Cornwall Care Limited

Cedar Grange

Inspection report

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Ratings

Is the service safe?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 6 May 2015. After that inspection we received concerns in relation to how people's behavioural needs were being managed by staff, the recording of these incidents and whether this information was being passed to the local authority safeguarding team to investigate; people not being supported at appropriate times because call bells were not in reach and there were insufficient staffing levels; and the cleanliness of the environment. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Cedar Grange on our website at www.cqc.org.uk.

Cedar Grange is a nursing home providing care and accommodation for up to 60 older people, some of whom are living with dementia and may have mental health needs. On the day of the inspection there were 60 people living at the home. Cedar Grange is part of Cornwall Care Limited.

The service has four separate units to cater for people's needs. The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 visited in the evening between the hours of 6pm and 10.30pm and observed people having supper and looking happy and relaxed with the staff. People and relatives were happy with the care staff provided. One person said; "No grumbles."

People's care records held information about how people wished to be supported. Records were regularly updated to reflect people's behavioural needs. However we found details of an incident that should have been passed to Cornwall safeguarding team. The information

Summary of findings

documented was found to have inconsistencies in the dates, times and details, and there had been no investigation by the registered manager to help ensure people remained safe.

People were observed to have call bells within reach and staff were observed attending to people when assistance was required. The senior nurse and staff on duty confirmed staffing levels were below normal during our visit. However neither felt this had an impact on the care provided.

People were in a service that was clean and well maintained.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) 2014. 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?

The service was not always safe.

People were not always protected from the risk of harm as the service had not always acted appropriately to ensure people were safe. However, staff had a good understanding of how to recognise and report any signs of abuse.

People's needs were met by sufficient numbers of skilled and experienced staff.

The home was clean and hygienic.

Requires improvement

Cedar Grange

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 was 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 undertook a focused inspection of Cedar Grange on 1September 2015 between 6pm and 10.30pm. This inspection was carried out after concerns were raised. We inspected the service against one of the five questions we ask about services: is the service safe?

The inspection was undertaken by one inspector and was unannounced.

Before our inspection we reviewed the information we received held about the service, including notifications received and concerns raised.

We spoke with three people who lived there, two visitors, two senior staff and 11 care staff. We looked at four people's care records, staffing rotas, risk policies and incident reports.

Requires improvement

Is the service safe?

Our findings

Following the comprehensive inspection on 6 May 2015 we received information of concern in relation to people's behavioural needs being managed by the staff, the recording of these incidents and if this information was passed to the appropriate agencies, for example Cornwall's safeguarding team, to investigate. We also received concerns about people not being supported or assisted in an appropriate time because call bells were not in reach and there were insufficient staffing levels. Concerns were also raised about the cleanliness of the environment.

At this inspection we found one person's care plan held details about their behaviour that could be challenging with a documented incident not following the service's own safeguarding protocol. The information was inconsistent with dates and times recorded conflicting with each other. A significant event form could not be located to check further details. A staff member completed an overview of significant events and this incident had not been recorded on this form. The registered manager stated an incident form had been completed. We asked for a copy to be sent to us but this has not been received. An action plan recorded "no concerns" when the form highlighted this person had received injuries and the organisation's protocol stated any issues of concern should be passed to the local authority safeguarding team for them to investigate. The person's GP had visited them prior to this incident and was aware of previous bruising that had occurred because of an accident and that further bruising may continue to develop. However staff did not know if new bruising was caused by this accident or the incident that had occurred more recently.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had risk assessments in place and these risk assessments highlighted areas of risk. For example, if people were at risk of falling and how staff could support people when needed. People, who could be perceived as being challenging to others, had individual risk assessments in place. For example, where people may place themselves and others at risk due to living with dementia or mental health needs. There were clear protocols in place for managing these risks.

People and staff said there were normally enough staff on duty. However on the day we visited we were informed the service was two staff down on normal numbers. However senior nurse felt this did not impact on the care provided. Staff agreed that this was unusual and "generally staff levels are OK." However some staff raised concerns about the staffing levels at night time. They went onto say this was generally due to the pressure of work on the senior care staff carrying out medicine rounds and leaving fewer care staff to complete personal care tasks for people.

During a tour of the premises we saw people had access to call bells. We observed and people confirmed they did not normally wait for staff assistance.

People were kept safe by a tidy environment. All areas we visited were clean and hygienic. Domestic staff were responsible for the cleaning and there were daily checklists for night staff to complete. Protective clothing such as gloves were readily available throughout the home to reduce the risk of cross infection. Staff understood the importance of following infection control procedures. Some staff raised concerns about the current number of domestic staff employed. However, the nurse in charge explained this was only a temporary issue due to staff absences.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 (1) (2) (3)** **People who used the service were not protected due to unsafe systems and processes in place to investigate any allegation or evidence of abuse.**