here." Relatives we spoke with also told us they thought their family members were safe.

We looked at the safety of the premises and found there were appropriate and timely checks carried out. For example we found there had been recent checks on the gas and electrical supplies. We saw there was a system in place for staff to report maintenance requirements, these were recorded and addressed. However we found numbers had been taken off the bedroom doors for decorating which meant the personal evacuation plans available to emergency rescue services were of no use. We found in the upstairs staff room a white board which detailed who was in which room. Staff having their break told us the board was incorrect as people had moved rooms. This meant rescue services would not have the correct information available to them in an emergency. We saw an emergency evaluation slide was stored underneath a stairwell on the ground floor. We were not clear why this was not placed on the upper floors to help people evacuate quickly using the stairs. When we pointed this out to the registered manager and the regional manager they took it upstairs and put it in a more accessible place.

We saw one lounge had two call bells but neither were accessible to people. We found one call bell cord was tangled up in an electric cord and inaccessible on the floor. A second call bell cord was underneath someone's seat and could not be reached. In another lounge we found two call bells were installed but neither was accessible to people. One call bell did not have an extension cord attached to it, which meant that it could only be used if people were able to walk to it and press the button on the wall. A second call bell had an extension lead attached but this was behind a chair and not accessible. This meant it was not easy for people to get help quickly when they needed it. We made the manager aware of our findings who did not verbally respond.

We looked at doors with the sign 'Fire Door Keep Locked' and found we could open the fires doors and behind some doors were walk in cupboards. This meant people were not protected from risks associated with fire. We spoke to the registered manager who agreed to seek advice from the local fire prevention officer regarding these doors.

We looked at the cleanliness of the home. One person told us their room was cleaned every day and a relative told us, "The place is clean to a certain extent but they need more everyday cleaning and her bedding needs changing more often." We found one bedroom was malodorous. We checked the mattress which began to disintegrate when we unzipped the cover. The mattress cover was torn and the cover had brown stains on the inside. The registered manager was advised of our findings and agreed to replace the mattress.

We looked at the external patio area and found the paving stones had subsided which caused trip hazards. We also found bathrooms to be cluttered with wheelchairs and toilet frames. This meant people were also put at risk of trips and falls and were unable to use these safely.

We found a cleaning schedule folder for nightshift staff in the Tempest lounge. This had not been updated since 31 March 2015. Staff were not able to tell us whether cleaning had been recorded elsewhere or whether it meant that nightshift staff had not had time to clean.

During our inspection we heard a relative complain to the registered manager that their family member's bedroom had been left unlocked, despite a previous request that this be secured at all times following thefts from the room. The manager spoke to the person concerned and offered an explanation.

We found the provider had not protected people against the risk of the unsafe and unclean premises. This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked to see if people were given their medicines safely, one person said, "They bring my medication to me even if I am in the garden and stay while I take it." We randomly sampled people's medication administration records (MAR) and found these were up to date with no gaps. We reviewed the clinical rooms and found there were recorded checks in place for the room temperature and the drug fridge temperature.

We noted there was a PRN (as and when required) medication protocol sheet in place for those people who required it which explained the rationale for using such medicines. We also noted that PRN Lorazepam was being given to one resident as intended, on an infrequent basis, with no evidence of over use.

Requires Improvement

Is the service safe?

We observed moving and handling techniques used by staff and found people were safe and people were given clear explanations by staff. One relative told us there was always two staff to support their family member. During our inspection we noted a member of staff stated they had put a person to bed on the Tempest unit. There was no other member of staff available to support them at the time. We noted their care records stated they needed two staff to support them to move. We could not be assured the person had been transferred safely to their bed. We reported this to the registered manager who took immediate action.

Staff we spoke with demonstrated awareness of Safeguarding and Whistleblowing. They were able to articulate key issues to consider in relation to potential abuse by either staff or visitors to the home. They showed a clear understanding of how to report concerns and stated they would challenge any colleagues who may be abusing a person in their presence. We found staff had undertaken e-learning in the Safeguarding of Vulnerable Adults.

We saw the provider had risk enablement assessments in place. Each document said, 'Risk enablement takes into account each person's strengths and abilities, identifying the least restrictive option'. We saw the document balanced the benefits and risks to each person and listed actions to be taken to enable activity and minimise risks. This meant the provider had in place a system to inform staff of the risks to people and had detailed actions to mitigate those risks.

We found one member of staff on the Tempest Unit on their own with 12 people, some of whom required two people to care for them. They told us their colleague was on their break. We found there was insufficient staff to give people appropriate mealtime support in the Tempest unit as described in their care plans.

