Cornwall Care Limited

Cedar Grange

Inspection report

Cross Lanes
Lanstephan
Launceston
Cornwall
PL15 8FB

Tel: 01566773049
Website: www.cornwallcare.org

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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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 14 and 17 March 2017 and was unannounced.

Cedar Grange provides care for up to 60 elderly people who require support due to old age, dementia, mental disorder, and physical disability. The home also provides nursing care. The building is split into four units or suites as they are known, each accommodating up to 15 people.

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

People's safety was not always protected. We identified issues in the recording and management of risks to some people. People who were vulnerable due to not being physically mobile, were not protected against the risk of other people entering their bedrooms and engaging in activities which were harmful. People did not always have call bells within reach and the stairgates intended to provide a barrier to people accessing bedrooms could be opened by some people living at the home.

People had risk assessments in their records, however these were not always reflective of the care being provided. There was an inconsistent approach to the recording of people's resuscitation wishes, meaning that their treatment may not be provided in the way they wished, or might be delayed in the event of an emergency.

People's medicines were not always managed safely. We found a range of errors on people's medicines administration records (MAR). These had not been recorded on the computerised system as required. Although medicines audits were taking place, the frequency of these had been reduced from weekly to monthly, meaning that some incidents were not quickly identified. We found an excess of some medicines, expired medicines and medicines which had been opened without having the date of opening recorded.

Some people were prescribed medicine covertly; this means it was crushed in their drink or food. We saw that this had been agreed in consultation with the person's doctor and this agreement was kept in their records. However, we saw little evidence of best interest processes to consider less restrictive alternatives to this practice. In addition, we saw that consent was not recorded appropriately in relation to people's medicines, with relatives signing to give consent without the correct legal authority to do so.

There were systems in place to monitor the quality of the service at Cedar Grange, however these systems had not identified the issues we found during the inspection in relation to the management of medicines or the administration of covert medicines. In addition, the issues with the recording of consent and resuscitation wishes had not been identified. This meant that these systems were not always fully effective.

People and their relatives told us the service was safe. Staff had undergone training in safeguarding adults and knew what action to take should they witness a person being mistreated, including which external agencies they should alert. People were supported by staff who had been safely recruited. For example, they had undergone checks prior to commencing their employment to ensure they were suitable to care for people who were vulnerable. Although we observed suitable levels of care staff during the inspection, we were told that nursing staff felt under pressure at times and were often interrupted during their nursing duties, including medication rounds. We saw an example of one person missing their medication because the medication rounds had taken too long, meaning their doses were too close together.

People and relatives told us the service was caring. Comments from relatives included; "The staff show they care, they are so tender" and "They get the best out of my mum." We observed kind and compassionate interactions between people and staff. People were treated with respect and their dignity and confidentiality were promoted by staff. People were encouraged to maintain relationships with people who mattered to them and there were no restrictions on visiting times.

The environment was spacious, bright and dementia friendly. For example, people's bedroom doors and corridors were decorated individually to help people orientate themselves. One room had been decorated as a vintage tea room where people could go to enjoy afternoon tea. Another room was called the "Cedar Arms" and had a pub feel, with games machines and a pool table. People were seen spending time in these rooms and appearing comfortable and content.

There was a programme of activities for people to participate in, both inside the home and in the community. The service employed three activities coordinators who were constantly looking for new activities for people to enjoy. There were regular visitors and entertainment which people told us they enjoyed. People were encouraged to remain active outside of Cedar Grange and to form links with other generations. The home was using assistive technology to increase people's independence and reduce risk.

Staff received a suitable induction which including shadowing more experienced staff members Staff were supported with an ongoing programme of supervision and an annual appraisal. Staff had received training in order to carry out their roles effectively and there was a system in place to remind them when it was due to be refreshed or renewed.

People had enough to eat and drink. People and their relatives told us the food was of sufficient quality and quantity and there were a range of alternatives to choose from. People who required assistance with eating were supported promptly by staff. The lunchtime experience was pleasant and sociable.

People had access to a range of health and social care professionals. People's health care needs were appropriately monitored at the service, for example, there was a structured approach to the care of diabetes and tissue viability. Where risks to people's health had been identified, these were well documented, monitored and linked to the person's care plan to guide staff on what action they needed to take to support the person.

People and their relatives told us they knew how to make a complaint and felt that issues raised would be dealt with to their satisfaction. There was a process in place for receiving and investigating complaints which was underpinned by an up to date policy. Any lessons learned from complaints were shared with staff and used to drive improvement within the service.

The provider undertook a range of audits to monitor the quality of the service and there was regular oversight and support from senior management. Feedback on the service was sought through a variety of

forums, such as staff meetings, relatives' meetings, comments cards and a regular cycle of quality assurance surveys. Feedback was used to raise standards within the service. Morale within the service was good and the individual characteristics of staff were recognised and celebrated by managers, for example through the staff awards ceremony. Staff had access to work related incentives such as a wellbeing scheme.

