Messrs A & M & K Desai - Desai Care Homes

Cedar Park Nursing Home

Inspection report

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Ratings

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

Overall summary

We carried out this inspection over three days on the 12, 14 and 17 November 2014. At our last inspection in December 2013 no concerns were identified.

Cedar Park Nursing Home provides accommodation for up to 52 people who require personal and/or nursing care. At the time of our visit there were 50 people living at the home. Cedar Park is made up of two adjoining units known as the Georgian wing and the Orchard wing. The Georgian wing is able to accommodate 32 people over three floors. The Orchard wing can accommodate 20 people over two floors. Both wings have their own passenger lift, nurse's station and communal areas including a lounge, dining room and conservatory. There are single and shared rooms in both wings and a central laundry and kitchen.

The home had recently appointed a new manager who was responsible for the day to day operation of the home. They were in the process of applying to become the registered manager of Cedar Park. 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

Summary of findings

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. The home manager was present during the whole of our inspection.

Risks to people's safety were not always reported and acted on. Assessments identifying risks were not always up to date. Information showed some people were not drinking sufficient amounts but intervention to address this was not evident.

People were encouraged to make decisions about their daily lives including what to eat, what to wear and how they spent their day. However, the process for those people who did not have the capacity to make specific decisions was not being followed according to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards legislation.

People and their relatives were happy with the care provided. However, not all people were sufficiently supported to minimise their risk of pressure ulceration. Some people remained in the same position during our inspection and care charts did not demonstrate the frequency of repositioning, as detailed within care plans.

Care plans did not consistently reflect people's individual and changing needs. Staff had written some pertinent information in the evaluation section of the plan and had not updated the main care plan. This meant there was a risk that information would be missed and not all staff would be fully aware of people's needs.

Staff told us they felt supported and had the training they required but records did not evidence effective systems were in place. Staff were not consistently receiving supervision according to the home's policy. Not all staff had received up to date training in mandatory subjects such as manual handling and safeguarding.

Questionnaires which had been used as a training tool had not consistently been marked, which meant potential shortfalls in staff's knowledge were not being identified.

The home had systems in place to monitor the quality of the service. These included a range of audits and the use of questionnaires and meetings to gain people's views. However, the systems did not fully reflect the Quality Assurance policy and action plans were not always clear in terms of any issues raised. Some action plans were not specific and not re-visited to ensure any remedial work had been completed, as required.

Staff spoke and interacted with people in a polite, caring and sensitive manner. Staff regularly engaged with people and promoted conversation. Staff fully involved people in interventions such as using the hoist and gave reassurance throughout.

Staff were aware of people's needs and were committed to their wellbeing. People had access to varied social activities based on their personal preferences. Staff were clear about promoting people's privacy and dignity and consistently demonstrated this within their practice.

Staff managed people's medicines in a safe manner. The home's policies and procedures were followed. All medicines were stored securely and records demonstrated the safe receipt, administration and disposal of medicines. People's medicines were reviewed by regular contact with GPs. Records showed that people had good access to a range of professionals, to meet their health care needs.

People were offered sufficient nutritious food, which was cooked "from scratch". People's health and cultural needs and individual food preferences were catered for. People chose their meal the previous day and were offered alternatives, if they did not like what was on the menu.

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?

Requires Improvement

This service was not always safe.

Risks to people's safety were not always identified and appropriately reported and acted on.

The home had safeguarding and whistleblowing procedures in place. Staff were able to demonstrate they were aware of reporting concerns to reduce the risk of harm to people.

Robust recruitment and selection processes were in place, which minimised the risk of people being supported by unsuitable staff.

Is the service effective?

Requires Improvement

This service was not always effective.

Staff did not always receive effective monitoring during their induction. Records did not demonstrate that staff had received the required training to enable them to do their job effectively.

The home was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The decision making process for people who did not have the capacity to make certain decisions was not evidenced within their care records.

People were provided with a choice of nutritious food and were able to have an alternative if they did not like what was on the menu. People who were at risk of poor nutrition were assessed using a screening tool. Those people at risk of dehydration were not sufficiently monitored and supported to drink, to ensure adequate intake.

Is the service caring?

Good

This service was caring.

Staff were aware of people's needs and spoke about people with respect and sensitivity.

Staff involved people in interactions, promoted conversation and were concerned about individual's welfare.

Staff spoke to people in a friendly, polite manner. They were attentive and promoted people's privacy and dignity.

Is the service responsive?

Requires Improvement

This service was not always responsive.

