Care Quality Commission

Cedarwood House Limited

Cedarwood House

Inspection report

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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

We inspected Cedarwood House on the 6 and 12 May 2015. Cedarwood House provides accommodation and care for up to 20 people. On the day of our inspection 17 older people were living at the home aged between 76 and 103. All people at Cedarwood House were living with varying degrees of dementia. People had various long term health care needs including diabetes and other conditions which impacted on mobility putting people at risk from falls. Cedarwood House was last inspected in December 2013 where they were judged compliant with the Regulations inspected.

An acting manager was in post however they were not the registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider. The previous registered manager had left their post in October 2014.

Throughout our inspection, people spoke positively about the home. Comments included, “Nice place to live”

Summary of findings

and, I'm happy with the home." However, we identified a number of areas that required improvement. Although audits had been completed these did not identify all areas that needed action.

People told us they felt safe living at Cedarwood House. However we found staffing levels at busy periods and night time were not sufficient to protect people's health, safety and welfare.

Although medicines were managed safely there was not clear guidance for staff and a blanket approach to the administration of covert medicines. We have made a recommendation.

People's dignity was not promoted at meal times. Meal times were not a positive experience for some people. However people were provided with a choice of healthy food and drink ensuring their nutritional needs were met.

Staff knew the individual personalities of people they supported. We saw staff were kind and compassionate however we also found examples where people's privacy, dignity and choice had not been promoted.

The lay out of the premises in certain areas impacted on people being able to move freely around the home independently.

The provider employed a part time activities co-ordinator at Cedarwood House; they were seen to interact with people positively however at the times when they were not working people's social needs were not consistently met.

Relatives and staff spoke positively regarding the acting manager however they were not registered with the CQC and we found they did not have complete over sight and control of all aspects of the home. Staff supervisions were not occurring as frequently as the previous registered manager had indicated.

Training schedules confirmed staff members had received training in safeguarding adults at risk. Staff knew how to identify if people were at risk of abuse or harm and knew what to do to ensure they were protected.

Robust recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work and staff received a range of training that enabled them to support people living at Cedarwood House.

People's health and wellbeing was closely monitored and staff regularly liaised with healthcare professionals for advice and guidance.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the acting manager understood when an application should be made and how to submit one.

Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure decisions were made in the person's best interests.

People's friends and family were made welcome and relatives spoke positively about the welcome they received. One told us, "I can pop in anytime and know I will be made welcome."

Assessments were undertaken prior to people moving into the home and care plans designed to assist staff in being responsive to people's needs.

A complaints procedure was in place and regular satisfaction surveys were undertaken with people, their relatives and staff.

Staff meetings were used as a forum to share key operational information about the running of the service and provide updates on individual people.

The provider had ensured there were systems in place to ensure rolling improvements to the service were routinely undertaken.

We found breaches in Regulations. You can see what action we told the provider to take at the back of the full version of this 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?

Requires Improvement

Some aspects of the service were not safe.

There were occasions where there were not sufficient numbers of staff deployed to ensure people's safety and welfare were protected.

Medicines were managed safely however there was not clear guidance for staff on the administration of covert medicines.

People who used the service and relatives told us they felt safe with the staff that supported them. Risk assessments were in place to ensure people were safe within their home and when they received care and support.

The provider had carried out checks on staff to ensure they were suitable and safe to work with people at risk.

Staff had a clear understanding of what to do if safeguarding concerns were identified.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not effectively supported and their dignity was not promoted at meal times.

The layout of building in some areas did not effectively meet people's needs to mobilise independently.

A suitable training programme for staff had been established and was being delivered.

All staff had a basic understanding of the Mental Capacity Act 2005 and consent issues. Senior staff knew what they were required to do if someone lacked the capacity to understand a decision that needed to be made about their life.

Staff understood people's health needs and responded when those needs changed.

Is the service caring?

Requires Improvement

The service was not always seen to be caring.

Although staff were kind and compassionate people's dignity, privacy and choice was not consistently promoted.

Care plans contained limited information on people's preferences or choices regarding their end of life decisions.

Confidential information was held securely and there were policies and procedures to protect people's confidentiality.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's social needs were not consistently met.

Personalised information regarding people's daily routines was available to assist staff in supporting people with their preferred choices.

A complaints policy was in place and was seen to respond effectively when relevant.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Effective management arrangements had not been established and a registered manager was not in post. No one person had oversight of all areas of the service.

