

Cedar House Company Limited

Cedar House

Inspection report

6 Dryden Road
Enfield
Middlesex
EN1 2PP

Tel: 02083608970

Website: www.cedarcarehome.co.uk

Date of inspection visit:
14 September 2017

Date of publication:
29 November 2017

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 14 September 2017 and was unannounced.

During our previous inspection on 7 June 2017 we identified three breaches of the Health and Social Care (HSC) Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to staffing levels, infection control and good governance.

We rated the service during our inspection on 7 June 2017 overall requires improvement.

Cedar House sent us an action plan dated the 22 July 2017 advising us that improvements had been made to address these breaches. These included providing refresher training in infection control for care workers on 11 July 2017, and the implementation of a robust quality monitoring system to monitor and improve infection control practices. The service had appointed a manager, who recently left Cedar House, but a clearer management structure had been put into place. An interim manager had been appointed to oversee the service until a suitable manager had been appointed. The interim manager was supported by the operation manager. The provider told us in the action plan that the needs of people who used the service had been reviewed to ensure appropriate staffing levels were maintained.

Cedar House is a privately owned care home for older people in Enfield. The home is registered to accommodate 17 older people, most of them living with dementia. During the day of this comprehensive inspection Cedar House had six vacancies.

The home currently has no manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the 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.

People told us that they felt safe living at the home. Staff told us that they had received safeguarding training and showed an understanding of how to report safeguarding concerns.

Risks to people were not always managed effectively; risk management plans lacked detail and did not always provide appropriate guidance to staff to ensure safe care and treatment was provided.

Sufficient staff were deployed to ensure people's needs were met and safe recruitment procedures were followed to ensure people were supported by staff that were appropriately vetted and checked.

While medicines overall were managed appropriately the lack of appropriate protocols and guidance in regards to administered medicines as required (PRN) could put people under unnecessary risk when receiving their medicines.

The provider ensured that appropriate infection control procedures were followed and that the home was clean and free of any offensive odours.

People spoke positively about the support they received. Staff told us that they felt supported in their roles.

We observed that people's consent was sought before they received support from staff and their decisions were respected. We found that processes were not always clear to ensure that all people's rights would always be met in line with the requirements of the Mental Capacity Act (2005).

People had been involved in menu planning at the home to help meet their needs and preferences and we saw that people were given meal options.

We observed positive, caring interactions and relationships between people living at the home and staff. People's cultural and religious needs were catered for and care was provided discreetly and in a dignified manner.

People spoke positively about their care and the support they received. Care planning processes however had not always ensured that all people would always receive care and support that met all their needs. We saw that improvements had been made for people to access activities, however further work is required to ensure activities were person centred.

There was a complaints process in place and guidance about how to use this was on display at the home. Relatives and people who used the service told us that they would raise concerns with the management of Cedar House.

At the time of our inspection we found that some improvements had been made at the home, however audits and records were not always robust, and care planning and risk management processes had not always been effective to ensure that people's needs were always met.

The registered provider did not always uphold all of their responsibilities to the Care Quality Commission (CQC). Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

We have found four breaches during this inspection. You can see what action we told the provider to take at the back of the full version of the report.

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. Risks of harm to people were not always assessed, managed and reduced through the effective use of risk assessments.

People told us that they felt safe living at the home. Staff told us that they had received safeguarding training and showed an understanding of how to report safeguarding concerns.

Sufficient staff were deployed to ensure people's needs were met.

Safer recruitment practices were adhered to which ensured appropriate recruitment checks were carried out to ensure that staff were suitable to work with vulnerable people.

The safe management of medicines required improvement and people could be at risk of not getting medicines as prescribed

Appropriate infection control procedures were followed and the home was clean and free of any offensive odours.

Requires Improvement ●

Is the service effective?

The service was not always effective. People spoke positively about the support they received and staff told us that they felt supported in their roles.

We observed that staff sought people's consent before supporting them and people's decisions were often respected. However, processes were not always clear to ensure that all people were always supported to have maximum choice and control of their lives. The principles of the Mental Capacity Act were not always applied.

