Cedarwood House Limited

Cedarwood House

Inspection report

Hastings Road
Battle
East Sussex
TN33 0TG

Tel: 01424772428
Website: www.cedarscaregroup.co.uk

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

At our previous inspection of Cedarwood House on 6 and 12 May 2015 we found breaches in regulation. We found there were not enough staff deployed to meet people's needs. We also found that people were not adequately supported at meal times and there was no Registered Manager in place. The provider sent us an action plan in August 2015 and told us they would address these issues by February 2016.

We inspected on the 16 and 17 August 2016 to follow up on whether the required actions had been taken. We found the provider was now meeting the legal requirements.

Cedarwood House provides accommodation and care for up to 20 people. At the time of our inspection 18 older people were living at the home aged between 77 and 96. All people at Cedarwood House were living with early stages to severe dementia. People had various long term health care needs including diabetes and other conditions which impacted on mobility putting people at risk from falls.

Cedarwood House was on two floors with five bedrooms on the first floor accessed by a lift in the dining room and 15 bedrooms on the ground floor. The ground floor also included a kitchen, a staff room, the dining room, the communal lounge, an office and a recently decorated garden or sensory room.

There was a registered manager at the home. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Throughout our inspection, people spoke positively about the home. Comments included, "No complaints whatsoever, it's lovely here" and, "I'm well looked after." Although staff knew people well and had a good understanding of their individual needs and choices there was a lack of consistent written information which could leave people at risk of receiving care that was inappropriate or inconsistent. This had not been identified through the quality assurance system. We have made a recommendation about improving the quality assurance process.

People told us they felt safe living at Cedarwood House. There were sufficient levels of staff to protect people's health, safety and welfare. The provider had improved staffing levels based on the dependency of people's needs.

Medicines were managed safely including covert and PRN medication. The provider had put in place clear guidance for staff on the covert administration of medicines.

People were provided with a choice of healthy food and drink ensuring their nutritional needs were met. Staff encouraged and supported people to eat and drink well. One person said, "The food is good, we get choices."

Staff knew the individual personalities of people they supported. We saw staff were kind, compassionate and patient and promoted people's privacy, dignity and choice. People were encouraged to be as independent as possible and we saw friendly and genuine relationships had developed between people and staff. One person said, "The staff are helpful and cheerful and treat me well." A staff member told us, "I would put one of my loved ones here because the carers are compassionate."

Training schedules confirmed staff had received training in safeguarding adults at risk. Staff knew how to identify if people were at risk of abuse or harm and knew what to do to ensure they were protected. Staff had received quarterly supervisions with their manager to discuss additional training needs and development. Staff were encouraged to attend further training, with a number having achieved National Vocational (NVQ) in health and social care.

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

People's health and wellbeing was monitored and staff regularly liaised with healthcare professionals for advice and guidance. A visiting healthcare professional told us, "If staff have any concerns they will call straight away."

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found appropriate policies and procedures were in place. The registered manager was familiar with the processes involved in the application for a DoLS, and had made the necessary applications to the authorising authority. Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure decisions were made in the person's best interests.

People's friends and family were made welcome and relatives spoke positively about the welcome they received. One told us, "I visit every day. If I could I'd give it 11 out of 10."

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

Cedarwood House was safe.

Risk to people had been assessed and managed.

Staffing levels were sufficient to keep people in the service safe.

Checks had been completed on staff to ensure they were suitable and safe to work with people at risk.

Staff had a clear understanding of the procedures in place to safeguard people from abuse.

Medicines were stored, administered and disposed of safely.

The premises and equipment at the service was well maintained.

Is the service effective?

Good

Cedarwood House was effective.

Staff had received training and regular supervisions to carry out their role.

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

People were provided with food and drink which supported them to maintain a healthy diet.

People were supported to have access to healthcare professionals when they needed it.

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

The environment was decorated to promote people's freedom, independence and wellbeing.

Is the service caring?

Good

Cedarwood House was caring.

Staff had a good understanding of the history, likes, preferences and needs of the people who used the service.

Staff communicated effectively with every person using the service.

Staff had built a rapport with people and treated them with kindness and respect.

Care plans were personal to each person and included detailed information about the things that were most important to them.

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

Is the service responsive?

Good

Cedarwood House was responsive.

People received consistent, personalised care and care plans were reviewed.

People decided how they spent their time, and a range of activities were provided depending on people's preferences.

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

Concerns and complaints were responded to appropriately.