Systems for quality review were in place however had not identified all areas requiring improvement.

Staff meetings were used as an opportunity to share and communicate key information on people and operational issues.

Cedarwood 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.

We inspected the service on the 6 and 12 May 2015. This was an unannounced inspection. The inspection team consisted of two inspectors.

We focused on speaking with people who lived in the home, speaking with staff and observing how people were cared for. We looked at care documentation and examined records which related to the running of the service. We looked at six care plans and three staff files, staff training records and quality assurance documentation to support our findings. We looked at records that related to how the home was managed. We also 'pathway tracked' people living at Cedarwood House. This is when we look at care documentation in depth and obtain views on how people found living there. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were unable to talk to us.

We looked at areas of the home including people's bedrooms, bathrooms, lounges and dining area. During our inspection we spoke with seven people who live at Cedarwood House, five visitors, five care staff, one activities co-coordinator, two domestic staff, the home's administrator and the acting manager. We also spoke with two visiting health professionals; these were a district nurse and a chiropodist.

Before our inspection we reviewed the information we held about the home, including the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We considered information which had been shared with us by the local authority and members of the public. We reviewed notifications of incidents and safeguarding documentation that the provider had sent us since our last inspection. A notification is information about important events which the provider is required to tell us about by law.

Requires Improvement

Is the service safe?

Our findings

People who were able to communicate with us said they felt safe living at the home. Visitors to the home told us they felt their relatives were safe. However we found there were times where the provider had not ensured people were safe.

During our inspection staffing levels matched what was planned on the staff rota. There were three care staff on duty between 8am and 8pm. The acting manager was unable to demonstrate the rationale as to how staffing levels were set and how people's fluctuating dependency needs were linked to setting staffing levels. We observed at certain times of the day people were left in lounges unattended for extended periods of time due to care staff undertaking other duties. For example when people were being given their medicines, whilst personal care was undertaken and at meal times. This meant there were times when there was an increased risk to people as there were reduced numbers of staff available to support people. Some people required two care staff to assist them to mobilise or support with personal care which would leave one member of care staff available to respond to the needs of other people in the home. On the first day of our inspection, whilst people were being given their medicines, a person identified to an Inspector that they had hurt their arm. They had sustained a skin abrasion to their forearm. This person had been identified as at risk of falls within their care documentation. They had been placed on 15 minute checks whilst in communal areas this related to concerns regarding behaviour that challenges due to physical aggression. Staff were unable to identify how this injury had been sustained.

We spoke to the acting manager regarding day time staffing levels; they advised they could work as an 'extra carer' at busy times. However due to ongoing recruitment they were working as care staff between 8am and 2pm on the first day of our inspection. The acting manager was contracted to work 18 hours a week on 'the floor' as a carer. They told us whilst additional care staff were being recruited they were working 25 hours a week as a carer. This meant that the opportunity for them to undertake management duties was reduced. During a busy period whilst the acting manager was working as a carer a person's relative wished to speak to them. The acting manager confirmed the relative had approached them in their capacity as manager. This meant that during this time there were two carers available to support people.

At night there were two care staff on duty who worked between 8pm to 8am. The acting manager felt more staff were required to ensure people's needs were effectively met at night. They told us they had raised this staffing level issue with the provider. We noted the acting manager was in the process of recruiting so there would be one additional member of staff working at night. This new staff member would work at busier periods and be a 'sleeper' at quieter times however be available 'on call' if required. However, at the time of our inspection the additional night time member of staff had not started. This meant that whilst one staff member was giving medicines to people there would be one member of staff available to respond to people. One night staff member told us, "It can be very busy at certain times." They added, the night shift, "Warrants another staff member." Additional duties night carers undertook included cleaning and laundry. They told us that when agency staff were required to work at nights it made shifts harder as they were required to guide them through the home's routines. They said, "As the permanent staff member you would do drugs round but they (the agency staff) do not know the home or residents."

We reviewed people's individual personal evacuation plans (PEEPS). These identified several people required two staff to assist them during an evacuation, this would mean during night time hours there would be no other staff available to remain with and support people who were evacuated. The majority of people at Cedarwood House were living with dementia in varying degrees. Leaving people without support could cause distress and create an elevated risk for accidents and incidents.

We found the provider had not safeguarded the health; safety and welfare of people living in the home by ensuring there were sufficient numbers of suitably qualified staff. This was in breach of the Health and Social Care Act 2008 Regulation 18 (Regulated Activities) Regulations 2014.