Those people at risk of pressure ulceration were not consistently supported to ensure healthy skin.

Summary of findings

Care plans had not been updated as people's need changed. Some updated information had been written in the evaluation section of the care plan, which was not highly visible. This increased the risk of staff not having the information to meet people's needs.

People, their relatives and staff were aware of how to report concerns. Information about concerns and complaints was not captured so that it could be used to improve the service.

Is the service well-led?

Requires Improvement 

The service was not always well-led.

The home's recording did not enable an overview of systems such as staff training and supervision. It was not clear when staff had undertaken their training or if refresher training had taken place. The home's supervision policy was not being implemented in terms of each staff discipline and frequency.

Senior managers visited the home to monitor the service but no records were maintained. This meant it was not clear what issues had been raised or whether any areas required attention.

Systems were in place to monitor the quality of the service. However, not all shortfalls were being identified and action plans were not consistently being developed or followed through.

Cedar Park Nursing Home

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.

This unannounced inspection took place on the 12, 14 and 17 November 2014 and 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.

We spoke with 16 of the 50 people living at Cedar Park and 7 visiting relatives about their views on the quality of the care and support being provided. We also spoke with an operational director, the operations manager, the manager, 2 nurses, 7 carers, the chef, the activities co-ordinator and the administrator. We looked at 8 people's care records and documentation in relation to the management of the home. This included staff supervision, training and recruitment records, quality auditing processes and policies and procedures. We looked around the premises, observed care practices and the administration of medicines.

Before the inspection, the provider completed 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 also looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification.

Requires Improvement

Is the service safe?

Our findings

Assessments were in place to identify some risks to people's safety such as pressure ulceration, malnutrition and falling. Other risks to people were not always identified. For example, staff told us one person was being nursed in bed, as they were unsafe sitting in a chair. Whilst the person's care plan made reference to this, the most recent risk assessment referred to the assistance the person required before their needs had changed. Two further risk assessments of other people showed similar out of date information. Both assessments made reference to when each person was able to sit in a chair. Staff confirmed that one person was now too unwell and was nursed in bed, whilst the other person used to slip out of their chair. The assessments did not identify these risks or explain the impact they had on each person's care. Another care plan stated that the person was on a normal diet but sometimes preferred to eat a soft diet. Staff told us this person received a modified diet only. This conflict of information within the care plans, did not ensure an accurate reflection of people's needs, which increased the risk of inappropriate or unsafe care.

People told us they felt safe living at Cedar Park. The home's annual survey confirmed this with 88% of people saying they always felt safe in the home. 8% of people said they usually felt safe, whilst 4% said they rarely felt safe.

One person told us they felt safe because there were caring staff around them. Another person said they felt safe, as there were sufficient staff who were available when they wanted them. One person commented "I leave my door open and no one ever comes in. When I buzz for staff they come quite quickly, staff are very helpful and kind they treat me with dignity and respect". Another person told us "I'm very happy. The carers all wave to me when they pass my room and they come in and chat."

Not all people had their call bell within easy reach. One person told us they shouted to gain staff assistance. They said this generally worked. A staff member confirmed the person should have had a call bell and they would look into it. Two people asked us to gain staff assistance for them. One person felt unwell but had not used their call bell to inform staff. They did not explain why this was so. The other person was in the lounge and needed to use the bathroom. The five people in the lounge did not have access to a call bell. When asked how they summoned help, one person said "you have to get a woman to go to the office for you." Care records did not detail how people unable to use their call bell were supported to remain safe. A member of staff told us they regularly checked on people and knew those who needed more monitoring, in particular those who needed prompting or assistance to drink.

Care plans did not detail how individuals were to be supported if they became upset or distressed. We saw that one person had episodes of shouting loudly and another person could become tearful. Staff gave clear ways of using positive distraction and de-escalation techniques to support these people. However, their care plans did not identify potential triggers or what should be avoided to prevent such reactions. Three personnel files showed that the staff had received training specific to behaviour psychological symptoms of dementia. Two other staff had received training to support them with depression and behaviour techniques. The training matrix showed only 19 staff out of 53 had received training in dementia awareness this year and 13 staff had received training in managing challenging behaviour. This meant that the majority of staff had not received this training, which increased the risk of inappropriate care.

Visitors were equally positive about the safety of their relative. One visitor told us "at this home, I can go away and feel that mum is safe." Other comments about people's safety were "I have no worries, no qualms at all. They do a fantastic job" and "I have no worries about mum's safety. It's clean, the staff are good and mum's happy so I couldn't ask for more."