Is the service well-led?

Requires Improvement

Cedarwood House was not consistently well-led because records did not consistently include the information about the care people needed or received.

Incidents and accidents were documented but not always analysed to identify trends to prevent reoccurrence.

Feedback from people, relatives and staff were gathered however where suggestions for improvement had been made there was not always an action or response recorded.

The home had a registered manager who provided clear leadership and support.

Quality Assurance audits were undertaken to ensure the safe running of the home.	

Cedarwood House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 and 17 August 2016. This was an unannounced inspection. The inspection team consisted of two inspectors.

We focused on speaking with people who lived in the home, speaking with staff and observing how people were cared for. As some people had difficulties in verbal communication we spent time observing to see the interactions between people and staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were unable to talk to us.

We looked at care documentation and reviewed records which related to the running of the service. We looked at seven care plans and five staff files, staff training records and quality assurance documentation to support our findings. We looked at records that related to how the home was managed. We also 'pathway tracked' people living at Cedarwood House. This is when we look at care documentation in depth and obtain views on how people found living there. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We looked at areas of the home including people's bedrooms, bathrooms, lounges and dining area. During our inspection we spoke with five people who live at Cedarwood House, seven visitors, six staff and the registered manager. We also spoke with one visiting district nurse.

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

notification is information about important events which the provider is required to tell us about by law.

Good

Is the service safe?

Our findings

At our inspection on 6 and 12 May 2015 the provider had not met the regulation in relation to sufficient numbers of staff to ensure people's safety and welfare. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) 2014.

At this inspection we found improvements had been made and the provider was meeting the requirements of Regulation 18 in relation to staffing. Staffing levels matched what was planned on the staff rota. There were three care staff on duty during the day, two waking night staff as well as a member of staff who was referred to as a 'sleeper'. An extra shift had been put in place to provide more support at meal times between 12 noon and 6pm. The registered manager told us that the staffing levels were based on individual dependency. The dependency of people was reflected in the care plans and ranged from total to low dependency based on the people's fluctuating care needs. Staff told us, "We know how many staff we need. We have put the 'sleeper' on so that we have an extra person in case of emergencies and we have introduced the 12 noon to 6pm shift to ensure that meal times are adequately covered."
In addition to care staff there was a head cook, housekeeper, an administrator and a maintenance person employed at the home. We saw that the registered manager worked 5 days a week and was often found sitting and talking with people and their visitors. One staff member told us, "I think there are enough staff. There is plenty of time to sit and chat with the residents. If there was a need for more staff I would raise it." One visitor said, "It doesn't matter how busy they are they find time." We saw that staff responded quickly to the needs of people and call bells were answered promptly. Staff had time to sit with people without the need to rush. There were enough staff to meet the needs of people living at Cedarwood House and these were assessed and monitored regularly.

People said they felt safe living at the home. One person told us, "I'm so relieved to be looked after, so relieved someone has taken responsibility from me." Visitors to the home told us they felt their relatives were safe. One relative said, "Staff can tell me, almost to the second what she's been doing all day." Another relative told us, "I know that she is safe here and that's important to me

There were appropriate arrangements in place for the safe receipt, storage, administration and disposal of medicines to ensure people received their medicines safely. A lockable trolley was held in the staff room to store medication and a further lockable trolley was secured to the wall outside. Both trolleys had thermometers inside to ensure that the medication was stored at the right temperature. Medicines were supplied in blister packs. We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of safely.

People's medicine administration records (MAR) were accurate and clear. They showed each person had an individualised MAR which included a photograph of the person and any allergies. MAR charts are a document to record when people received their medicines. We observed two separate times when people were given their medicines and they were given safely. Staff had a good understanding of people and the medicines they required. We heard a staff member saying, "How is your back today? Do you have any pain and do you want a pain killer?"

There was clear guidance in the MAR charts on as required (PRN). PRN medicines are only given when people require them and not given routinely for example for pain relief or anxiety. Three people received covert medicine. Covert is a term used when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink. The best interests decision to give the medicines covertly was in consultation with the GP who visited Cedarwood House every week, relatives and the local pharmacist.

Care plans showed each person had been assessed before they moved into the home and potential risks identified. People's care documentation contained assessments such as risk of falls, skin damage, nutrition and moving and handling. They provided specific guidance for staff on how to manage risks, for example what equipment would be required. These had been reviewed on a monthly basis. One staff member told us, "It is really important to understand the people here so that we can prevent falls, encourage independence and ensure that we reduce the risk to people while they move around the home."