The home had appropriate arrangements in place for the safe receipt, storage and disposal of medicines. There were records of medicines received, disposed of, and administered. We looked at people's medicine records and found that the recording was accurate and clear. Any anomalies recorded were followed up by senior staff, such

Is the service safe?

as when staff signatures were missing. One person told us, "I get my pills that I am supposed to take on time." However, all care plans we looked at contained a template which was signed by people's GP. It included the following two statements. 'The resident lacks the mental capacity to understand the need for prescribed medication' and 'The resident can have their medication administered in a covert manner to ensure their best interests'. Covert means medicines could be hidden within people's food or drink. The template identified that if a statement was not relevant it could be deleted. No care plans looked at had either statement deleted. The acting manager told us two people had their medicines covertly administered. This meant that the service had adopted a blanket approach to the administration of medicines, rather than a person centred one, for people who potentially may refuse medicines. There was no clear rationale documented for individual people or other ways of administering medicines explored.

We recommend the provider reviews guidance from a relevant source on the covert administration of medicines.

Care plans showed each person had been assessed before they moved into the home and potential risks identified. People's care documentation contained assessments such as risk of falls, skin damage, nutrition and moving and handling. They provided specific guidance for staff on how to manage risks, for example what equipment would be required. These had been reviewed on a monthly basis. Staff told us they used people's risk assessments to better understand how to manage situations safely. People's care plans and 'day care summary' used information from people's risk assessments to identify the most appropriate way to support them. For example, how many staff were required when assisting people to mobilise.

Staff received training on safeguarding adults. Staff confirmed they knew who to contact if they needed to report abuse. They gave us examples of potentially abusive care and were able to talk about the steps they would take to respond to it. Staff were confident any abuse or poor care practice would be quickly spotted and addressed immediately by any of the staff team. Policies and procedures on safeguarding were available in the office for staff to refer to if they required.

We looked at staff recruitment files and found that there were robust recruitment processes. Files contained a completed application which included previous work history, qualifications and experience of the person applying for the job. There were two employment references and criminal record checks requested and received before the provider employed the person to work at the home. This ensured as far as possible that the people who lived at Cedarwood House were protected from possible harm from unsuitable people working in the home.

Requires Improvement

Is the service effective?

Our findings

People told us they generally liked the food at Cedarwood House, one person said, "The food is pretty good." We observed the lunch time meal service on both days of our inspection. People either ate in their rooms, the dining room or in one of the home's two lounges. The menu identified that there were two choices for the lunch time meal. People who ate in the dining room mainly ate independently. We saw that plate guards were used by some people to assist them to eat independently. One staff member said, "It is a busy time for us, residents can be quite spread out." On the first day of our inspection, eight people ate in the dining room; two in one of the lounges and seven ate in their rooms. Food was brought out from the kitchen at the same time for people who did not require assistance with eating. Due to their medical conditions several people required encouragement and prompting to eat however due to staff deployment people were not supported in a timely manner. We saw the activities co-ordinator assisting people to eat however the activities coordinator only worked part-time at Cedarwood House which meant they would not be available to undertake this routinely. A radio was on in the dining room however due to it having poor reception there was an intermittent signal, this created a distraction for one person as they attempted unsuccessfully to rectify the problem.

People's dignity was not promoted during the lunch service. On the second day of our inspection two people were falling asleep with their meal cooling in front of them in one of the lounges. One member of staff was observed assisting a person to eat; they were kneeling by their side which meant it was more difficult for the staff member to pick up non-verbal cues from the person. This is not best practice. One person was positioned too far away from their table to comfortably reach their plate. People were not effectively supported and their dignity was not promoted during the lunch service.

The issues related to food and people's experience of meal times were a breach in Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, people were provided with enough to eat and drink. People were offered breakfast, lunch, afternoon tea and a light supper. People were regularly offered drinks, fruit and snacks throughout the day. People who were on a pureed diet had their food presented in an appealing way; foods had been separated so as to retain flavours. People were able to have their breakfast when they chose and we saw one staff member using visual flash cards to assist with prompting a person with choosing their breakfast. The home's cook was very familiar with people's dietary requirements, likes and dislikes. They were seen to accommodate people's preferences in a professional and caring manner. Where people changed their mind regarding their choice of meal this was accommodated.