Staff told us they would immediately report any poor practice or abuse they suspected or witnessed, to the senior nurse on duty or the manager. They said they would have no hesitation in doing this and felt confident any issues would be addressed appropriately. A registered nurse told us they would inform the manager or senior management of any such issue, so that a safeguarding alert could be made if required. They said staff were very good at noticing specific issues such as bruising and reporting it to them. One member of staff was clearly able to explain the different types of abuse to us. Staff told us they had received training in safeguarding adults. Records showed

Requires Improvement

Is the service safe?

that nine staff had completed this training in March 2014. The training matrix however, sent to us after our inspection, showed that 38 out of 53 members of staff had not received training in safeguarding this year.

The provider had policies in place for safeguarding and whistleblowing, which were available to staff. Records showed when safeguarding alerts had been made. These were appropriate although one record showed that a community psychiatric nurse was consulted for advice and they advised that the safeguarding team was alerted. The manager told us the allegation was currently being investigated and the person had received a visit from the safeguarding team.

Staffing levels were determined according to the number and needs of people. Senior managers, the manager and staff told us that the home was divided into different zones and staff were deployed to each zone. This enabled sufficient deployment of staff to all areas and greater consistency of care. Staff told us the numbers of staff on duty were sufficient to meet people's needs. They said and records showed that in the Georgian wing there were six carers and a registered nurse on duty during the day. In the Orchard wing, there were four carers and a registered nurse. Throughout our inspection, there was a clear staff presence and any call bells were answered in a timely manner.

Overall, we received positive feedback about the number of staff on duty. One person told us "I'm lucky, as I don't need much help but I know they'd be there if I needed them." A member of staff told us "we're a good team and we work together brilliantly". Another staff member said "there are certainly enough of us here, as we work together. Many of us have been here a long time so we know people. It works well." A visitor told us "there are always staff around and they always 'pop' in to make sure mum is alright." Another visitor however, told us that sometimes their relative's preference of when they got up was restricted, as the staff had so many other people to assist. They said this often caused delays and meant the whole morning routine would then run late.

Records and procedures for the administration of medicines were in place and being followed. Nurses administered people's medicines in a safe and organised manner. The timing of the administrations meant that people were not disturbed whilst they were eating. A nurse told us people did not store or administer their medicines independently although they could if they were safe to do so. The nurse told us a competence and safety assessment would be undertaken if a person wanted to manage their own medicines.

All administration records were signed appropriately to demonstrate the medicines people had taken and those which had been declined or not required. Some medicines had been prescribed on an "as required" basis. These medicines were identified in people's care plans although there was not clear guidance for staff in terms of when it should be given. A nurse told us they had recently completed training in medicine administration. Staff files of two nurses demonstrated this. The staff training matrix identified three registered nurses had undertaken training in 'medicines in the elderly' and a medicines update, this year.

There were robust recruitment and selection processes in place. This minimised the risk of people being supported by unsuitable staff. Six personnel files demonstrated that appropriate checks had been carried out before new members of staff started work with people. The files contained relevant information showing how the manager had come to the decision to employ each member of staff. There was appropriate paperwork in place for those staff who lived outside of the United Kingdom. Two new staff had a probation summary in place. The manager told us this would be reviewed at the end of their three month probation. This enhanced people's safety as new staff were assessed as suitable before being able to continue.

Requires Improvement

Is the service effective?

Our findings

Staff did not always receive effective monitoring during their induction. Records showed that two recently appointed staff had completed an induction programme when they began employment at the home. This included watching DVDs and completing questionnaires in various topics. However, the questionnaires were not marked so it was not clear if the members of staff had reached a satisfactory level of learning. In addition, the lack of marking did not enable any shortfalls in knowledge to be identified, so there was a risk that poor practice would go unnoticed. Two staff told us they were able to work with more experienced staff when they started employment at the home. They said they were well supported and could readily ask if there was anything they needed to know. One member of staff said the shadowing process within their induction process was useful, as it enabled them to get to know the people they were supporting.

A mixture of classroom, DVD and questionnaire style learning methods were used to facilitate on going staff training. A number of questionnaires used for training purposes, were located on staff member's files. As with the questionnaires used for induction, not all were marked. The lack of analysis did not demonstrate the training had been effective and had increased the member of staff's knowledge.