We observed one person with learning difficulties on the Tempest Unit shouting for help from their bedroom. A staff member went to see them and returned to the communal area to seek a colleague. We heard the person become increasingly distressed. Both staff left to support the person leaving no one to support the remaining people. We spoke with the registered manager and the regional manager about our concerns; they arranged for an additional member of staff to be on the Tempest unit for our second day of inspection and said they had put in place arrangements for this to continue.

We found the provider had not protected people against the risk of unsafe staffing levels. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found accidents and incidents were recorded and these were routinely monitored by the registered manager to identify trends.

We looked at the recruitment records for five members of staff and saw that appropriate checks had been undertaken before staff began working in the home. We saw prospective staff members were required to complete an application form detailing their education, training and past work experience. The provider also carried out Disclosure and Barring Service (DBS) checks and obtained two written references. This meant that the provider had a robust recruitment andselection procedure in place and carried out all relevant checks when they employed staff.

Requires Improvement

Is the service effective?

Our findings

People told us their needs were met and staff had the right skills to look after them. One relative said, "They seem to be alright, my mother is thriving and drinking better since she came in here, they monitor what she drinks. There is always juice on the lounge table if she needs it." A person who used the service said, "They would notice if I was unwell."

We looked at people's nutritional and hydration needs. One person told us, "They will always do something else if I don't like what is on offer." Another person told us, "I have gained weight since being in here" and "If I have a lie in they will bring my breakfast to me anytime." People told us they had plenty to eat and there was always second helpings if they wanted. We saw staff offering people second helpings on a lunchtime.

In one dining room we saw that there were enough staff to help people to enjoy their lunch safely. We observed staff were kind to people and encouraged a sociable atmosphere. Staff were also aware of the risks to people. For example, a care assistant said to a person, "Be careful, the bowl is really hot" and "Don't touch it yet."

We noted one person had lost a significant amount of weight loss. We were unable to establish from their care records what action had been taken since the weight loss began in the latter part of 2014. There was no up to date or specific care plan which clearly described the problem and actions to manage this weight loss. We noted a referral had recently been made to the Community Dietician. A visiting health professional provided us with an explanation of an underlying medical condition for which we found no care plan was in place for this same person. This meant the provider did not have in place up to date plans to support this person nutrition and hydration needs.

We looked at people's food and fluid balance sheets and found the cumulative fluid totals were not always recorded daily. We saw the mid-afternoon assessments of people's food and fluid intake were not carried out and no actions were put in place to address any concerns. This meant the food and fluid balance sheets were not being used to support people's needs.

We overheard a person who had not enjoyed their lunch ask for soup instead. They reminded a staff member in the afternoon when they were offered a hot drink. The member of staff said that they would find out where it was without apologising or offering the person any reassurance. The person's soup was finally delivered to them over two hours after they first asked for it. We found the service did not respond to this person's nutritional needs in a timely manner.

We found there were notable differences between the delivery of nutrition in the Tempest unit and the remainder of the home. We looked at people's records in the Tempest unit and found some people were at risk of losing weight or had lost weight. We observed staff were not supporting people to eat as recorded in their care plans. For example in one person's plan we saw they needed support to eat and observed they were woken up and their lunch was put in front of them but no support was given to them. We saw in another person's care plan they could eat independently but in another document about the same person it was recorded they needed support to eat. We observed the person was given no support to eat. This meant we could not be assured that people's nutritional needs were being met.

We found that 30 out of 76 staff listed had not completed training in nutrition.

We found the registered person had not protected people against the risk of inadequate nutrition. This was in breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. During our inspection the registered manager showed us a list of people for whom they had applied to the relevant authority to deprive people of their liberty. We saw people were going through local authority assessments and applications had been approved. The registered manager had notified the CQC of applications being approved. Staff told us they had received training in DoLS and were able to demonstrate an understanding of the requirements.

We checked to see if staff had received training appropriate to their role. Staff confirmed to us they had received training in First Aid, Dementia Awareness, Whistleblowing and Safe Handling. One staff member told us they had also done, "Other training on the computer." We looked at the

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Is the service effective?

provider's training records and found staff had undertaken e-learning in equality and diversity, dementia, moving and handling. During our inspection staff were undergoing moving and handling training in the building.

We looked at staff supervision records. A supervision meeting takes place between a staff member and their line manager to discuss their progress, their training needs and any concerns they may have. We found staff received regular supervision meetings in line with the provider's policy. We saw staff received an annual appraisal.