People had been involved in menu planning and were given meal options.

People had access to healthcare support to help promote their health.

Requires Improvement ●

Is the service caring?

Good ●

The service was caring. People told us that staff were caring. We saw positive interactions between people and staff.

People told us and our own observations confirmed that staff promoted people's privacy and dignity.

Is the service responsive?

The service was not always responsive. People's care plans were not always centred on their individual needs and preferences.

People had not always access to activities of interest to them. We saw that people had improved access to activities and progress in this area was on-going.

There was a complaints process in place through which people and relatives could raise their concerns.

Requires Improvement ●

Is the service well-led?

The service was not always well led. Quality assurance systems were in place, however, these were not always effective. Care planning and risk management processes had not always ensured that all people's needs could always be safely met.

The registered provider and registered manager did not always uphold all of their responsibilities to the CQC.

Improvements were required to ensure that people received high quality and safe care.

Requires Improvement ●

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 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.'

The inspection of Cedar House commenced on 14 September 2017 and was unannounced.

The inspection was prompted in part by notification of an incident following which a person using the service alleged abuse. This incident is subject to an investigation and as a result this inspection did not examine the circumstances of the incident.

The inspection was carried out by one lead inspector, one other adult social care inspector and one 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 and had experience with dementia.

Due to the short notice of this comprehensive inspection we did not ask the registered 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.

Before our inspection we reviewed the information that we held about the service. This included notifications and other information that that we had received from the service.

We spoke with three people who used the service and two relatives. We also spoke with the activity co-ordinator, cook, four care workers, the interim manager and the operation manager. We also observed people who used the service during lunch time and during activities.

We looked at three care plans and care records in detail, viewed six staff records including supervision and training records. We also looked at records relating to management of the service, these included medicines records, menus, rotas and various quality assurance monitoring records.

Is the service safe?

Our findings

People who use the service told us that they felt safe. One person told us "I am safe enough". We asked people how they were treated by staff, people said "I will talk to anyone who will listen to me" and another person said "Yes, staff listens to me, but there is no manager."

There was a lack of consistency around risk assessments. Some risk assessments were not in place for identified risks. For the three people's risk assessments we looked at, some information was in the risk assessment section and some risk information was only in the care plans. For some risks, guidance was provided to staff. For example, a person that displayed behaviour that challenged during personal care had a detailed risk assessment providing staff with detailed information on how to work with the person effectively to mitigate the risk. However, for other risks there was minimal guidance. For example, one person that required pureed food, recommended by Speech and Language Therapist [SALT], had no risk assessment regarding choking. The person's care plan stated that they required pureed food but there was no further information on why the person required a specialist diet. However, there was specific guidance on the kitchen wall available for staff to view when they were preparing food for people who had swallowing difficulties.

For another person identified as being at risk of falls, there was no risk assessment and no specific guidance for staff within their care plan. The person's care plan stated, 'staff to give gentle reminder to [person] while she is mobilising herself'. The care plan did not say what reminder the person required or how staff needed to work with the person to mitigate the risk of falls. Another person was using bed rails. However, there was no risk assessment and risk management guidance around the safe use of bed rails in place.

Another person's care plan stated that staff were to, 'ensure meal and fluid intake is monitored and maintained'. However, there was no risk assessment in place to provide staff with guidance on how this was to be accomplished. There were also no food or fluid monitoring charts in place. The person was also identified as being at risk of a type of skin infection. Although this was mentioned in the care plan there was no risk assessment in place. The care plan did not describe the condition or include guidance about how staff could identify its symptoms. We spoke with two staff and asked if they were aware of what the skin infection was, both staff said that they did not. However, both staff also said that if they saw redness on a person's skin they would refer to the district nurse.

Another person was at risk of skin problems due to their continence issues. There was a risk assessment in place. However, the risk assessment stated, 'Ensure good continence care'. There was no further information or guidance for staff on how to do this to ensure the person's skin integrity and meet their continence needs.