The layout of building in some areas did not effectively meet people's needs. We observed people who used walking frames experienced difficulty manoeuvring around one corner within a main corridor. This corridor linked the main house to people's rooms. One of the toilets was small, a staff member said, "It can be tricky assisting some (people) in and out of there." Eight people used commodes in their rooms however there was no sluice facility within the home. We did not see this impacting on cleanliness however the acting manager told us, "It is not the most efficient way to clean commodes." We discussed these issues with the acting manager who identified the provider had submitted plans to expand the home however these remained at the planning application stage.

During the inspection we heard staff ask people for their consent and agreement to care. For example we heard the staff say, "Here are your tablets, are you ready to take them?" and "Can I help you to the bathroom." Staff had knowledge of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 sets out how to support people who do not have capacity to make a specific decision. Policies and procedures were available to staff on the MCA and DoLS. These provided staff with guidance regarding their roles and responsibilities under the legislation. Staff understood the principles of the MCA and respected people's rights, where they had capacity, to make 'unwise' decisions (decision that may place them at risk). One staff member told us, "I try my best to help people make their own decisions." On the day of our inspection, one person was subject to a DoLS. The acting manager was clear on how to process an application and told us there were other applications pending with the managing authority.

Staff undertook a range of training which was appropriate to enable them to care for people living at Cedarwood House. Mandatory training included areas such as, First Aid,

Requires Improvement

Is the service effective?

infection control and challenging behaviour. The acting manager had engaged support from a Local Authority team who were providing specialist training and advice to support staff for people living with dementia. For example, care staff had completed training in 'meaningful activities' and 'the use of anti-psychotic medicine'. One staff member told us, "I have found the recent dementia training really interesting, I feel more confident in supporting our residents." We spoke with the Local Authority who confirmed the acting manager had been receptive to the support. They said, "The staff have engaged very well with the support and taken up lots of ideas we have provided."

Staff demonstrated they had knowledge and understanding of how to support people to maintain good health. People had been referred to a range of health care professionals, these included dieticians, District Nurses and Speech and Language Therapists (SALT). The acting manager informed us, "Our residents are registered with the same GP practice and they respond when needed." People had access to routine appointments with chiropodists and opticians. We spoke with two visiting health professionals during the Inspection. They both visited the home regularly and were positive about the home and the staffs' responsiveness. One said, "I am in and out regularly, I am happy with the communication. Staff are welcoming and receptive to feedback."

We observed the staff handover between shifts. Staff were provided with a clear overview of how people had spent their time, their mood and any specific health concerns. For example identifying a new small skin pressure damage area on one person.

Requires Improvement

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. People and their relatives stated they were satisfied with the care and support they received. One person said, “Nice staff here.” Despite positive comments we found examples where the service was not consistently caring.

We observed one person was using a commode however their door had been left open. This did not protect their dignity or privacy. Another person was seen to be wearing trousers that were too loose, this resulted in them having to hold their trousers up to prevent them falling down. We identified this to a member of staff who discreetly offered to assist them in private.

Cedarwood House had no dedicated space within communal areas for people to meet with family or visiting professionals. The options available for people’s visiting relatives were to sit in communal lounges, the dining room or people’s room. One relative said, “It would be nice to have another option to sit somewhere.” We saw that one person went back to their room for privacy when they had a meeting with their social worker. Staff took chairs from the dining room up to accommodate the visit. The visiting hairdresser was seen cutting people’s hair in a communal lounge. Although we did not see this cause any anxiety to people who were having their hair cut it was not clear if this was their choice and if alternatives had been offered. This is an area that requires improvement.

Care plans contained limited information on people’s preferences or choices regarding their end of life decisions. Some care plans identified comments related to preferences regarding burial or cremation and who to contact however there was no evidence people or their families had been involved in gathering views and choices. We spoke with the acting manager regarding this issue. They told us although this was a sensitive area to discuss with people more work was required to capture people’s wishes. The issues identified related to respecting people’s privacy and dignity require improvement.

However, staff were knowledgeable about individual personalities of people they cared for and supported. Staff shared people’s personalities with us during the inspection and they talked of people with respect and affection. One care staff member said, “The residents are what it’s all about, they come first.” Although it was busy there was a calm atmosphere in the home. Staff were unable to spend as much time as they wished with people. However, when they were attending people they worked at the person’s own pace and did not rush them. We observed a member of staff attending to one person; they took their time and were patient. They did not leave the person until they were sure their needs had been met. Staff chatted with people whilst providing support.

Care plans demonstrated that people had been asked about gender preferences of care staff supporting them. People’s rooms had been personalised with items and furniture. One person said, “I love my photos around me.”