Staff had received safeguarding training and knew who to contact if they needed to report abuse. They gave us examples of potentially abusive care and were able to talk about the steps they would take to respond to it. One staff member told us, "We have to make sure that there are measures in place to make people safe. If I have any concerns I report them to the registered manager, the provider or the operations manager." Another staff member said, "If I witnessed inappropriate care I would speak to the registered manager, social services and the CQC."
Policies and procedures on safeguarding were available in the office for staff to refer to if they required.

Staff files included relevant checks on staff suitability including completed application forms, two references, a medical questionnaire, employment history and a Disclosure and Barring Service (DBS) check. These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable adults. This ensured that only suitable people worked at Cedarwood House.

All staff had received fire safety training and a fire safety policy and evacuation plan was in place. A fire risk assessment had been carried out on 10 January 2016. Whilst fire tests were carried out monthly and staff knew where to assemble when the alarms sounded, a full evacuation had not been completed. This meant that it was not possible to determine if staff knew what to do in the event of a fire. We spoke to the registered manager who told us that they would seek guidance and advice in order to carry out a practical evacuation without causing unnecessary anxiety to the people living at Cedarwood House. We reviewed people's individual personal evacuation plans (PEEPS). These identified the support people required during an evacuation.

People were cared for in an environment that was safe and clean. People were able to move safely around the home with walking aids and the floors and corridors were clear of obstruction. Regular health and safety checks ensured people's safety was maintained. There were regular servicing contracts in place including checks on the lift, gas, moving and handling equipment and electrical appliances. Maintenance was carried out regularly with additional monthly checks completed on radiators, pressure mats, water temperatures and fire equipment.

Good

Is the service effective?

Our findings

At our inspection on 6 and 12 May 2015 the provider had not met the Regulation in relation to adequately supporting people at meal times. This was a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) 2014.

At this inspection we found improvements had been made and the provider was meeting the requirements of Regulation 14 in relation to meeting nutritional and hydration needs.

People told us they liked the food at Cedarwood House, one person said, "We get a good meal here." The head cook told us, "All of the food is homemade from fresh ingredients and we have four weekly menus. Every day I ask everyone using visual flash cards what choices they would like. There are two choices for lunch and three choices for supper. We do 'old school' cooking here which reflects the preferences of the residents. If someone wants something that is not on the menu I will cook it for them. We also have specific dietary needs such as pureed food and diet controlled diabetes which we cater for."

We observed the lunch time meal service on both days of our inspection. People either ate in their rooms, the dining room or in the lounge. On both days the majority of people ate in the dining room and ate independently. There were four dining tables which were well presented with soft drinks and condiments. We saw that plate guards were used by some people to assist them to eat independently. Staff ensured that people were positioned comfortably at their table and interacted in a respectful and supportive manner. Where people declined their meal, alternatives were offered. One person who declined to eat their main meal was offered an alternative and when this was also refused was offered toast and jam which they ate.

People were provided with enough to eat and drink. They were offered breakfast, lunch, afternoon tea and a light supper. People were regularly offered drinks, fruit and snacks throughout the day. People were able to have their breakfast when they chose. A member of staff told us, "It's nice to work in a home that is not regimented. Here it is about choice."

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 so that they can 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 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. Policies and procedures were available to staff on the MCA and DoLS. These provided staff with guidance regarding their roles and responsibilities under the legislation. One staff member told us, "The best interest meetings are attended by the registered manager, a GP and a family member in order to accurately assess capacity." DoLS applications had been applied for and mental capacity assessments were in place for all of the people at Cedarwood House.

Staff received training in safeguarding, falls awareness, moving and handling, fire safety and infection control. They completed an induction when they started working at Cedarwood House and 'shadowed' experienced members of staff until they were competent to work unsupervised. One of the floor managers who was responsible for induction of new staff told us, "I always advise new staff to take time to look at the care plans so that they can get to know the residents." A member of staff who had just completed their three day induction said, "I only started four days ago but I spent three days shadowing and looking at the care plans. Cedarwood has changed what I thought about care homes as one of my relatives had a bad experience. We get time here to have one to ones with the residents."

