Care Quality Commission

Cedar House Company Limited

Cedar House

Inspection report

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Ratings

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

Overall summary

This inspection took place on 12 November 2015 and was unannounced. At our last inspection on 17 September 2014 the service was meeting all the standards we looked at.

Cedar House is a care home for older adults. The maximum number of people they can accommodate is 16. On the day of the inspection there were 14 people residing at the home.

A new provider had recently taken over the running of this service and prior to this, there had not been a registered manager in post for several months.

There was a newly registered manager in post. 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.

Staff training had been inconsistent and not all staff had undertaken the refresher training they needed in order to keep up to date with current best practice.

Summary of findings

People told us they felt safe and had no concerns about how they were being cared for at the home. They told us that the staff were kind and respectful and they were satisfied with the numbers of staff on duty so they did not have to wait too long for assistance.

The registered manager and staff at the home had identified and highlighted potential risks to people's safety and had thought about and recorded how these risks could be reduced.

We saw that risk assessments, audits and checks regarding the safety and security of the premises were taking place on a regular basis and were being reviewed and updated where necessary.

Staff understood the principles of the Mental Capacity Act 2005 (MCA) and told us they would presume a person could make their own decisions about their care and treatment in the first instance. Staff told us it was not right to make choices for people when they could make choices for themselves.

People had good access to healthcare professionals such as doctors, dentists, chiropodists and opticians and any changes to people's needs were responded to appropriately and quickly.

People told us staff listened to them and respected their choices and decisions.

People told us they were happy to raise any concerns they had with the staff and management of the home.

People told us they enjoyed the food and staff knew about any special diets people required either as a result of a clinical need or a cultural preference.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People told us they felt safe at the home and safe with the staff who supported them.

Risks to people's safety and been discussed with them where possible and action had been taken to minimise any identified risks.

There were systems in place to ensure medicines were handled and stored securely and administered to people safely and appropriately.

Is the service effective?

Requires improvement

The service was not always effective. People were positive about the staff however not all staff had the knowledge and skills necessary to support people effectively.

Staff understood the principles of the MCA and told us they would always presume a person could make their own decisions about their care and treatment.

People enjoyed the food and staff knew about any special diets people required either as a result of a clinical need or a personal preference.

People had good access to healthcare professionals such as doctors, dentists, chiropodists and opticians.

Is the service caring?

Good

The service was caring. We observed staff treating people with respect and as individuals with different needs. Staff understood that people's diversity was important and something that needed to be upheld and valued.

Staff demonstrated a good understanding of people's likes, dislikes and cultural needs and preferences.

Staff maintained and respected people's privacy including keeping people's personal information secure as well as ensuring people's personal space was respected.

Is the service responsive?

Good

The service was responsive. People's decisions and choices about their care were recorded, respected and acted on. The registered manager and staff responded to any changes in people's care needs.

People told us they were happy to raise any concerns they had with the staff and management of the home.

Care plans included an up to date and detailed account of all aspects of people's care needs, including personal and medical history, likes and dislikes, recent care and treatment and the involvement of family members.

Summary of findings

Is the service well-led?

Good

The service was well-led. People and their relatives confirmed that they were asked about the quality of the service and felt the registered manager took their views into account in order to improve.

The service had a number of quality monitoring systems including surveys for people using the service, their relatives and other stakeholders.

Staff were positive about the management and told us they appreciated the clear guidance and support they received.

Cedar 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 checked 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 undertook this unannounced inspection of Cedar House on 12 November 2015. This inspection was carried out by two inspectors 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.

Before the inspection, we asked the provider to complete 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. We reviewed the completed PIR and previous inspection reports before the inspection. We also reviewed other information we held about the service, which included notifications of significant events made to the Care Quality Commission since our last inspection.

We spoke with nine people currently residing at the home and three relatives. We spoke with six staff, a visiting social care professional and the new management of the home including the registered manager.

We observed interactions between staff and people using the service as we wanted to see if the way that staff communicated and supported people had a positive effect on their well-being.

We looked at six people's care plans and other documents relating to people's care including risk assessments and medicines records. We looked at other records held at the home including six staff files, health and safety documents and meeting minutes.

Good

Is the service safe?

Our findings

People told us they felt safe and that they had no concerns about how they were being cared for at the home. One person commented, "It's a lovely place. People are nice." Another person told us, "We're all very well looked after."