Care records were stored securely in the office area. Confidential information was kept secure and there were policies and procedures to protect people’s confidentiality.

Visitors were welcomed throughout our visit. Relatives told us they could visit at any time and were always made to feel welcome. A visitor said, “I visit regularly and stay as long as I want, I am made welcome and always offered a drink.”

Requires Improvement

Is the service responsive?

Our findings

The home employed an activities coordinator. Their time was split between Cedarwood House and another of the provider's services. Their working pattern alternated as such they were at the home for either two or three days a week. They were clear on the function and remit of their role. They told us that for people living with dementia group activities were not the most effective way of engaging people. They said, "Residents enjoy time on a one to one basis." People enjoyed the time the activities co-ordinator spent with them, for those who were unable to communicate verbally demonstrated via body language and expressions they were content. We asked the acting manager who led activities on days when the activity co-ordinator was not at Cedarwood House. They told us a volunteer visits on one of the week days, at other times carers led activities. Three staff told us that they felt when the activities co-ordinator was not at the home people were not as actively engaged. One said, "At weekends and busy times we do not have as much time, it's better for residents when the activities co-ordinator is here." People's social needs were not consistently being met. This is an area that requires improvement.

The PIR identified that 'life books' were completed for all people on admission to the home by people and their families. We found this was not happening. Life books provided staff with background information about peoples past and experiences and what they liked to do. We found two people's care plans where this information had not been collated. This meant that staff did not have information available to inform them of people's preferences regarding what they like to do. One person who had not had their life book completed had a family member visiting on the day of our inspection. Staff did not approach the family member to request them to complete this documentation. This is an area that requires improvement.

There was a timetable available that identified other activities took place such as visits from therapy dogs, music for health and a singer. One person told us they enjoyed the singing. One of the lounges doubled up as an activity area. Music was heard playing, there were books, magazines and photos available and people's art work displayed. There was a calendar and weather chart which helped to orientate people to the date, weather and seasons. The patio doors were open on the second day of our inspection and people were enjoying the grounds and sitting in the sunshine. One person said, "It's lovely seeing all the different birds." In the afternoon people were listening to music in the large lounge and care staff were seen dancing with people. There was a relaxed and friendly atmosphere. A relative told us, "It's really nice to see people joining in and seeming happy."

Prior to a person moving into the home a senior staff member undertook an assessment to make sure the staff could provide them with the care and treatment they required. Assessments and care plans were completed with the person, and where appropriate, their representative, and included information about their likes, dislikes and choices as well as their needs and these were reviewed monthly. Within people's room there were personalised 'thought clouds' on walls that identified people's likes, dislikes and preferred topics of conversation that would engage them. For example, details about their family and their favourite foods. One person's identified they like it when people sat and chatted with them about the village where they used to live. Staff told us these served as an effective way to make quick connections with people. Personalised information about individual daily routines was recorded for example what time people liked to get up and what equipment would be required for mobility. Staff told us this information was useful and helped them to support people effectively.

A complaint policy and procedure was available. The complaints log showed there had been no recent complaints. When previous complaints had been raised we saw information about what actions had been taken to address and resolve them. There was a comments book available at reception for visiting relatives. One relative told us, "I have seen the book but I would chat directly to the manager if I had concerns."

Regular satisfaction surveys were undertaken with residents, people's family and staff. The most recent family survey had been undertaken in January 2015 and 16 out of 21 forms had been returned at the time of our inspection. The feedback was seen to be positive and there were no suggestions identified for the home as to how or where they could improve.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was not in post at the time of this inspection. A registered manager is a person who has registered with the CQC to manage the service. There were arrangements in place for the day to day management of the home. The provider had informed the CQC in the absence of a registered manager the management of the home would be overseen by themselves and the area manager. The provider had visited the service on a fortnightly basis but the area manager had not visited Cedarwood House since 23 April 2015. The acting manager told us they had had discussions with the provider regarding registering with the CQC however the acting manager stated they would want additional training before they did this. They told us they had been, "promised further management training." The acting manager had therefore not applied to be registered with the CQC.

The provider is required to ensure the registered location has a registered manager in accordance with their condition of registration. Not to have a registered manager is a breach of a condition imposed upon the provider's registration contrary to Section 33 of the Health and Social Care Act.