The training information we saw during our inspection was difficult to follow and did not provide an overview of the training staff had undertaken. The records showed a series of dates for training and refresher courses. However, the dates did not follow. For example, one person had completed safeguarding training on 31/03/14 but their refresher training was identified for March 14. The record showed another staff member had completed abuse, manual handling, dementia care dementia, safe working practice, health and safety, challenging behaviour and food hygiene training, all on one day. As the record was not clear, we asked the manager to send us further information to add clarity. The manager sent us a range of information about staff training in a timely manner. However, the records did not correspond to the previous list we had been given. The record showed that 38 out of the 53 staff had not received up to date training this year in safeguarding people or the Mental Capacity Act 2005. Seven registered nurses had not undertaken up to date manual handling refresher training.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had sufficient training available to them and were well supported in their role. They said there was good communication within the team and they were kept up to date with any issues. Records showed a mixture of individual and group staff supervision sessions took place. These forums enabled staff to meet with their supervisors to discuss any issues with care provision or their training and development. The group supervision was held with attendees of both senior and care staff. We asked how staff learnt from these sessions when there was such diversity in knowledge and experience. An operations director told us that the diversity was used as an advantage and enhanced staff's learning experience. Staff were unable to confirm if there was a set arrangement with how often group supervision sessions were arranged. The supervision matrix showed that some staff had received different amounts of individual and group supervision than others. It was not clear, why this was. The staff supervision policy stated that group supervision would be conducted with each staff discipline/department every two months. Records of supervision sessions did not evidence this part of the policy was being followed. It was also stated within a quality audit, that supervision with the kitchen staff and housekeepers was behind schedule.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are an amendment to the Mental Capacity Act 2005, which allow the use of restraint or restrictions but only if they are in the person's best interest. Staff were aware of encouraging people to be involved with making day to day choices and decisions. This included people choosing what they wanted to eat, where they wanted to spend their time and what clothes they wanted to wear. There was evidence that the legislation had been taken in to account for some people who did not have the capacity to make certain decisions. This included the decisions to initially to move into Cedar Park and to have a flu injection. However, assistance with all daily living tasks had been grouped into

Is the service effective?

one decision making process. There was no evidence that specific parts of the person's care had been considered, in terms of their capacity and the ability to make such decisions. For example, there were a high number of people who were being nursed in bed. The reasons for people being in bed and information about who had been involved in this decision were not stipulated within care records. One visitor told us their relative used to like going to the lounge but staff had not taken her there for a while. The visitor said that she had asked staff why this was and was told it was because her mother's had a sore bottom. The visitor continued to say "they were worried it would make her soreness worse. They won't even take her for just an hour which is a shame, because she really used to enjoy it. Now all she does is lie here, in bed." The visitor was concerned that due to this, her relative received reduced stimulation and interaction with others.

In Orchard wing, the list which identified people's preferences for their lunch time meal showed that ten people had a modified diet. A member of staff confirmed this was accurate. We looked at three of these people's care plans and saw that there was no reference to the modification or who had been involved in the decision making process.

People spoke positively about the care and support they received. Four people told us they were able to make choices about their care and independence. One person said 'I'm a very independent person, I always have been and I can be here too.' Another person said 'I like my room door open at night, I don't want it closed and they always do that for me.' A visitor told us that their relative was able to choose what they wanted to do. They said "sometimes she just doesn't feel up to getting up and she can stay in bed then." The person added "normally, I get out and sit in my chair for a bit in the morning and the afternoon, but I need a rest in the middle of the day. The staff are lovely and they come and help me get in and out and settle me comfortably."

Visitors were also positive about the care their relative received. One visitor said "X has improved since being here. They know X well and have learnt how to manage frustrations, which X can display". Another visitor said "I can't fault the care here. You won't find anything better. The staff really care about people. It's more like a family than a home."

Drinks were served mid-morning, mid-afternoon and at mealtimes but not all people had a drink in front of them, which they could access or be assisted to have, when they chose. Records showed that some people did not have enough to drink. Care plans did not state how staff should encourage these people to drink more to enhance their wellbeing. Staff told us some people had their fluids thickened with a supplement to minimise the risk of choking. Two care plans lacked detail in relation to this specific need. This did not ensure people were supported safely.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 9(3)(b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were provided with a choice of nutritious food. The chef told us there was a winter and summer menu based on people's preferences. They said they welcomed feedback about the meals provided and whilst the menus were in place, they were flexible according to people's views and the produce available. The chef told us as far as possible, all food was cooked from scratch. They said they catered for particular diets related to people's health and cultural needs and tried to accommodate individual wishes.