We observed staff interacting with people in a kind and friendly way. Staff could explain how they would recognise potential abuse and were aware that they could report any concerns to outside organisations such as the police, the Care Quality Commission or the local authority. They said they would not only look out for physical signs of injury but also for any possible changes in the person's behaviour that might indicate they were distressed or unhappy.

Some newly recruited staff, who had just attended safeguarding training, were not always confident in describing the different types of abuse that people could face in a residential care setting. We discussed this with the registered manager who told us he would ensure that staff were supported after any training to make sure they were competent and had fully understood the training they had undertaken.

Assessments were undertaken with people to identify any risks and records we saw provided clear information and guidance for staff to keep people safe. There were risk assessments specific to individual's needs such as falls, capacity, mobility and eating and drinking. Assessments were regularly reviewed and updated to ensure they were current. However, we saw that the risk assessments for one person had not been completed in full. The person at times demonstrated challenging behaviour, and we did not see a risk assessment listing possible de-escalation techniques to manage their behaviour that may challenge the service in order to keep people and staff safe. We discussed this with the registered manager who told us he would ensure an appropriate risk assessment was completed as soon as possible.

People with a risk of falling were monitored and this was recorded on a "falls recording form", which listed the date of any fall and incident along with action to minimise the risk of re-occurrence such as placing bed sensors or carrying out hourly checks in people's room. There was a "fall support plan" for people with a risk of falling, which included monitoring people when they were mobile and placing their Zimmer frame close to them. We saw staff being attentive to people when they were mobilising around the home and making sure they had their walking frame with them.

Care plans had been updated where changes in a person's care needs and subsequent risks had been identified. Staff gave us some examples of the risks people faced which matched the risks identified in their care plans.

We saw that risk assessments, audits and checks regarding the safety and security of the premises were taking place on a regular basis and were being reviewed and updated where necessary. This included the fire risk assessment for the home. The registered manager had made plans for foreseeable emergencies including fire evacuation plans for each person.

Recruitment files contained the necessary documentation including references, proof of identity, criminal record checks and information about the experience and skills of the individual. The registered manager made sure that no staff were offered a post without first providing the required information to protect people from unsuitable staff being employed at the home. Staff confirmed they had not been allowed to start working at the home until these checks had been completed.

People using the service and staff told us they had no concerns about staffing levels at the home. One person told us, "Yes there's plenty of staff." The staff rota showed that there were always at least three care staff and usually four on duty during the day. There were two "waking" staff on duty throughout the night. The registered manager told us that staffing levels were adjusted to meet the dependency needs of people and extra staff were deployed if people needed more support. The help and support people needed to keep safe had been recorded in their care plan and this level of help and support was being regularly reviewed.

Staff told us that they were busy but not rushed and they had enough time to meet the needs of the people they supported. On the day of the inspection there were 14 people residing at the home and four care staff supporting them. We saw that staff had time to be with people, sit with them occasionally and support them safely.

People told us they were satisfied with the way that medicines were managed and that they received their

Good

Is the service safe?

medicines on time. A relative told us, “They bring it in and she takes it. I think they wait until she’s taken it.” One person confirmed that their medicine was given on time and that pain relief was “here when you need it”.

All medicines in use were kept locked in the medicine trolley, which was safely stored when not in use. We saw satisfactory and accurate records in relation to the management of medicines at the home with one exception. Medicines received from the pharmacy into the home were not being recorded individually. This meant that it was difficult to audit the amount of medicine at the home at any one time.

The registered manager told us that, from now on, each type of medicine coming into the home would be separately recorded. Despite this we saw that the management and administration of medicines was being audited regularly and action taken when issues had been identified. For example, we saw that a staff member had been reminded of the safe management of medicines procedure when a recording error had been picked up. People’s medicines were reviewed on a regular basis by their GP and by appropriate healthcare professionals.

Requires improvement

Is the service effective?

Our findings

The registered manager had carried out an audit of staff files and told us that some documentation in relation to staff supervisions, appraisals and training had not been found. Some staff confirmed that their supervisions, appraisals and training had not been taking place on a regular basis. As a result the registered manager had completed a training audit for all staff and had highlighted the training all staff required to meet this standard. We saw that training had been organised and the provider told us that a training organisation was coming to the home shortly to organise National Vocational Qualification training for all care staff.

Staff had attended some recent training including safeguarding people. However, we found that some staff had not fully integrated this training in to their working practices. The provider told us that this would be discussed in staff meetings as well as in one to one supervisions and that competency assessments would take place after staff had attended training.