Staff also received specific training to meet people's needs, for example dementia care and challenging behaviour. One staff member told us, "I have just completed my NVQ Level 3 in Health and Social Care and I am also a dementia champion so we aim to make all of the care staff dementia friends." One staff member said, "I am currently doing my Institute of Leadership and Management Level 3 in Leadership and Management and in October I am attending a Dignity and Care course. If we need any training we ask the registered manager." Staff we spoke to and observed demonstrated a good understanding of dignity and dementia. Staff were patient and kind in their interactions with people.

Staff received supervision every three months to develop staff and monitor the effectiveness of the training that they had completed. Staff told us that the supervisions were a good reminder of best practices and ensured that they were up to date with the latest procedures and guidance. One staff member said, "The supervisions are a good way to make sure we are doing things properly for people."

Staff demonstrated they had knowledge and understanding of how to support people to maintain good health. People had been referred to a range of health care professionals, these included dieticians, District Nurses and Speech and Language Therapists (SALT). We spoke with one visiting health professional during the inspection. They visited the home quite often and were positive about the home and the staffs' responsiveness. They said, "The care appears good including pressure area care and end of life care. If there are any concerns staff call straight away." Healthcare professional visits were noted in the care plans.

During the shift handover staff were provided with detailed information about what people had done, the care they had received and the care they needed. It also included what people had eaten and whether they had drunk well. For example, a new staff member was instructed on what to do and reminded to ask staff if they were not sure of anything.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. People and their relatives stated they were satisfied with the care and support they received. One person said, "The staff treat me well and I am happy here." A relative told us, "Nothing is too much trouble. They are all brilliant." Another relative said, "I visit every day at different times and I don't just see how they deal with my mum, I watch them with other people. I can't speak highly enough of them, I'm overwhelmed with the care." Our observations confirmed that staff were caring in their attitude to the people they supported.

There were similar comments in the service's compliments file. One relative had written, "I am so pleased that we found and chose Cedarwood House for my mum. The kindness, patience and care that I have witnessed has been truly outstanding."

There was a calm and relaxed atmosphere at Cedarwood House. A staff member told us, "I like working here, it's beautiful." Another staff member told us, "It's calm here, which I like." People were supported to spend their day as they chose. Interactions and conversations between staff and people were positive and there was a friendly chat and good humour. Staff made time to talk to people whilst going about their day to day work. One person who was sat in their bedroom started to sing 'Singin' in the rain' and the housekeeper who was cleaning the room next door started to join in..

On the first day of our inspection we observed staff interacting and engaging with the people at Cedarwood House in a positive and responsive manner. One person was struggling to eat an apple whole so the member of staff offered to have the apple cut up for them. The member of staff returned from the kitchen with a fresh apple cut into pieces. The person smiled and thanked them and continued to eat the apple. Another person looked distressed so the member of staff asked if they could help, sat with them and reassured them by holding their hand and listening to their concerns.

Staff were aware of the importance of providing the right level of support to ensure that people's needs were met, but also to enable them to do as much for themselves as possible. We saw staff encouraging people with walking aids to move to different parts of the building safely. Staff were patient and took time to support them if necessary.

The outside of each bedroom on the ground floor had been painted and given a name, for example Bluebell Cottage. Small white fences and a trellis were attached to the wall outside the bedrooms and covered in colourful plastic flowers. The deputy manager told us, "The colours make the rooms look like individual cottages and it brings the residents' happiness looking at the flowers."

Staff always knocked on people's doors before entering and were consistently discreet when offering to provide personal care to people. One person was calling out from their bedroom and we saw a member of staff knock on their door even though the door was open, sit with them and stroked their hand while offering reassurance and support.

The service had a 'dementia champion' who led by example and challenged any staff actions that might diminish a person's dignity in any way. They were able to give us examples of ways of protecting people's dignity, such as covering the person with a towel when undressing for a bath and closing doors and curtains to maintain privacy when giving personal care.

The hairdresser styled people's hair in the bathroom adjacent to the garden room. This provided privacy and dignity and the opportunity to have one to one private conversations. Friends and relatives told us that the care staff provided nail care and hand massages for people if they chose to. One visitor told us, "My friend was delighted to have her nails done as she has never had them done before she came here. The care is wonderful."

Care plans contained information on people's preferences regarding their end of life decisions. Three relatives told us how supportive and considerate the registered manager had been during the end of life of a person at the home. People and their families where appropriate, were involved in their day to day care. Care plans and risk assessments showed they had been consulted on their views of their care and asked what was important to them.