The registered provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's potential for developing pressure ulcers was assessed by using the Waterlow scale. The Waterlow scale is a specific way of estimating the risk to an individual of developing a pressure ulcer. If an individual is

classed as medium or high risk their pressure mattress suitability is re-assessed. Records showed that Waterlow assessments were completed each month for people. Where a higher risk was identified people were referred for further assessment and for appropriate equipment. The home currently had no people with pressure ulcers. Where people had been assessed as being at high risk of developing pressure ulcers, we saw that pressure equipment such as pressure mattresses and cushions were in place.

Each person had a detailed personal evacuation plan (PEEP) in place in case of a fire. This gave information about the person and their moving and handling needs especially during an emergency and the directions staff were to follow.

We looked at medicines administration records (MARs) for four people. MARs were clear and corresponded with the actual stock levels of medicines stored in the home on behalf of people who used the service. Staff had received training in the administration of medicines and their competency was assessed as part of their training. Staff told us that the interim manager changed the medicines administration system, following consultation with care workers and introduced two signatures on the MARs to ensure that medicines was always checked after they were administered to people. People who used the service told us "I get enough tablets to sink a battleship, I get them on time. If I need anything extra I just ask for it."

Medicines were stored in a medicines trolley located in the lounge on the ground floor. We noted that the medicines trolley was not secured to the wall, which could result in people who used the service or visitors moving it. Current guidance for "Managing medicines in care homes (2014)" from the National Institute for Health and Care Excellence (NICE) states "Secure storage with only authorised care home staff having access". This meant that if a trolley is used to store medicines, it must be locked and secured to a wall, or kept in a locked room to which only authorised staff had access, when not being used to administer medicines.

We found that individual "as required" (PRN) use when necessary medicines were administered to people who used the service. While we found that staff were able to tell us what certain PRN medicines were for and how and why they were required to be administered we did not find individual PRN protocols. These are needed to ensure these medicines were administered when needed, as prescribed, safely. The lack of clear instructions can also lead to errors when PRN medicines were administered.

The above is evidence of a further breach of regulation 12 safe care and treatment of the HSC Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they had received safeguarding training. One care worker told us "I would always tell the manager or operations manager if there is anything I would be concerned about." Care workers gave us practice examples how they would recognise abuse and told us that they would report any allegations of abuse to the manager, operation manager, local authority, police or Care Quality Commission. The provider sent us a training matrix, which confirmed that all but one staff had received safeguarding training recently. The operation manager told us that he was currently reviewing the home's contract with a new training provider to ensure that safeguarding training was provided regularly.

During our last inspection in June 2017 the provider was in breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing. We found that care workers were rushed and the rota did not reflect the actual numbers of staff on duty. We also noted that the numbers of staff on duty were not based on people's dependency.

During this inspection people who used the service told us "There is plenty of staff around" and another person told us "If I ring the call bell they come quickly. If they are busy they come and tell me and then come

back later." We looked at the rota and saw that three care workers were on duty during the morning and three care workers were on duty during the afternoon. We saw that during the night two staff were working at the home. One was a waking night worker and the second was a sleep over staff. We spoke to both night staff and they told us that this worked well and that only two people may require support during the night. They told us that the waking night staff would call for the sleep over staff in such instances, but they also told us that this does not happen every night. We observed staff during the whole day of our visit and saw that people were not rushed and staff responded well to their requests and needs and managed situations when people became upset and required additional support in a calm and skilful manner. This meant that sufficient staff were deployed during our inspection to meet people's needs and the provider was no longer in breach of Regulation 18.

The operation manager advised us that people's dependency levels had been assessed and staffing levels will be reviewed once more people were admitted and when people's needs changed.

The provider followed safe recruitment practices. We saw the recruitment policy and procedure that was in place. It gave clear guidance on how staff were to be properly and safely recruited. We saw interview records in personnel files which showed how care workers had demonstrated their knowledge and skills during the interview process.