People generally told us they liked the food served at the home. They said they had a choice, usually of two dishes and the chef would make an alternative such as an omelette, if they did not like the choices. People told us they chose their meals in advance, the previous day. They said they had sufficient food and it was well cooked. One person said "the food's good but there are some things like the sausages, I don't like but that's me, you can't please everyone, all of the time." Another person said "on the whole, it's very good. There's always too much but I can leave what I don't want."

The lunch time meal was served from a heated trolley and in accordance with people's preferences and appetite size. The meal on the first day of our inspection was roast lamb or sausages with potatoes and vegetables. There was sufficient food available and people were given encouragement and assistance to eat, depending on their need. One person however, within Orchard wing, had their lunch placed on a tray in front of them. After about ten minutes, the person had not eaten their food. A staff

Requires Improvement

Is the service effective?

member said “oh [person’s name], shall I help you?” They sat down and put a fork of food to the person’s mouth but the person turned their head away. The staff member did not give any further encouragement and went out of the room. They returned after five minutes and removed the person’s uneaten food without discussion. The person’s relative told us that they felt staff did not always encourage her mother to eat or drink. They said “if mum refuses, they take the food away.” The relative believed this was generally because the staff were overworked although they did things to the best of their ability. The relative told us their mother was prescribed food supplement drinks but they did not like a particular flavour. They said they had told the staff this but there continued to be bottles of this flavoured drink in the person’s room. The relative said there were also often jugs of juice in the room, but the person only liked to drink water or tea. These issues did not promote the person’s intake which presented a risk to their wellbeing.

The operations manager told us people had regular access to health care professionals dependent on their need. This included a review by the continuing health care team, to ensure people’s health and personal care needs continued to be met. Staff told us a GP visited the home on a Wednesday to monitor people’s health and to review their medicines. Staff said this ensured continuity and enabled any issues to be identified and treated at an early stage. Whilst a GP visited weekly, staff told us other visits would be undertaken as required. Staff told us people received good support from the GP surgeries which were used. One registered nurse described an occasion when they prompted a GP to prescribe a particular treatment for a person. Another registered nurse gave us a clear update of two people’s changing health care needs and their planned medical reviews. Records showed people had access to regular intervention from health care professionals.

Good

Is the service caring?

Our findings

People spoke positively about the care and support they received. One person told us "they are so lovely. They make me feel better with what they do." Another person said "they know what I'm like. We have a laugh and a joke." One staff member assisted us to communicate with a person, as they had very poor hearing. The person told us "all staff are very good and this one [looking directly at the staff member] is the best".

Visitors spoke positively about the care and support their relative received. One visitor said their relative was always treated with respect and staff were very polite and gentle with her. Another visitor said 'the staff here are marvellous, they really care. They're [people] not treated like residents, they're family.' Three relatives told us they felt welcomed and could visit whenever they wanted to. One relative said "we can come and go at all hours".

Staff were friendly and caring in the way they spoke to people. They addressed people by their preferred name and asked about their wellbeing. Staff were attentive to people's answers and talked further to gain additional detail or to promote general conversation. Staff noted that one person appeared sleepy and not their usual self. They tried to find out what was wrong in a sensitive manner and asked the person if they wanted to return to their room to rest.

Staff involved people in interactions and offered choices. Staff assisted one person to move from their wheelchair to an armchair using the hoist. They informed the person what was happening and gave reassurance throughout. Another staff member assisted a person to eat. They were attentive and asked the person what they wanted next. The member of staff acknowledged the person's painted finger nails and talked about the music that was quietly playing in the background. This led to wider discussions about singers of different eras. Staff encouraged people to make choices by asking people where they wanted to sit, where they wanted to eat, whether they wanted their television on or their bedroom door opened or closed.

People told us their privacy and dignity was respected. One person told us "they always knock on my door and call out before entering, they don't just barge in." Another person said "they're very sensitive when they help you. With the shower, it's usually the same staff so you know them and they know you. That makes it easier, as you don't feel so conscious."

Staff confidently described how they promoted people's privacy and dignity. This included knocking on doors before entering, drawing curtains and making sure people were appropriately covered during the provision of personal care. One member of staff told us they treated people "as they wanted to be treated". Another member of staff told us they thought that promoting privacy and dignity was something the staff did well.

Staff undertook all personal care in private and consistently knocked on bedroom doors before entering. Screens were used to enable staff to discreetly move a person using the hoist in the lounge without observation from others. A visitor told us "staff are very good at promoting privacy and dignity. They'll ask us to leave the room if they're providing personal care. They talk to people properly and really care about them".