The management arrangements had not ensured effective management of the home. The acting manager told us they did not feel they had complete oversight of all aspects of the home. For example they said, "There are parts of the home's computer system that I do not have access to and would require training on." The provider was in regularly telephone contact however did not have oversight of people's day to day care needs. The home's administrator was responsible for functions including fire checks, contracts, staff files and overseeing the servicing of equipment. They told us since the previous registered manager had left they had taken on additional responsibility however they were still required to liaise with the provider regarding operational issues. They said, "When we require agency staff we clear it with the provider over the phone, this can sometimes slow things down."

Recent staff meeting minutes referred to an accident that had not been managed effectively. A person had an accident, and night staff had provided a verbal handover to day staff concerning the incident however no staff member had completed an accident form or handed this information over to a senior member of staff. This omission had been investigated by the Local Authority as a result of anonymous information of concern they had received. We discussed this incident with the acting manager who told us that they had only recently begun to have oversight of all accidents and incidents. Staff told us the acting manager had implemented a new procedure for reporting accidents and incidents. A senior member of staff was now responsible for reviewing and signing off all accident forms. The acting manager said, "This will ensure I am aware of every accident that happens within the home."

The PIR stated that staff supervisions were scheduled to be completed on a three monthly basis. We looked at recent supervision records; they identified areas for staff development had been discussed. Staff said they were useful to be able discuss any issues. However the home's administrator and acting manager confirmed supervisions were running behind. Records showed that five members of staff were overdue in having supervisions. One was due in February, two in March and two in April 2015. The acting manager told us they had fallen behind due to ongoing issues with staff recruitment and the additional hours they had been required to work as a carer. However staff identified that they felt supported by the acting manager.

The acting manager told us they felt they did not have control over specific staffing issues that impacted on the smooth operational running of the home. Cedarwood House shared a maintenance person, activities co-ordinator and administrator with another of the provider's services. They said, "This can mean on some days it feels we do not run as efficiently." We identified that on days when the administrator was not at the service the acting manager and care staff were responsible for answering the home's phone.

The issues identified relating to the management at Cedarwood House requires improvement.

However people's relatives, staff and visiting health professionals spoke very positively of the acting manager. Staff told us that they had noticed significant improvements, since the acting manager had been in post, in the level of care people received and felt more supported. One told us, "I can't speak highly enough of them; they are always supportive and listen." Another said, "The standard of care has really improved a lot in a short period of time."

Requires Improvement

Is the service well-led?

A quality assurance audit was undertaken by the providers area manager or a registered manager from one of the providers other services. These were undertaken on a three monthly basis. The audit covered areas such as care plan reviews, staff files and standards of cleaning. This information was supported by staff interviews, observations and reviewing of documentation. A report of findings was produced for the acting manager and areas that required attention were discussed. We saw that improvements in cleaning had been identified as an area of improvement and an action plan implemented. The acting manager undertook monthly audits in areas such as medicines, environmental health and safety and housekeeping. However the acting manager had only recently begun to use information from accidents and incidents to identify trends and form part of the quality assurance process. The provider's quality assurance process had not identified the issues we found with staffing levels and meal times.

Staff meetings were held for all staff on a regular basis. Staff told us that these were helpful and provided an opportunity to discuss various issues ranging from the running of the home and individual people. One staff member said, "We recently talked about the correct way to store pressure mats."

Staff knew about whistleblowing and said they would have no hesitation in reporting any concerns they had. They said the acting manager would support them to do this in line with the home's policy.

The provider had a philosophy statement for Cedarwood House. It was displayed at the reception and explained that the service strove to provide people with 'Optimum state of health' and 'Individual uniqueness." Staff we spoke to did not use these terms when describing the service instead referred to the 'homely feel' of Cedarwood House. This was supported by the PIR that referred to the service as having a 'homely environment'. One staff member said, "I used to have a relative that lived here and when I visited it always had a nice homely feel to it, it still feels like that even though I work here now."

The provider had an annual facilities budget allocated for Cedarwood House. This was planned and prioritised by the providers head office facilities manager. The acting manager told us that they had input to areas they would like improved. On the second day of our inspection improvements were being undertaken on corridor flooring in line with the providers plan.

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 18 HSCA (RA) Regulations 2014 Staffing **There was not sufficient numbers of staff deployed in order to ensure people's safety and welfare.** Regulation 18(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **People were not adequately supported at meal times.** Regulation 14(4)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Section 33 HSCA Failure to comply with a condition **The Registered Provider must ensure that the regulated activity personal care is managed by an individual who is registered as a manager in respect of that activity at or from all locations.** Section 33 (b)