The staff files contained evidence of identity, application forms that documented a full employment history, a medical questionnaire, a job description and two professional references. Checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

During our last inspection in June 2017 we found that there were areas of the home that were not cleaned to a satisfactory standard. This included dirty toilets and bathrooms. This meant the service was not always following appropriate infection control procedures to minimise the risk of spreading infections. This was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the provider had addressed this issue.

We arrived at the home at 6.00am. The home was clean with no malodours in any area of the home. We looked at six people's bedrooms which were clean and had fresh bed linen. People's hairbrushes were in their bedrooms to ensure that only the person the hairbrush belonged to was able to use it. On arrival we observed a staff member preparing a bathroom for a person's personal care and saw that they had gathered the person's items from their bedroom including their hairbrush.

We observed that soiled waste was being disposed of appropriately. There were four soiled waste bins in use in the front garden and we saw that soiled waste was placed in a yellow plastic bag before being disposed of in the correct rubbish bin. There was no soiled waste stored in the back garden. Staff that we spoke with understood the process for disposing of soiled waste. The home had a contract with a clinical waste disposal company to ensure safe disposal of soiled waste. The home still employed a cleaner who worked four hours a day, five days a week. When the cleaner was not there staff were expected to clean the home.

Is the service effective?

Our findings

We asked people who used the service if staff had the right skill and knowledge to provide them with the care they needed. People who used the service told us, "They do their best, the care is pretty good" and another person told us "Yes I think so."

The MCA 2005 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 DoLS.

Following the inspection, the interim manager sent us a full list of people that required a DoLS and when the DoLS needed to be renewed. All people that required DoLS had one in place. However, we found that the home was not fully complying with the MCA. Care plans were signed by the manager only, no people or relatives had signed the care plans. People's capacity and information about DoLS were not included in care plans. Capacity is decision specific and people can have differing levels of capacity. The home did not take into account when people may have been able to make decisions for themselves and include this in planning people's care. The interim manager told us, "Families are definitely consulted." A relative told us that they had been consulted on planning their relatives care. However, this had not been documented.

We saw three care plans where relatives had signed a one page 'consent to care' document. However, this was signed once and failed to state what they were consenting to and only stating that the person did not have capacity. There was no information on what a person's capacity was and if there were areas of their life they were able to make a decision about.

For two of the care plans we looked at the people were diagnosed with dementia and did not have capacity to make some independent decisions, such as accessing the community on their own. The consent to care document had been signed by a relative but there were no best interest meetings for decisions regarding the person's care documented. A best interests meeting is when people have been deemed unable to be involved in aspects of their care and staff, healthcare professionals and relatives, make decisions on their behalf and in their best interests.

Understanding of how to implement MCA was not consistent, for another care plan we looked at, the person had no family, but the home had referred them to an Independent Mental Capacity Advocate (IMCA) and there were best interest meetings meting decisions in place.

This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care workers told us that they found training easy to access and recently appointed care workers told us that they had an induction, which included training in safeguarding, Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS), Health and Safety, Infection control, manual handling, fire safety, first aid and food hygiene. They also confirmed that in addition to mandatory training their induction included time to shadow more senior staff during the start of their employment. We saw that induction of new staff was based on the care certificate. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers. Training records viewed confirmed that staff had received this training. We also saw in training records that some staff had received training in mental health, nutrition and hydration, epilepsy and dementia training Level 2. Staff records showed that all staff had received regular supervisions every two months and an annual appraisal. This ensured that that staff had the necessary skill and training to meet the needs of people who used the service.

We asked people if they were happy with food provided and if they were able to choose what they enjoyed to eat. One person told us, "My porridge was a bit lumpy this morning. If I don't like what's for lunch I just leave it and they have something else they will give me. I can have biscuits or anything else that is available." Another person told us, "The new cook is very imaginative and there is more variety since she has worked here. Yesterday we had butternut squash with couscous. It was really nice." Another person told us, "I liked the liver and bacon for lunch today, I don't know what hummus and pitta bread is for dinner." We asked the person after dinner if the person enjoyed the dinner. The person said, "Yes it was very nice." One person's care plan noted, '[Person] does not like ham. She prefers chicken instead of other meat'. This meant care workers asked people for their preferences and offered alternatives if people did not like what was offered on the menu.