Whilst privacy and dignity was promoted, some people shared a room with another person. There were six shared rooms in the home. The decision to do this and the impact of sharing a room was not detailed within people's care planning information.

Staff were knowledgeable about the people they supported. They spoke about people with respect and sensitivity. One member of staff told us they had worked at the home for many years but still found people's deterioration and the end of their life very difficult due to the attachment, which had been established. Five staff told us in detail about people's preferences and the support they required. One member of staff told us about a person who could answer specific questions although what they said may not be what they meant. The member of staff said it was important to check the information further to ensure it was accurate. Another member of staff told us how they gauged a person was enjoying the television by the way they were interacting.

A registered nurse told us they appreciated having a good staff team who really cared about the people they supported. They said "without good carers you're at zero without a chance. They are my eyes and I need to count on them to monitor and raise issues. Luckily I can do this, they're really good".

Good

Is the service caring?

Care plans contained information about what was important to people. There was some information about people's wishes, such as daily routines and what people liked to wear. People had documentation about their life history including family and previous occupations. Care plans were signed by the person or their family representative, as an accurate reflection of need and the support required. However, any changes in the plan did not show the person or their representative's involvement or consent. One visitor told us they had been invited to their relative's review to discuss whether the care provided, continued to be suitable. The operations manager told us each person's placing authority also completed regular reviews to which people's relatives were invited to attend. The surveys, which were returned as part of the home's quality assurance system showed that 46% of people said they were always involved in reviews about their care. 50% said they were usually involved.

Requires Improvement

Is the service responsive?

Our findings

Staff told us about some people's individualised care. This included treatment for an infection, a person's deterioration and mouth care and pain control, for a person at the end stages of their life. One person received their nutrition via a Percutaneous endoscopic gastrostomy (PEG) feeding tube as they were unable to maintain adequate nutrition with oral intake. Staff were knowledgeable about this procedure and managed it in a discreet manner. However, whilst these care issues were positive, not all people received care in response to their needs. For example, staff told us some people were given assistance to change their position on a one to two or three to four hourly basis. This was to minimise their risk of developing pressure ulceration and was detailed in their care plan. However, these people remained in the same position for the majority of the first and second day of our inspection. Care charts did not consistently show people had been given assistance to change their position at the required intervals. One record showed a person had been repositioned to sit up at 15:00 but it was only 14:47 when we looked at the record. At 14.25 on the second day of our inspection, a record stated that the person's last positional change was at 09.00am. This indicated that the person had remained in the same position for nearly five and a half hours. Their care plan stated that they required two to three hour positional changes. Another record showed a person had been turned from their back to their left side and their left side to their right side. However, staff told us that due to their condition, the person was tilted to relieve pressure rather than their position being changed completely.

Care plans did not consistently show people's needs and how they were to be met. Care plans had also not been updated to show people's daily routine choices during the day and night, when their wellbeing had changed. Where people were unable to voice their daily preferences, there was no confirmation of who had been involved in the decisions made. One visitor told us their relative was now cared for in bed as they had been unwell. They said they had not been involved in this decision and there was no record to demonstrate how it had been made. This showed that where people were unable to express their wishes, relatives were not always included in alternative care decisions.

Staff told us about one person and their ethnicity and how their deterioration in health had impacted upon their ability to express or meet their cultural and spiritual needs. The person's ethnicity did not flow through the content of their care plan and key factors such as whether the person spoke English or their native language, were not stated. Another care plan indicated the person had a catheter and required support with this. Staff told us the person's catheter had been removed. The care plan had not been updated.

The evaluation section of the care plans showed monthly reviews had been undertaken. However, the information generally stated "remains the same" or "goal maintained". Within a care plan about a person's vision who was registered blind, the evaluation stated "No change in his vision". There was no evaluation about the support the person needed in terms of their sight or whether this remained appropriate. Some updated information about people's care had been included in the evaluation section of the care plan. It had not been updated on the initial care plan. This increased the risk of staff missing information and therefore not being responsive to people's needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 9(3)(b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to using the service, people's health and social care needs were assessed to ensure the service was suitable and could meet their needs. This assessment consisted of discussions with the person and their relative in their own or hospital environment. Discussions were also held with interested health care professionals such as the GP or hospital staff. The manager told us any specialised equipment would be sourced before the person was admitted to the home. They said in addition to assessing the person's individual needs, consideration would be given to other people within the home. For example, if there were a high number of people receiving end of life care, the admission of another person with high dependency needs may be delayed. This would ensure staffing and dependency levels were compatible, enabling individual needs to be met.