We found the registered manager had put in place staff meetings to offer support to staff and disseminate information. In the staff meetings we found staff had been told for example about keeping sluice rooms clear and how to communicate with each other.

Although we saw each person had documents in their care plans to indicate consent to care, these were not completed consistently. One person who had a capacity assessment to show that they were able to make their own decisions had not signed any consent forms for their care. In another care plan we found that a person's daughter had signed a form to consent to their photographs being taken but the person themselves had been assessed as having capacity. Some people had signed photograph consent forms but it was not specified what the photographs could be used for. This meant that it was not clear if people understood what they had given consent to or how staff understood what each person had consented to.

Requires Improvement

Is the service caring?

Our findings

One person said, “I am happy with my care, they are excellent, they do anything for you.” Another person commented to us about the kindness of staff in helping them celebrate their wedding anniversary.

People we spoke with said they were treated with respect and dignity and their privacy was respected; one person said "I can lock my door if I wish.” We observed staff knocked on the door before entering and closed doors on toilets and bathrooms when residents went in.

We observed the interactions between people living in the home and staff. We saw where direct care was given by the staff the interactions were appropriate and friendly. However there were lengthy periods of time when residents sat in the lounge with the television on, and nobody apparently watching it. In the minutes of a team meeting we found the registered manager had tried to encourage staff to provide additional interactions with people by suggesting they used activities. The manager had also told staff they should not be writing people’s notes together at the same time. However during our inspection we saw staff completing records in the lounge areas with minimal interaction with residents. We spoke to the manager about our findings who did not verbally respond.

We observed a staff member assist a person to their bedroom without speaking to them. When the person was comfortable in their bedroom they offered the staff member a chocolate, which the member of staff refused. The person demonstrated escalating frustration and anxiety at this, repeatedly asking the member of staff to take a chocolate. We saw that the member of staff showed very poor de-escalation skills and little recognition of how to be kind to the person in this circumstance. The member of staff left the person in a state of distress, talking anxiously to themselves. After walking away, we heard this member of staff complaining about being ‘forced’ to have a chocolate. We found this member of staff’s attitude to be inappropriate and not conducive to supporting people to be happy and content.

During the tea round we found staff to be polite and aware of people’s privacy, for example knocking before entering someone’s bedroom. However we observed the tea round was task-led and staff did not try to engage people in conversation. In most cases staff spoke to the person only to ask what they wanted to drink. People were not offered a snack and if they wanted to chat we noticed that the person had to start the conversation themselves.

We later saw another staff member enter a person’s bedroom during the tea round. Again we saw that staff did not exhibit appropriate social skills, kindness or patience. For example, the person tried to have a conversation with the member of staff about their husband and previous family life. The member of staff was detached and demonstrably uninterested. For instance, the person asked the member of staff in a friendly and conversational manner how old they were. The member of staff said, “Oh it doesn’t matter how old I am.” The person was left in silence because the member of staff did not have the skills to be able to support them conversationally.

We observed a member of staff feed a person. On completion of the meal, they said, “Well that’s that.” without any reference to the person about their meal. We found people’s care was delivered in a functional manner which did not engage people in a meaningful way. We fed back to the registered manager and the regional manager we found the care given to be functional. Neither manager responded verbally.

We spoke with one member of staff who described working on the Tempest unit; they said it was like, “Mental Torture here for a 12 hour shift” and told us staff rotated working on the unit. This meant staff focused on their working needs and did not demonstrate they valued or respected people in their care.

We observed one resident on the Tempest unit became extremely distressed and noisy during the late afternoon, and this was clearly having an effect on other residents. We saw the situation was dealt with calmly and appropriately by a care assistant, with no use of restraint. The resident was gently escorted to a less stimulating environment and allowed to calm down.

We saw that in most cases staff understood the needs of people. For instance, during a tea round a member of staff knew that a person needed thickener in their drink and prepared this appropriately. We observed a senior member of care staff stopped a colleague serving a person’s drink in a cup that they would not have been able to hold safely.

We talked to people about their advocacy needs. One person said "I speak up for myself, when I first came in I

Requires Improvement

Is the service caring?

could not do anything for myself. I have come on leaps and bounds I am independent." We saw family members acted as natural advocates for their relatives and spoke up for them when they needed to.

We spoke with people about their involvement in their care. One person said "I am involved with my Care Plan with my social worker." Another person said, "My partner and son take care of the Care Plan." A relative told us "We are involved with the Care Plan and the review, we go to the monthly residents meetings." Another relative said, "There are meetings my Dad goes to, I would like to go but I have never been asked." One relative we spoke with told us that they had not been involved in their family member's care plan and that they had not been offered the chance to see it, despite their relative having limited capacity. We found people had mixed experiences of being involved in the care of their relatives.