Staff had met individually with the regional manager in order to discuss the expectations of the new provider and to bring up any concerns or uncertainty they may have had about the changes. We saw that one to one supervisions had been booked for all staff. The registered manager had started the new induction process called, the care certificate, with all new staff at the home.

Staff said the registered manager was open and approachable and they felt able to be open with him. Staff also told us they would always talk to the registered manager when they needed to and that they would not wait until their supervision.

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 Act 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff understood the principles of the MCA 2005 and told us they would always presume a person could make their own decisions about their care and treatment. They told us that if the person could not make certain decisions then they would have to think about what was in that person's "best interests" which would involve looking at the person's past history, asking people close to the person as well as other professionals. Staff told us it was not right to make choices for people when they could make choices for themselves.

We observed staff asking people for permission before carrying out any required tasks for them. We noted staff waited for the person's consent before they went ahead. People told us that the staff did not do anything they did not want them to do.

The registered manager had a good understanding of the policy and procedure in relation to Deprivation of Liberty Safeguards (DoLS). We saw that a number of people had a DoLS in place and that this was being reviewed. The registered manager acknowledged that more people at the home should be subject to this safeguard and that he would be shortly referring those people concerned to the relevant authority.

People told us they liked the food provided at the home. People's comments about the food included, "It's quite good," "I like the food," "I get enough to drink" and "That's one of the good things we like."

People confirmed that choices of menu were available to everyone and the menu was discussed with them. One person did not want either of the meals on offer for lunch, so was offered a sandwich instead. People were offered drinks, biscuits and fruit in the afternoon. One person told us they were offered cakes and biscuits in the morning and that people, "can get tea anytime".

The cook had been employed at the home for some time and knew what people liked to eat, which was detailed in

Requires improvement

Is the service effective?

their care plan and they were aware of any special diets people needed. Most people were of British origin so most meals were traditional. However the cook made sure that other people were given culturally appropriate meals where they had requested this.

People weight was monitored regularly and there were nutritional assessments in place listing people's food preferences and dietary plan such as cutting food into small portions.

We saw records that showed a person losing weight had been referred to a dietician; the record showed the dietician outlined no further support was needed as the person was at a suitable weight after the referral. There was an eating and drinking plan in order to support this person to eat regularly such as encouraging eating healthy food and eating meals regularly. We saw evidence that a food intake chart was in place that recorded and monitored what people ate during meal times where this was required.

People's records contained information from health professionals on how to support them safely, such as advice from speech and language therapists regarding healthy eating and advice on potential swallowing problems. Each person's personal records contained documentation of health appointments, letters from specialists and records of visits.

We saw that assistance from medical professionals was sought quickly when people's needs changed. People confirmed they had good access to health and social care professionals. Relatives told us they were satisfied with the way the registered manager and staff dealt with people's access to healthcare and social care professionals such as the GP, opticians, chiropodists and community nurses.

Good

Is the service caring?

Our findings

People told us they liked the staff and they were treated with dignity and respect. One person told us, “My daughter fetched me here and she’s more than happy.” A relative commented, “What I’ve seen, they’re doing the best for [my relative].”

We observed kind and friendly interactions between staff and people throughout the day and saw that these interactions had a positive effect on people’s well-being. We saw that people were very relaxed with staff and it was clear that positive and supportive relationships had developed between everyone at the home.

We saw that a few people had commented and had input in their care plans. One person told us that they had been asked about their likes and dislikes. However, people we spoke with said they always had a say in how their care was delivered and that staff respected their decisions.

The registered manager told us that, in future people would be included in any review of their care and that one-to-one key worker sessions would be undertaken to facilitate this. There was a section entitled “Who am I” for each person providing information on people's background and life history, hobbies and friends and family network.

We saw that all staff members, including domestic and maintenance staff were supportive of people and had a positive relationship with them. For example a domestic worker had noticed that one person had become distressed and they gently calmed and reassured her.

We saw that staff had discussed people’s cultural and spiritual needs with them and recorded their wishes and preferences in their care plans. For example, how and where people wanted to follow their chosen faiths.

People told us that staff respected their privacy and staff gave us examples of how they maintained and respected people’s privacy. These examples included keeping people’s personal information secure as well as ensuring people’s personal space was respected. One person told us, “They always knock on the door before they come in.”

Good

Is the service responsive?

