Community Integrated Care

Cedar 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**

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Cedar House is a respite care home providing personal care to six people at the time of the inspection. The service can support up to seven people.

People's experience of using this service and what we found

Right Support:
The service did not support people to have the maximum possible choice, control and independence. Staff did not support people in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Staffing levels led to staff focusing on completing tasks and failing to promote people's strengths. There was a lack of meaningful activities to support people's interests. Restrictions placed upon people were not monitored so it was not possible to review and plan care to reduce restrictions.

The environment was not safe, well-furnished or well-maintained so did not always meet people's needs. Care plans did not support people's ability to be involved in planning their own care. Medicines were not managed safely. Staff supported people to play an active role in maintaining their own health and wellbeing.

Right Care:
Staff understood how to protect people from poor care and abuse. However, the care provided at times placed people at risk of harm. Staff had training on how to recognise and report abuse and they knew how to apply it to protect people. There were not enough staff to meet people's needs and staff were task focused. People's care plans had not recently been reviewed with them or their relatives and were not in an accessible format.

Right Culture:
Staff turnover was high, so people did not receive personalised care from a staff group who knew them well. Agency staff did not know people or their needs well. Staff did not fully reflect best practice in the way they cared for people and did not always follow the registered manager's instructions to keep the service safe.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 24 August 2020 and this is the first inspection.

The last rating for the service under the previous provider was Good, published on 7 March 2020.

Why we inspected
The inspection was prompted in part due to concerns received about the overall quality of the care provided. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to the safety of the care provided, the numbers of staff available to support people, not ensuring people's rights to make decisions and to keep them in the building were managed in line with legal requirements and the overall monitoring of the home at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Requires Improvement

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement

Cedar House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The team consisted of two inspectors

Service and service type
Cedar House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Cedar House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 5 relatives about their experience of the care provided. We spoke with 5 members of staff including the area manager, registered manager, senior care worker and 2 care workers.

We reviewed a range of records. This included 3 people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Staff had failed to manage the safety of the living environment and equipment. For example, the laundry door had been propped open giving people access to laundry and cleaning detergents they may not realise were a risk to them. A hosepipe had been left outside unravelled and was a risk to people with poor mobility. The outside paths had not been swept and contained debris such as splinters of wood. We saw one person walking outside with no footwear and so was at risk of having an injury.
- People were not always kept safe from avoidable harm. This was because staff did not always know their needs as there was an increased reliance on agency staff. A relative told us how they had found a door wedged open at one stage and this worried them as their loved one, who was unable to keep themselves safe outside of the home, may leave.
- Another relative told us how their family member liked to press buttons and had pressed a door release button and left the home unsupervised in the middle of the night. Staff had only realised they had left when they saw them outside the home on the CCTV.

Using medicines safely

- Staff had not ensured they followed the systems and processes to, administer, record and store medicines safely. We found that some people had prescribed creams unsecured in their bedrooms. There were no risk assessments in place to show this was safe and there were no measures in place to prevent people accessing the creams.
- Some medicines had specific storage requirements, but this was not available in the home in line with legal requirements. In addition, the record keeping for these medicines was also not in line with best practice.
- Some people were having their medicines administered to them in their food. Advice had not been sought from a pharmacist to check this was safe and to ensure it did not impact on the efficacy of the medicine.
- There had been some issues of people not having enough medicine when they arrived for their stay. People brought their medicines with them from home. The registered manager had put a system in place to ensure all medicine was checked before people left the home, so that issues were identified early. However, staff repeatedly failed to follow the new system increasing the risk of medicines incidents for people.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection.

Staffing and recruitment

● Staffing levels were not based upon people's individual needs unless the person had specifically commissioned hours. The provider told us staffing levels were set at two in the contract with the local authority. This meant at times there were not enough staff to ensure people received the care they needed. For example, one relative raised concerns about one to one support staff not being in place consistently. They explained how this had left their loved one at risk when left alone in the bathroom. Another relative told us, "There has been one or two instances when staff have taken their eyes off [Name]. For example, [Name] tried to go on the trampoline in their wheelchair."

● Care staff were responsible for the housekeeping tasks in the home. For example, the cooking, cleaning and laundry. This meant at times they needed to focus on completing housekeeping tasks rather than supporting people. During inspection we observed that a relative had to assist staff with a household task as staff were not deployed effectively.

There were not enough skilled staff to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider followed safe recruitment processes to ensure staff were safe to work at the home. This included DBS checks. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● Visiting was supported in line with government guidelines.

Learning lessons when things go wrong

● People received safe care because staff learned from safety alerts and incidents.

● The service managed incidents affecting people's safety well. Staff recognised incidents and reported them appropriately and managers investigated incidents and shared lessons learned. For example, after a person left the home unsupervised they were moved to a different room away from the exit they had used.