Staff were knowledgeable about individual personalities of people they cared for and supported. Staff shared people's personalities with us during the inspection and they talked of people with respect and affection. One staff member said, "Getting to know the residents is lovely. We get time to have one to ones." When staff were attending people they worked at the person's own pace and did not rush them. The deputy manager told us, "Residents need the time they need." We observed a member of staff attending to one person; they took their time and were patient. They did not leave the person until they were sure their needs had been met. Staff chatted with people whilst providing support.

Care records were stored securely in a locked office area. Confidential information including personnel files were kept secure and there were policies and procedures to protect people's confidentiality.

Visitors were welcomed throughout our visit. Relatives told us they could visit at any time and were always made to feel welcome. A relative said, "The staff are supportive to me and the family as a whole. When I can't come in I don't have any concerns, they keep me informed, we keep communicating and I know what's going on."

Good

Is the service responsive?

Our findings

Visitors told us their relatives received care that met their needs. One visitor told us, "This is the best care home for my mum, we wanted something small and homely. She was becoming more isolated and reclusive. I now see her in the lounge interacting with people."

People's needs had been assessed before they moved into the home. This was to ensure their needs and choices could be met. People's care plans contained information about personal care, communication, health and social well-being, mobility and mental health in addition to a falls, continence and nutritional risk assessment. Regular reviews of the care records were completed with relatives.

Assessments and care plans were completed with the person, and where appropriate, their representative, and included information about their likes, dislikes and choices as well as their needs and these were reviewed monthly. Within people's room there were personalised 'thought clouds' on walls that identified people's likes, dislikes and preferred topics of conversation that would engage them. Staff told us these served as an effective way to make quick connections with people. Personalised information about individual daily routines was recorded for example what time people liked to get up and what equipment would be required for mobility.

There was a timetable of weekly activities on display in the hallway. These activities included pet therapy involving a dog, rabbit and hamster, the cooking club, hand massage, nail care and a singer who visited the home every fortnight. Activities were individualised for people but the timetable provided activities for those people who wanted to participate. The notice board also showed forthcoming events and photographs of people at Cedarwood House enjoying the activities that they took part in.

The registered manager had introduced the Pool Activity Level (PAL) assessment. This is a framework for providing activity-based care for people who are living with dementia. The PAL assessment identifies a person's ability to engage in activities which are then developed for each individual; this included a detailed life-history and information about people's specific hobbies and interests. The registered manager told us, "We no longer have an activities coordinator as I think the care staff are better placed to engage with the residents. They can build on the relationship that they already have with the individual and use the tool to stimulate activities which are one to one and more person-centred." A member of staff said, "We have residents with difficult behaviours. Agitation can be from boredom so we keep them busy with things that we know they enjoy doing." The deputy manager told us, "Our approach with dementia activities has changed. We establish activities based on individual need." One person's activity plan stated that they enjoyed reminiscence by looking at old photos, listening to music and one to one time with staff. We saw two people sitting at a table in the dining room counting counters. They were both very happy for some time until one became agitated with the other and no longer wanted to take part. A member of staff intervened and calmed the situation by taking one person to the lounge area.

On another table two people were completing a jigsaw puzzle of the British Isles. One piece of the puzzle had Dublin on it and the member of staff sitting with them asked whether either of them had been to Dublin.

They said no and then sang "Molly Malone" together.

One person told us, "I can mainly do what I like, I go out for walks twice a day for a bit of exercise, the food is good and we get choices." Another staff member told us, "Residents get options of what they can do. It is not a tight schedule. They can stay in bed or get up early it is up to them."

We observed one person who was very distressed sitting in the garden room with the registered manager for a long time. The registered manager took them to the dining room and gave them an activity to complete, their mood changed and they seemed happier.

Staff had introduced a cooking club which we observed during our inspection. Staff supported two tables of people to make pizzas by putting a selection of vegetables onto pastry sheets. Staff were patient and considerate and explained to everyone at each stage what they needed to do next.

People were listening to music in the lounge and care staff were seen dancing with people. There was a relaxed and friendly atmosphere. A relative told us, "At the recent garden party I noticed how staff spent time with people who didn't have any family or visitors. They made sure everyone was involved."

A complaint policy and procedure was available. The complaints log showed there had been no recent complaints. There was a comments book available at reception for visiting relatives. A compliments folder contained written feedback and cards received from visitors with one comment dated August 2016 stating, 'The kindness, patience and care that I have witnessed have been truly outstanding.'