During our inspection we discussed end of life care with the manager. They told us there was no one receiving end of life care on the day of inspection. However we saw the provider had in place End of Life policies and found the majority of staff had undertaken end of life care training.

Requires Improvement

Is the service responsive?

Our findings

One person told us, "If I felt unwell I would press the buzzer and they would come straight away. We spoke with relatives visiting their family member, they said, "[Person] has only been here two weeks but I ring every morning and I get feedback. [Person] had a fall so the District nurse came in and the falls team." Another relative said, “I transferred [my relative] recently into this home. It’s like a five star hotel in comparison. There’s always plenty to do, lots of stimulation for them . There’s often trips out to the park in Chester-le-Street in fine weather and the food is amazing. I’m very happy with everything.”

We spoke with people about activities in the home. One person said, "I prefer to be in my room, I read and watch TV.” Another person said, "I go in the lounge, I knit, watch TV, sit and go to sleep that is all.” "Another person said, “I sometimes go in the garden, I am taken to church and sing. In August I will be going to the caravan with the staff." We spoke with the activities staff who were in the summer house where people were sitting and singing. They confirmed they take people on holiday.

We saw people on the upstairs units were sleeping for lengthy periods in armchairs, with no evidence of any planned activity or stimulation. One person said, "My partner or son take me for a walk, I go in the garden, I do painting by numbers, there is not much else I would like more to do, I would like to read a book but there are none. One relative told us, "More activities are needed." They felt their relative was under stimulated. We found that whilst some people were happy with the activities on offer not everyone was involved at some point.

One person told us, "We can get up and go to bed at any time.” A relative said to us "I rang about my mother but she'd had a bad night so they left her to sleep.” This meant the service was able to respond to support people’s sleeping preferences.

We found the provider had in place a complaints policy and saw people had made complaints. People were aware of the complaints policy and told us if they had a complaint they would go to the registered manager. One person said, "I have been to her a few times and she acted on it." During our inspection we heard a relative complain to the registered manager about issues which they said they had previously complained about and actions which had not been carried out. This meant people had mixed experiences of using the complaints process. We looked at the complaints file and found there were two complaints that had been logged, both of which had been investigated and resolved by the registered manager. This meant where people had made a formal complaint the registered manager had taken action.

One staff member said, “It is quite horrendous at times in here. Some people are in inappropriate parts of the building. We should be promoting peoples’ independence but this isn’t always the case because they are placed in the wrong part of the home.” We saw people had pre-admission assessments in place which varied in detail. For example we saw one pre-admission assessment where the home had not collected information on which they could base a decision about meeting a person’s needs. We saw documentation on people’s files from service commissioners which demonstrated people’s needs. We found further work was required to ensure people’s needs were assessed and they could be appropriately placed in the correct unit.

We looked at the care plans of four people who lived in the home. We saw that each person had a recent photo in their file, for which consent had sometimes been obtained. This meant that people were easily identifiable to staff. Each person also had sections titled, ‘This is me’ and ‘My Day’. These documents enabled staff to understand each person’s likes and dislikes as well as how they liked their daily routine to be. In some cases this information was very detailed and structured. For instance staff recorded one person’s particular religious observances. People were encouraged to express their personal preferences for all aspects of their personal care. We saw people had been asked about their favourite brand of shampoo, soap and deodorant to promote their own personal hygiene routine.

We found the provider had put in place a system to prevent a person being financially abused. We saw people had in place a financial support plan. This included evidence of the person’s capacity to understand their own finances as well as the names and signatures of everyone involved in the person’s financial affairs.

Staff had used a monthly Malnutrition Universal Screening Tool (MUST) to help monitor each person’s nutritional intake and reduce the risk of malnutrition. We saw that these were detailed and kept in the best interests of each person. For example, a person who had previously shown

Requires Improvement

Is the service responsive?

little appetite had been found to have painful gums. Staff had obtained medical advice and were able to give the person appropriate pain relief before a meal so that they could eat more comfortably. However we found whilst the provider used the screening tool the outcomes were not always followed in practice.

One relative told us following a meeting with hospital staff their family member moved onto the home. They told us they were disappointed that despite recommendations from the hospital the correct bed was not in place when they arrived and they had asked a staff member about this. We looked at care records which supported the relative's viewpoint and found the person had fallen out of bed during their first night in the home causing an injury. Bedrails had been put in place for the second night. We found the transition between services had not been well managed and had not protected the person from injury.