People told us staff were responsive to their needs. One person said "all the staff are good. They know I'm deaf and they speak clearly in my ear and give me time to answer.

Requires Improvement

Is the service responsive?

They repeat things if I haven't got it. They're wonderful." Another person said "they know I want to be as independent as I can, so they always ask if they can help but let me get on with it if I say I'll be alright." On the second day of inspection, it was a person's birthday. Staff took a cake and sang "Happy Birthday" to them. The person was pleased with the gesture and said "I'm so happy, I feel all teary". They were not able to physically blow out the candles but staff said "make a wish and we'll do it for you." Staff had assisted one person to be smartly dressed, as they were going out for a family celebration. Staff told the person how handsome they looked and gathered together to wish them well, as they left.

One person told us they were able to join in with a wide range of social activities provided. They said they also spent time with their friends [other people using the service] in the lounge at teatime, trying to answer the questions of quiz programmes on the television. This person said they were asked for suggestions for activities and these were included in the overall activities programme. The person showed us an activities planner and a newsletter, which they said people were given to keep them informed of what was going on in the home. A member of staff told us "we ensure activities are centred on people's preferences, as what would be the point? Nobody would join in and it would be a waste of time." The staff member showed an awareness of people's past history and hobbies. They also showed an appreciation that people may have frustrations caused by their frailty and said "due to this, we try to work with people as they are today, rather than look too much into the past." There were a number of photographs displayed on a notice board in the entrance hall, showing activities people had been participated in.

People and their relatives told us they would raise any concern they had with the staff on duty. One visitor told us "you won't find any faults here so there's nothing to complain about. They're always asking if everything is alright." One person told us they sometimes "grumbled" about the food if they did not fancy what they were eating. The person told us staff often joked with them and said "are you moaning again?" The person said they did not mind this and would ensure their concerns were taken seriously if it was something more serious.

Staff told us that 'resident and relatives' meetings were held every few months. Records of the meetings showed good attendance and a range of interaction and the sharing of views. Some concerns were raised and discussed. However, there was no follow up discussion at the next meeting to show such areas had been resolved or improved upon. It was not possible to see what had been learnt in relation to the concerns, which had been raised.

Staff told us they would speak to the nurse in charge or the manager if they had any concerns about the care and support people were receiving. Staff said there was an "open door" policy so they felt confident they could raise any concerns, as they arose. There was a complaints file in the manager's office. No complaints had been recorded since October 2013. This was despite issues being raised in other forums, such as meetings. There were three documented complaints in 2013 which all related to clinical care. Letters showed the complaints had been acknowledged in a timely manner. The complainant had been informed that their complaint would be taken seriously. However, the investigation did not evidence what had been found or whether the complaint had been upheld or not. This did not enable complaints to be used as a learning experience or to develop or improve the service in response to concerning information. An operations director told us any concerns raised would be recorded on the person's individual care records. They confirmed this did not give an overview of the concerns raised and would address this accordingly.

Requires Improvement

Is the service well-led?

Our findings

The home had recently appointed a new manager who was responsible for the day to day operation of the home. They were in the process of applying to become the registered manager of Cedar Park. The manager had been in the home for three days when we started our inspection. They told us they were aware of the home due to working within the organisation for many years but were beginning to learn about people's needs. The manager told us they were aiming to ensure the home provided good quality, safe care, which would be compliant with the requirements of the Care Quality Commission. Another member of staff confirmed the ethos of the home was to "keep people safe and be looked after and to thrive." They said that all staff knew their roles well and these were brought together to achieve the home's overall aim. The manager confirmed they had not identified any initial challenges and were positive about the staff team. In addition, they were looking to build on existing systems rather than changing what was already in place.

The manager told us they had received support in their new role from senior managers and could contact them at any time, as required. The manager said they were aware of their responsibilities and had been informed of senior manager's expectations of their performance. A staff member told us the operation manager and director visited them informally to discuss and monitor service delivery. However, no minutes of these meetings were maintained so it was not clear what the findings and any action points decided upon were. This conflicted with the home's quality assurance policy which stated compliance would be monitored through monthly visits to the home by senior managers. The policy also stated that the manager would action the findings of the Regulation 26 report.