Our findings

People told us that staff knew them well and responded to their changing needs and preferences. One person told us, "Yes I get what I need."

We saw that the registered manager and staff responded appropriately to people's changing needs. For example, we saw that, where someone's general health had deteriorated over time, their increased care needs had been regularly updated in their care plan. Staff told us that the registered manager kept them updated about any changes in needs of the people using the service. Staff had a good understanding of the current needs and preferences of people at the home. We saw that where people had become unwell, the staff had ensured that the GP had been called out to see them.

We looked at six people's care plans. These plans covered all aspects of the person's personal, social and health care needs and reflected the care given.

A variety of activities were offered to people throughout the day. In the morning the activity coordinator led group singing and then provided jigsaws for people to complete. In the afternoon the activity coordinator played card games with individuals. Magazines and papers were provided which staff shared and discussed with people. The activity coordinator also supported one person who was feeling a bit down by going for a walk with them. The activities coordinator told us that she had started to record what activities people took part in each day and how this impacted on their well-being.

We also saw that people chatted with each other and staff. People told us they liked to sit and chat with each other and did not raise any concerns about how they kept occupied and engaged throughout the day.

People and their relatives told us they had no complaints about the service but felt able to talk to staff or the management if they did. One person told us, "I don't put up with it."

Staff told us that people were encouraged to raise any concerns with the registered manager and at meetings. We saw, from minutes of meetings with people using the service, staff and the registered manager, that everyone was reminded how they could make a complaint. A relative also showed us a newly developed service user guide which included clear details about how to complain

We saw, from the complaint record, that there had been one recent complaint about missing laundry. The registered manager had responded appropriately to this complaint and had apologised and reimbursed the relative for the missing clothes.

Prior to this inspection the Care Quality Commission received anonymous concerns about the service in relation to staff not being allowed to talk with people, the home being cold, people not being allowed to stay in their rooms and that staff were not allowed to turn on lights within the home.

Throughout the inspection the home was very warm except a few times when the kitchen door was open and a draft came through the lounge. We saw that staff spent time with people and everyone was moving freely around the home and coming and going to their rooms. When we asked if people could go to their room when they wanted, one person said, "If I wanted to, I could."

We asked the provider about the issue of turning lights off both in the day and at night which would clearly be unsafe for people going to the bathroom or toilet. The provider told us that this was a misunderstanding and that they had discussed with staff and people using the service the possibility of using sensor lights in the corridors so that the light would always go on when someone left their room to use the bathroom.

Good

Is the service well-led?

Our findings

Although the new provider and registered manager had only been at the home for about a month, most people were aware who he was. One person told us, “The manager’s quite good.” We saw that he interacted positively with both staff and people using the service.

People and their relatives we spoke with confirmed that they had received an introductory letter about the new provider taking over and that they had been asked to share their views, potential concerns and any suggestions for improvement. A relative showed us a “service user guide” which provided information about the new provider including its visions and values.

Because the new provider had only recently taken over the running of the service, quality monitoring systems had yet to be fully implemented. However we saw that these had been planned for the coming year. This included quality surveys, coffee mornings for relatives, meetings with people using the service and monthly visits by the service manager. There had been one meeting so far with people using the service. The minutes of this meeting had recorded that the management was, “open to discussion and suggestions”.

There were some mixed views from staff about the new provider taking over the service. Some staff told us they were anxious about what effect this would have on them. However other staff we spoke with said they were very happy and that this new provider had brought order and structure back to the home after a period of instability. One staff member we spoke with told us, “I think they are very good. Communication is very good and things are improving here.”

The provider was aware of the concerns from some staff and had arranged a number of staff meetings and individual one-to-one sessions in order that staff could raise any potential concerns and to try and reassure staff.

Relatives also said that the new provider had improved the running of the home within a short space of time. Relatives told us the home had been newly decorated and looked much better.

We saw that there were newly implemented systems to audit health and safety within the home which included environmental risk assessments including fire, gas and electrical checks, fire procedures and safe working practices. All these systems were checked and audited each month during visits by the service manager.

We checked the records of accidents at the home. Prior to the new provider taking over, the number of falls recorded had been high. The provider told us that they were in the process of carrying out a falls analysis to see if any patterns could be detected that would help staff reduce the number of falls. We saw that the incidence of falls had reduced recently and the registered manager told us this was because of improved supervision of people using the service and by following people’s risk assessments properly.