We saw in people's care plans they needed support with hearing aids and glasses. We observed in a person's care plan, 'Staff to support [person] by ensuring glasses are cleaned daily'. During our inspection we did not see this person wearing glasses. We spoke to another relative who told us their family member needed to wear hearing aids so they could join in and watch TV. We spoke with the person who could not hear what we were saying to them when we were standing close to them. We saw in their care plan they needed to wear their hearing aids so they could watch the TV. We saw in another person's care plan they needed to wear their glasses at all times to help them be orientated. We heard them calling out for one person and asked the member of staff who were they calling out for, and they did not know. We saw they were not wearing glasses and the member of staff on duty was unsure as to where they might be. We later spoke to their relative who told us they had found their glasses in a dirty condition down the side of the chair where they were sitting. This meant people's care needs had not been met.

We found the provider had not protected people against the risks associated with inappropriate care. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw people had a communication support plan, which was used to help staff communicate more effectively with people as individuals. For example, a person at risk of depression had a communication support plan in place that enabled staff to spend time with them on a one-to-one basis to reduce the risk of social isolation. We saw in another person's care plan staff had worked with a person to reduce their aggression. This person's communication plan included information to help staff keep the person safe as well as to reduce the risks associated with aggression. Although this information was detailed we saw that staff did not always follow this. For instance, the person's care plan stated that staff should always enter their bedroom in pairs. During our inspection we only saw staff enter the person's bedroom alone. This meant staff were not following a person's care plan to keep themselves and the person safe.

We found people in the home had received an annual review by a nurse or clinical lead. We saw that the reviews were detailed and had involved the person discussing their care needs with the member of staff. People had been given the chance to discuss their risk assessments and the level of care they received from staff. People had also been able to express their unmet needs, such as a person who felt that they were not given the opportunity to leave the home on trips often enough. This meant the provider had involved people in their care reviews.

Requires Improvement

Is the service well-led?

Our findings

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. Cedar Court had a registered manager in post.

People were complimentary about the service; one person said "Yes the manager listens to me." Visitors to the home told us they were made to feel welcome, one visitor said, "Yes of course we are, we are offered a cup of tea", another visitor said, "Yes we are made very welcome we can come anytime." A staff member spoke with us and told us they wished they could be more like the registered manager.

We looked at people's records and found they did not always provide a contemporaneous record, for example we found food and fluid sheets were not always completed. We saw that archived records had been stored in two cupboards, one on the ground floor and one on the first. Both cupboards were unlocked and the doors were open. Records were not stored securely and the personal information of people, such as Medication Administration Records (MARs), fluid balance charts and daily notes were discarded around the cupboards and not organised into secure files. This meant that the confidential records of people were not protected or stored appropriately.

We found staff had left records out on chairs or on top of an open filing cabinet after they had made entries. We found that a person's care file had been left between two seats in the Tempest lounge. We pointed this out to staff who had not noticed where the file was. These records contained a range of daily care records for example, personal hygiene and observations and were inappropriately stored in an open filing cabinet in lounges to which visitors and people had access.

We found the registered person had failed to securely maintain records. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the registered manager conducted a number of monthly audits to look at the quality of the service. These included for example, monthly mattress audits listing which mattresses were to be replaced and cleaning audits. We also saw the registered manager had in place a refurbishment plan. They showed us a timeline for the refurbishment to take place and orders they had placed for new furniture. This meant the registered manager was improving people's environments.

We read the minutes of the heads of department's meetings and staff behaviour had been discussed including where a supervisor felt staff did not respect them. We saw the registered manager had given advice to her staff and supported them.

The registered manager had in place resident and relative's meetings where the manager explained current developments in the home. We saw relatives raised issues about staffing levels and activities across all the units. The registered manager had responded to the relative's queries.

From our observations we found there was not a clear leadership structure in place on the upper floor, particularly in the Tempest unit. For example, a care assistant finished their shift and left without informing their colleagues. This meant that other staff were unsure as to how many people were on shift and had to call to another unit for extra staff to be provided.

We saw the registered manager had recently sent out questionnaires to relatives. Out of 57 sent out eight had been returned. Although the number of returned questionnaires was low we saw the responses were largely positive. This meant the manager had sought feedback on the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People who used the service were not protected from receiving inappropriate care.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **People who use services and others were not protected against the risks associated with unsafe premises.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **People were not protected against the risks associated with their records not being confidentially maintained.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **People were not protected against the risk associated with low staffing levels.**

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs People were not protected against the risk associated with inadequate hydration or nutrition.