Systems and processes to safeguard people from the risk of abuse

● Staff had received training on how to recognise and report abuse. They told us they were confident to raise concerns both within the home and with external agencies. However, concerns were not always raised. For example, the local safeguarding authority and CQC had not been told of the incident when the person left the home unsupervised.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider had not ensured that people's rights were protected. They had not applied for DoLS applications when people were unable to make the decision to stay at the home. After the inspection the provider told us they were working with the local authority to rectify this issue.

Systems had not been established to ensure any deprivation of liberty was lawful. This placed people at having their rights violated. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where people were unable to consent to restrictions there was no best interest decision recorded to show this was the least restrictive option to keep people safe. Restrictions of people's freedom were documented in their care plan. However, there was no ongoing monitoring of how often restrictions were used and no review of the care plan following use of restrictions.
● For example, one person had protective equipment which restricted their arm movement to stop them hurting themselves. Staff told us they would use these when the person was hurting themselves. However, there was no record of when these were used or why they had been needed.
● Where restrictions were in place there was no mental capacity assessment to see if people were able to

agree to them. For example, there was no assessment in place to show people understood they were taking their medicine when it was administered covertly hidden in their food.

Systems had not been established to ensure consent or best interest decisions were in place. This posed a risk people's rights may not be upheld. This was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We raised this with the registered manager who confirmed there were no mental capacity assessments in place, and they acknowledged it was an area they needed to work on.

Staff support: induction, training, skills and experience
● Staff did not always have training in key areas. Some relatives raised concerns that staff needed more training in how to support people who are autistic or have a learning disability. The registered manager told us the provider had reviewed the training and identified this gap in the training provided. They were launching a new capability standard for staff and it included further training in supporting people safely and with dignity. The training matrix showed that staff had completed 82% of the training required.
● Staff new to the provider received an induction, this included two weeks shadowing an experienced member of staff. Existing staff had ongoing training to ensure their skills remained up to date. Systems were in place to remind staff when their training was due to be renewed and completion rates were monitored.
● The induction process for agency staff did not always ensure they knew how to take into account people's individual needs, wishes and goals. For example, we saw one agency staff was given a very quick verbal briefing before supporting a person on a one to one basis.
● Staff were also supported with regular supervisions. This ensured staff had the space and time to discuss any concerns with the registered manager and allow them to identify career progression pathways.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Relatives felt that the support when people were unwell did not always support the respite process. One person told us, "When people fall ill the first contact is parents. I feel at times this impacts on parent's ability to do things during respite, as you need to stay available to fetch the person if needed."
● Care plans contained some information on people's health where the information might be needed to support them during their stay at the home. For example, there was good information on action to take if a person had a seizure. However, there was no information on what action to take should a person become ill while at the home.

Adapting service, design, decoration to meet people's needs
● The environment was not homely or stimulating and was in need of maintenance.
● Drain covers were missing from some showers. Furniture was old and some parts were missing, for example, we saw a chest of drawers had a drawer front missing.
● The outside environment was also in need of some attention. The fence, near the gate, was in poor repair and increased the risk of people leaving the service when they were unable to keep themselves safe. There was an old shed with no windows which needed to be refurbished. The outside environment was not a welcoming place to spend time in. For example, flower containers were falling apart, the trampoline was covered with leaves and twigs, and staff smoked on the back patio and disposed of their cigarette ends in an old tin.
● We raised our concerns about the environment with the registered manager. They explained they had also identified the same level of concern around the environment and advised that the provider had plans in place to update the environment.

Supporting people to eat and drink enough to maintain a balanced diet

● People received support to eat and drink enough to maintain a balanced diet. People could have a drink or snack at any time. Mealtimes were flexible to meet people's needs and to avoid them rushing meals.

● People with complex needs received support to eat and drink in a way that met their personal preferences as far as possible. Food and drink needs were identified in people's care plans and relatives told us staff provided the support needed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Staff completed a comprehensive assessment of each person's physical and mental health either on admission or soon after.

● People had care and support plans that were personalised and reflected their needs and included physical and mental health needs.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Relatives told us that the constant changes of staff and the use of agency staff impacted on the continuity of care and communication in the home. They told us their family members could become very frustrated when new or agency staff did not understand their needs. One relative told us of an incident where agency staff had not read the care plan and had not provided enough supervision when the person went to the shops. This meant the person had been able to purchase foods which did not support their health and well-being.
- We saw staff who worked at the home knew people and their needs well and interacted with them. However, agency staff did not have the same level of interaction with people. For example, one agency staff providing one to one support for a person sat inside watching them while the person sat outside. While this ensured the person's safety was monitored, it was not person-centred care.
- Relatives told us they did not always recognise the staff they were leaving their loved one with. One relative said, "It would be nice if they had some identification on."
- People commented on how the provider had been supportive in a family crisis. One relative told us how they had been supported at short notice following a bereavement, they expressed how grateful they had been for this support.

Supporting people to express their views and be involved in making decisions about their care

- People did not always have a say in making decisions about their care. The home was contracted to provide emergency care to people. Relatives told us how their care could be cancelled if a person needed the service in an emergency. One relative told us this had a major impact on their loved one and they would become very distressed. They said that the respite service needed to be consistent and steadfast as they used it to support their family life.