The manager said there were regular manager's meetings to discuss issues and experiences and to transfer good practices across the organisation's services. On the first day of our inspection, the manager had been at a manager's meeting but left to take part in our inspection. The manager said they attended forums, undertook training and read various articles to keep themselves up to date with current practice.

The manager, although being in the home for only three days at the start of our inspection, showed they had an understanding of people's needs. On a tour of the accommodation, people recognised the manager and her role. The manager told us they tried to speak with people every day in order to identify any issues and to monitor staff practice.

Throughout our inspection, the atmosphere of the home was calm, friendly and relaxed. Staff were welcoming, regularly engaging in conversation with people and were not rushed in any of their interventions or tasks they had to complete.

Staff told us that communication within the team was good. They said there were three handovers a day to discuss issues and people's wellbeing, so they were fully informed and kept up to date. One member of staff said they had staff meetings but they usually involved the staff who were on duty at that particular time. Another staff member said that staff meetings took the form of supervision, so there would be no staff meeting minutes on file. An operations director told us that this was because group supervision sessions were held instead and were found to be positive. There was little evidence of formal agendas for these meetings and how all staff were informed of the information they needed to know. There were no action plans in relation to pertinent issues. This did not enable monitoring and development of practice.

On the first day of our inspection, the manager told us a group supervision session had been organised for later in the day. This was to discuss the registration requirements for the home and the recent changes in regulation, so that staff were up to date.

The provider had systems in place to monitor the quality of the service. These included audits of systems such as care planning, medicine management and infection control. Whilst the audits had taken place, some questions within the audits were consistently ticked without evidence of any depth to the investigation. For example, those care plans we looked at which contained shortfalls had recently been audited by staff. The audit had failed to identify and address where changes to the person's care plan were required. This included ensuring assessments accurately reflected the person's current situation and preferred choices and concerns were being recorded and addressed in the care plan. With those care plans which had been ticked as partly compliant, comments to describe the

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shortfalls were not stipulated. Similarly a health and safety checklist showed staff were receiving adequate training and accurate records were being maintained. From the training records we saw, this was not completely accurate.

Within other audits such as medicines, where shortfalls had been identified, action plans were not always in place. This did not demonstrate how, when or who would address the issues identified. The action plans which had been identified were not always specific or re-visited to ensure the work required had been undertaken.

There was a document which totalled how many infections, pressure ulcerations, accidents and incidents had occurred each month. The record did not give specific detail and there was no analysis or action plans in order to respond to issues or trends. It was not clear how staff learnt from particular issues or what measures were put in place to prevent re-occurrences.

An overview of systems such as staff training was difficult to follow. Training information was conflicting and did not give an accurate portrayal of staff's individual training needs or the training they had undertaken. The staff training and development policy was dated as last being reviewed in July 2012. The policy detailed that staff were to undertake 6 monthly training in certain subjects such as food hygiene, first aid, moving and handling and dementia. Abuse training was to be undertaken every three months or following an incident. These timescales were not evident within the staff training records.

Staff told us the maintenance of the home, its decoration and standard of cleanliness were good. A member of staff told us the home was currently not full, as a room was being kept to support people whilst their own room was being decorated. Work was also being undertaken in the dining room to replace the smoke detectors. Records showed that equipment such as the passenger lift and mobile hoists were regularly serviced to ensure they remained in good working order. Portable electrical appliances had been tested so they were safe to use and external contractors had serviced the fire alarm systems as required.

The quality assurance policy stated that quality surveys would be conducted every three months to cover all aspects of the National Minimum Standards. This was out of date and staff told us surveys were sent to people and/or their relatives annually in order to gain feedback about the service. An operations director told us the results of the surveys had only just been coordinated to be used for our inspection. They said a meeting was in the process of being scheduled with the manager to discuss the feedback and to devise action plans. Due to the timescales involved, this had not as yet taken place. The received feedback had been coordinated into pie chart style diagrams to visually show the results. Positive comments from people had been recorded although more negative comments were not stipulated. This was despite percentages showing some less than satisfactory feedback. It was therefore not possible to gain more detail into people's concerns. The operations director told us this would be addressed during the forthcoming action plan meeting.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Planning and delivery of care was not always done in such a way to meet people's individual needs and ensure their safety and welfare. Care plans had not been updated as people's needs changed. This meant that up to date information about people's care and support was not always available.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Staff did not always receive effective induction, training and supervision. Questionnaires used as part of staff's induction and training had not been marked so any shortfalls in knowledge were not being identified. Group supervision was taking place but there was no system to ensure each member of staff was being formally supported in line with the home's supervision policy.