We viewed the menu, which showed that every day two different choices were offered for lunch. The cook asked people what they wanted to eat and provided them with the choice that they requested. The cook explained to us that some people had their meals mashed or fortified and showed us a list displayed in the kitchen. We observed lunch time and saw that care workers spent time with people, asked if they liked the meal and encouraged them to eat more. One person was assisted to eat and care workers took their time and spoke with the person explaining what they were about to do and asking if they enjoyed their meal. This meant that people were supported appropriately during mealtimes and were provided with a healthy, nutritious and varied diet.

Care records showed that people were supported with their healthcare needs and that visits were carried out by external healthcare professionals. This included weekly GP visits where appropriate, and visits from chiropodists, dentists, opticians, physiotherapists, district nurses and the falls clinic. Information included the day and time of visit, why people visited, the outcome of the visit and any follow up required. We asked staff what they would do if they noticed a change in a person's health. One staff member said, "I would report it and we would monitor it or refer to the GP."

People's care records contained information of health appointments attended, letters from specialists and records of attended health care appointments. People had access to their own GP. One person told us "I get to see the GP when I need to." Another person said, "I see the optician, my eyes are very bad."

We saw in one of the people's health records that the person was referred to the district nurse who attended regularly and checked that the person's skin was intact so the risk of the person developing pressure ulcers was minimised. This meant that people's healthcare needs were monitored and professional advice was sought to address specific health care needs.

Is the service caring?

Our findings

People told us that staff were "Very caring" and "Staff treat me with dignity and respect." Another person told us "Staff always knocks before they come into my room; it's a good team here." The same person told us "There is one staff member whom is difficult to understand, but slowly I get used to the accent." We asked people if they have access to meet their religious preferences. One person told us, "I am not bothered about Church, but my family visits me regularly." Another person told us, "I am a catholic, I have five members of my family nearby they take me out."

People looked well cared for, were clean, appropriately dressed and well groomed. One person told us they liked to wear their make-up, perfume and jewellery every day and that staff always ensured their wishes were met. Care plans noted people's waking and sleeping preferences, and staff were able to tell us approximate times that people liked to get up or go to bed. When we arrived at 6.00am we saw that everyone was still in bed. People were able to get up when they wished and were supported by staff when they were ready.

We observed that staff spoke quietly and treated people with kindness and respect. We observed when a person was becoming distressed a staff member went to a quiet area with the person and was encouraging them to look at and touch some flowers, discussing how delicate they felt. The person was then holding the staff members hand and kissing it saying, "She's ever so good to me. I love her."

The atmosphere in the home was cheerful, calm and relaxed. We saw that staff knocked and waited for an answer before entering bathrooms, toilets and people's bedrooms. This was to ensure people had their privacy and dignity respected. However, we overheard on one occasion care workers discussing a person's health care needs in front of other people. The person told us that this sometimes happens and the person would rather the care workers discuss it with the person in private. We asked if the person had mentioned this to staff before, but the person told us that this had never happened before.

Staff told us that people's religious and cultural needs were always respected and that people could choose to have their own clergy visit them. People's care plans noted if they had a faith and if they required support in maintaining their faith. One person had a priest visit to provide spiritual and pastoral support. This was confirmed by people we spoke with.

We asked care workers to tell us how staff cared for people who were very ill and at the end of their life. We were told that every possible resource was made available to facilitate a private, comfortable, dignified and pain free death. We were also informed that the staff at the home received good support from the community nurses and the local GPs. People who used the service told us that their family would help them and ensured that the home would follow their wishes. One person told us "I have not considered what happens when I get ill, but my family would help me."