Relative surveys were completed quarterly by the head office and gave relatives and friends the opportunity to raise concerns and provide feedback. Relatives scored subjects which included the atmosphere, how well they were informed and friendliness of staff. Comments included, "The staff do a great job" and "The registered manager is a caring and inspiring manager."

People were given the opportunity to provide feedback. Service user surveys were completed quarterly and locally in-house. The latest service user survey in July 2016 showed 10 responses were received out of 18. Feedback was positive and any areas of concern were acted upon by the registered manager. One comment suggested a trip to the seaside.

Requires Improvement

Is the service well-led?

Our findings

We carried out an inspection on 6 and 12 May 2015 where we found the provider had not met their condition of registration by having a registered manager in post. This was a breach of Section 33 (b) of the Health and Social Care Act (Regulated Activities) 2014. At this inspection a registered manager was in post and the breach met. People and visitors described the staff of Cedarwood House as approachable, open and supportive. One visitor told us, "It's lovely. My mum has everything she needs. Staff think of things before I do." Another relative said, "The staff are absolutely amazing."

Whilst we received positive comments from people we found Cedarwood was not consistently well-led. People's care plans did not always contain consistent information staff needed to look after people. This did not significantly impact on people because staff had a good understanding of their needs. However, staff who were not as familiar with people did not have clear reference documents.

A quality assurance audit was undertaken which covered areas such as care plan reviews, catering and cleaning, health and safety, infection control, medication and maintenance. However, the quality assurance audit had not identified the need for staff to fully document the care and support of people. We recommend the provider takes support and guidance from a reputable source on how to implement and deliver a full quality assurance system.

The accident and incident records were not always fully recorded, for example a fall which happened in June 2016 was well documented and as a result the position of a bed was changed. However, a fall which happened in August 2016 had no record of what action was taken to address the issue or a record of any future prevention.

Care plans including the daily records were not always clear and consistent to ensure that people received safe and person-centred care. For example, a risk assessment at the front of a person's notes stated that they were unable to communicate and that staff should be aware of different types of communication but there were no further details. The mental capacity assessment stated that they could communicate choices but there was no information about how staff would support them to make decisions. The skin integrity care plan did not include any details with regard to the use of a pressure relieving mattress. However, the social and well-being risk assessment stated that their position should be changed every hour. There were no turn charts in the person's room to monitor and check that their position had been changed. Staff told us how they communicated with this person and the care they provided to ensure the person's skin integrity was maintained despite the records not being accurate.

Staff told us how one person became distressed during personal care, however this information was not in the care plan or any information staff needed to support the person. There was also a note that one person could display inappropriate behaviours but no record of what the behaviour was how it may be triggered and how staff would deal with it. One person was high dependency for foot care due to diabetes but there was no record of foot care in their personal hygiene care plan or any diabetes care plan to inform staff how to support them in relation to diabetes.

Care plans did not include details of how people with fluctuating capacity could make choices and decisions. A consent form for the use of bed rails was completed in 2013 but the decision had not been reviewed. The registered manager was aware of this and said they would ensure this was completed.

Staff knew people well and had a good understanding of their individual needs and choices. However, the lack of written information left people at risk of receiving care that was inappropriate or inconsistent. We identified this as an area that needs to be improved.
We recommend the provider has an effective quality assurance system in place.

The registered manager worked with staff to provide a good service. We were told by staff that the registered manager had, "transformed the service" and the whole atmosphere was of "general happiness." One of the floor managers told us, "The registered manager and deputy manager are both very approachable. If I want to chat they will make time for me. They are both 'hands on' so it's all a joint effort. It is a small home and very family orientated."

The registered manager had notified us of all significant events which had occurred in line with their legal obligations. The manager had a good understanding of the issues that had occurred and demonstrated how she had put measures in place to prevent reoccurrence for example a sensor mat and stand aid was put in use following a person's return from hospital after a fall.

The registered manager completed a monthly operational service review which inspected all areas of the home and produced a summary of the findings and any outcome.

Quality meetings which were attended by managers and included discussions relating to various areas of the home such as care, maintenance, kitchen and housekeeping were held every other month. Staff meetings were held every six months or earlier if needed. Staff told us that these were helpful and provided an opportunity to make improvements and share best practices.

Staff surveys were completed annually by the head office. The latest staff survey in spring 2016 was very positive with 15 responses out of 20. Staff scored a variety of subjects including the atmosphere, communications and training. The only additional comments from staff were suggestions to have more activities. The registered manager and the service had responded to this feedback by improving the activities at Cedarwood House.