Respecting and promoting people's privacy, dignity and independence

- Relatives told us staff were not always respectful of people's belongings. One relative told us, "The biggest issue is they comes home in someone else's T-shirts." Other relatives also complained about laundry going missing. Following the inspection, the provider contacted us to say they had changed the policy for laundry to reduce the risk of it being misplaced.
- Staff did not always promote people's independence. For example, one person's television was set up on a table at the end of their bed but on a low table so they would be unable to watch it in bed. There was no room in front of the bed for person to sit to watch the television. This meant the television in their bedroom was unusable and they would need to go into the communal area to watch anything.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans reflected people's care needs but information on decision making processes were lacking. Plans were not presented in a format which would be accessible to people and encourage people to participate in planning their own care.
- Relatives told us they had seen people's care plans when they first started to use the service, but they had not seen them recently and were unsure if they still met people's needs.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- There was no information in people's care plans about how they preferred to receive information and how it could be made more accessible for them.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Activities were not always provided to support people's needs. For example, two people, who were at the home when we visited, had care plans which noted that they liked to go on the trampoline. However, the trampoline was dirty and full of leaves and sticks. No effort was made to clear it. We saw one person spend most of their day in the entrance area with little support from staff to engage in any activities.
- The registered manager told us their staffing levels made it difficult to support people to access the local town and its amenities. They said this was only possible when they did not have many people in the home. One relative told us they would like their family member to go to the town, but this did not happen.

The care was not person centred to people's individual needs. It was not planned collaboratively and people were not supported to understand their choices. . This placed people at risk of receiving poor quality care. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- The service treated all concerns and complaints seriously, investigated them and learned lessons from the

results, sharing the learning with the whole team and the wider service.

● Relatives were happy to raise concerns and were confident issues would be resolved. One relative told us, "I would talk to senior support staff, say what the issue is and can it be sorted. It always has been." However, relatives were not always clear on who to raise concerns with. We raised this with the registered manager who told us they would work to ensure all relatives knew who they were.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The governance processes in the home had failed to identify the concerns we found. There were audits in place, but they had failed to fully identify the concerns or to drive improvements.
- Action had not been taken to monitor areas identified for improvement such as the external environment as referenced in safe. There had been a failure to identify and address issues related to the safe management of medicines and care plans, People's rights had not been respected under the Mental Capacity Act (2005).
- The provider had failed to seek and act on feedback from relatives in a timely fashion. The provider had been registered to provide care at the service since August 2020. They had not gathered feedback from relatives until August 2022. This meant they had missed an opportunity to gather information on how the service could be improved.
- Where concerns had been identified the action taken was not sufficient to improve the safety of the home. Areas of the building which should have been kept secure to keep people safe from harm were unsecure. This was a known issue which had already been raised with staff. However, this action had not been effective and risks to people's health and safety remained.
- Relatives also told us there had been a lot of staff changes and this had impacted on the care provided. One relative said, "They keep changing staff, there is no leadership and a lack of communication." This impacted on their confidence when leaving loved ones at the home. Staff also raised concerns about the service and how they struggled to meet people's needs. Being short staffed meant at times senior care workers were needed to support people and so paperwork and management tasks were left. The provider told us staffing levels were outside of their control. There had recently been a change in registered manager and relatives were not always clear on who the manager of the home was. This meant they lacked clarity on who to raise concerns and issues with.
- The provider's vision and values were not implemented in practice. The staff team struggled to apply the provider's vision and values and meet people's needs with a reduced staff team and increased use of agency staff.

Systems established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service had not been effective. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had the skills, knowledge and experience to perform their role and a clear understanding of people's needs/ oversight of the services they managed. The registered manager had identified the concerns we raised during the inspection. They had already put plans in place to improve the environment. They were responsive to all the areas of concerns identified.

The provider responded immediately during and after the inspection to tell us how they would improve the care provided.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support, and providing truthful information and a written apology. There had been no incidents which met the legal requirements of the duty of candour. The registered manager was aware of actions they needed to take should an incident required them to.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider had started to implement systems to obtain feedback from people and those important to them. Relatives told us they had been surveyed for their thoughts on the care provided. This was a work in progress at the time of our inspection.

Continuous learning and improving care; Working in partnership with others

● Following the inspection, the provider contacted us to discuss the concerns we had identified. The provider had a clear vision for the direction of the service which demonstrated ambition and a desire for people to achieve the best outcomes possible.

● The provider was working with the local authority to improve the standard of care they provided.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 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 Care hand not been reviewed with people on a regular basis and was not presented in a format they could understand. Activities provided did not reflect people's care plans.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Decisions were made without mental capacity assessments of best interest decisions being recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not safely managed. Medicines were not safely managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There were no DoLS in place when people were unable to give consent to stay at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care	governance Systems to assess and monitor the quality of care provided had not been effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always enough staff to meet people's needs in a person centred way.