Staff we spoke with were aware of their responsibilities to ensure information about people who used the service was treated confidentially. We saw that care records were kept secure in a lockable cupboard in the

hallway and in the staff office. This was to ensure information about people was accessible to staff but kept confidential.

Is the service responsive?

Our findings

The home completed a needs assessment prior to people moving into the home. For the three care files that we looked at, we saw that a new needs assessment had been completed in 2017 for each person. Care records included a 'Who I am' document. This was a one page document that gave an overview of each person to help staff get to know them better.

We saw that people's care plans were reviewed monthly. Where people had been diagnosed with dementia, there was no information in people's care plans on how their dementia affected them as an individual. Care plans stated a general area that staff needed to be aware of but lacked detail on how this affected the person and what strategies may be useful to help staff support the person. For example, one person suffered from 'low moods' and their care plan stated, 'Staff to offer different coping strategies to [the person] to cope with their depression'. There was no further information on what strategies worked for the person and how staff should work with them. One care plan stated that the person required one-to-one support when out in the community but there was no information about how the person should be supported to access the community.

The home employed an activities coordinator 10.00am until 2.00pm twice a week. We spoke with the activities coordinator at the time of the inspection. One person told us, "I don't like the activities here, but the activity coordinator reads to me as my eyes are bad, I like Dorian Gray." The activities coordinator showed us a memory book that had been completed which contained photos of activities to help remind people of what they had enjoyed previously including group and one-to-one activities. This included arts and crafts, hand massage and movement sessions. The activities coordinator had created an activity time table for each day of the week with a morning and afternoon activity. Staff had the responsibility of ensuring activities took place when the activity coordinator was not present. We observed a morning activity on the day of the inspection, the activity was attended by eight people. One person's care plan stated that they liked to knit. The activities coordinator confirmed that the person was being supported to maintain this interest. The activities coordinator also told us about a recent activity where a company brought in some animals for people to pet. We observed activities offered during the day of our inspection which were attended by most of the people who used the service at different times.

However, despite the positive activities that were taking place within the home, we found that people were often wandering and had minimal interaction with staff to stimulate them. The activities coordinator confirmed that there were no external activities planned for people that lived at the home. One person had not left the home for a year. A relative commented, "[Person] hasn't been out at all. Not at all. Not even into the garden. There's no stimulation" A staff member told us, "Some families don't want us to take them out." Staff said that they may take people to the local shop but this was the only time they left the house unless going out with relatives.

The home did not have individual activity plans for people based on the interests and information that they knew about individuals. For example, one person had been a life-long member of the Salvation Army and another person had been in the Royal Navy. The home had not recognised that these were interests that

were important to these people as individuals and there were no individualised activity plans for these people who could have used the knowledge of their lives and interests to help plan activities that would stimulate them and enhance their quality of life.

The above is evidence of a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw people were provided with clear information about the procedure in place for handling complaints. A copy of the complaints procedure was displayed on notice boards in the corridors. The procedure explained to people how to complain, who to complain to, and the times it would take for a response. The people we spoke with told us they had no concerns about the service they received and were confident they could speak to the staff if they had any concerns. One person told us, "If I had something to say, I would just tell them." We saw that the registered provider kept a log of any complaints made and the action taken to address the issues.

Is the service well-led?

Our findings

People who used the service told us that there was no manager in place, but they confirmed that senior managers visit the home. One person told us, "There is no manager, but senior staff move about they visit the home." One relative told us, "The manager recently left, but [person's name] is managing the home at the moment, I can talk to her always, she is very good."

We identified a number of shortfalls in the way the service was managed, this included concerns related to the safety of the service, the implementation of the Mental Capacity Act and person centred care.

Systems in place to monitor and improve the quality of the service were not consistently effective. Although there was an audit system in place, this had not been effective in identifying or addressing the issues we found during our inspection visit. For example, audits related to medicines had not identified concerns related to medicines management found during our inspection. There was a failure to identify that some people who required "as required" (PRN) medicines did not have protocols in place to guide staff about the administering of these medicines.

The provider did not have sufficient systems in place to check people's care and support was carried out safely or in a way that met their needs. For example, care plans did not always accurately reflect people's current needs and contained contradictory information. This meant the provider was not assuring themselves that people's care was being delivered safely or in line with their needs and preferences. The provider was not ensuring that people's care plans were kept up to date to ensure staff had accurate information regarding people's needs and risks. We also found that activities provided were not always centred on the person and found that people did not always engage in activities offered.

We found that capacity assessments were not always completed where people's freedom of movement was restricted and evidence of decisions made in people's best interest recorded.

The lack of effective systems to check on the quality and consistency of the service meant there was a risk that people's care was not being delivered safely and in line with the regulations.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection in June 2017 we found that the service lacked a clear management structure and people who used the service were not clear whom to approach and talk to if they had any concerns. This was in breach of Regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the provider had addressed this issue.

Since our inspection in June 2017 the provider placed an interim manager in Cedar House, while relatives still raised some concerns about the management of the home they were generally positive about the current management arrangements. One relative told us, "This place does have a lot of positives. When it's

well run, such as [by the interim manager] it's fine. I feel so reassured and comfortable." The provider has also appointed a new operation manager who commenced employment shortly prior to our inspection visit. People told us that he had been visible and approachable, which was confirmed by staff we spoke with. One care worker told us "[Operation Manager] is very good; he listens to what we have to say and is happy to make changes." The care worker gave the example of two signatures on MARs when administering medicines.

We spoke with the operation manager and interim manager during our inspection and were advised that two potential managers had been interviewed and an appointment of a permanent manager was imminent. We contacted the home following our inspection visit and were advised by the interim manager that one candidate has been selected as a new manager and will be appointed subject to satisfactory references. This meant that the provider met the breach in regulation 17 (1) (2) found during our inspection in June 2017.

Staff also spoke positively about their work and the support they received from management. Their comments included, "We are a good team here, we work well together and [interim manager] will support us if we need help." Another care worker told us "I like coming to work and care for all the people." Staff received regular supervisions and appraisals and staff meetings were arranged for the staff team to meet and discuss issues in relation to the running of the service and support and treatment people who used the service received.

A service users and relatives survey carried out in April 2017 was generally very positive and comments included "I like the hand massage and chatting to staff", "Cedar House is warm and [there are] a lot of people to talk to", "friendly staff" and "No complaints about the staff's efforts." However people also mentioned that they would like to see a permanent manager, more selection of food at dinner time and that it is sometimes too quiet. Following the survey an action plan had been put into place and we found during this inspection that the provider has begun to address the concerns raised and had made improvements. For example the menu had been reviewed, efforts had been made to recruit a new permanent manager and work has started to review activities for people. But, we found that further work was needed to improve the overall quality of care for people who used the service.

The CQC had not been notified of specific events and incidents as required by law. The registered provider had not informed the Commission of an incident where one person alleged abuse. The operation manager told us that they had made a safeguarding alert to the local authority, but failed to notify the Care Quality Commission about the allegations made. We are currently making further enquiries in relation to this matter.

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The registered person must ensure that service users' care records were appropriate, met people's needs and reflected their preferences by enabling and supporting relevant persons to understand the care and treatment choices available. Regulation 9 (1) (a-c) (3) (c).</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>Care and treatment of service users must only be provided with the consent of the relevant person. If the person is unable to give such consent because they lack capacity to do so, the person must act in accordance with MCA 2005. Regulation 11 (1) (3).</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered person must ensure that care and treatment was provided in a safe way to service users by assessing the risk to the health and safety and doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (1) (2) (a) (b).</p> <p>The registered person must ensure that care and treatment was provided in a safe way to people who used the service by maintaining a safe and proper medicines administration and</p>

storing system. Regulation 12 (1) (g).

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA RA Regulations 2014 Good governance

The registered provider had failed to establish and operate systems to ensure compliance, and to assess, monitor and improve the quality and safety of the service. Regulation 17 (1) (2) (a).