The service had a whistleblowing policy, which supported staff to question practice, defining how staff who raised concerns would be protected. Staff confirmed they felt able to raise concerns and felt confident the management would act on their concerns appropriately. The provider and registered manager promoted the ethos of honesty, learning from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The Duty of Candour is a legal obligation to act in an open and honest way in relation to care and treatment.

We found breaches of regulation. You can see what action we told the provider to take at the back of the full version of the report.

We are considering our actions in line with CQC's enforcement policy. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Some aspects of the service were not always safe.

People's medicines were not always managed safely. There were errors on medicines administrations charts (MAR), excess stock and expired stock.

Systems in place to investigate abuse or mistreatment were not always effective.

People's risks were not always effectively managed or documented.

People's safety was protected by staff who knew how to recognise and report signs of abuse or mistreatment.

People were supported by suitable staffing levels.

Is the service effective?

Requires Improvement

People's rights were not always protected. It was unclear whether best interest processes had been followed under the Mental Capacity Act (MCA) in relation to the administration of covert medicines.

People's consent was not always appropriately recorded

People were supported by staff who had undergone training in order to carry out their role effectively.

People's health was effectively monitored at the service.

People had enough to eat and drink and told us they enjoyed the meals.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and caring. Staff spoke about the people they were looking after positively and with fondness.

People were cared for by staff who knew them well.

People's confidential information was securely stored.

Is the service responsive?

Good

People had the opportunity to participate in a wide range of activities inside the home and in the community.

People's care records were comprehensive and personalised.

There was a system in place for receiving and investigating complaints.

People were supported to maintain relationships with people who mattered to them.

People were encouraged to forge links with the local community.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality audits were not always effective in ensuring the quality of the service.

The risks associated with the opening up of the units within the home had not been adequately addressed in some cases.

There was a clear drive towards continuous improvement.

Morale was good. Staff were happy in their role and knew what was expected of them.

Staff had the opportunity to discuss and reflect on practice.

Cedar Grange

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 inspection took place on 14 and 17 March 2017 and was unannounced.

The inspection was undertaken by one adult social care inspector and a specialist advisor (SPA) who had a background in nursing. On 14 March 2017 we were also joined by 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.

Cedar Grange is a purpose built home and provides care for up to 60 elderly people who need care by reason of old age, dementia, mental disorder, and physical disability. The home also provides nursing care. The building is comprised of four units or suites as they are known, each accommodating up to 15 people. Each unit has its own dining area, lounge and kitchen area. At the time of the inspection there were 55 people living at the service.

Before visiting the service we reviewed information we kept about the service such as previous inspection reports and notifications of incidents. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern. 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.

During the inspection we spoke with 12 people who used the service and observed others who could not communicate verbally. We spoke with seven relatives and obtained their feedback. We spoke with the assistant operations director, the registered manager and 14 members of staff. During the inspection we spoke with four external health and social care professionals who visited the service regularly. We inspected the premises and observed care practices during our visit. This included the lunchtime experience. We

looked at ten records which related to people's individual care. We also looked at ten staff files a range of audits, policies and procedures and other record related to the running of the service.

Requires Improvement

Is the service safe?

Our findings

At the previous focused inspection on 1 September 2015 we found that people were not always protected from the risk of harm as the service had not always acted appropriately to ensure people were safe. People who used the service were not protected due to unsafe systems and processes in place to investigate any allegation or evidence of abuse.

At this inspection we found that some improvements had been made. There was a new computerised system for recording incidents. Accidents and incidents were recorded electronically by each staff member as they occurred. These records were logged centrally; rated from one -three in terms of severity and they were responded to accordingly. The records were reviewed by senior management to look for themes or triggers and to reduce the likelihood of a reoccurrence. Alerts were made to the local safeguarding team and the Care Quality Commission (CQC) as required. Learning from experience meetings were also held to inform staff and to improve practice. For example, one person had developed a pressure sore and a meeting was convened to consider if things could have been done differently. Lessons learned had been shared with staff. Despite this, we found issued with the recording and monitoring of some medicines errors. Medication errors had been missed and therefore not logged on this system.

We found that people's medicines were not always managed safely. We saw that medicine administration records (MAR) were completed for people living at the service. We reviewed a sample of these records and found a number of errors and omissions. Medicines errors were recorded on the service's electronic incident recording system. We reviewed the medicines errors recorded on this system, however they did not include those identified at our inspection. There had been a reduction in the frequency of medication audits from weekly, to monthly. We were told that this was due to a reduction in errors, however, we identified a number of errors at the inspection. As the medicine changeover had happened before the audit was due, there was a risk these medicines errors would not be identified. This was highlighted to the nurse who expressed disappointment and said that the frequency of medication audits would need to be reviewed. We also noted that there was no clear action plan or follow up on the audits of issues that had been identified.

We found an excess stock of some medicines. We also found some expired bottles of medicines and other bottles of liquid medicines which did not indicate the date of opening, meaning that we could not be sure that they were still safe to use.

We spoke with three members of staff who expressed that medication rounds were often late and regularly interrupted due to staff having to respond to other duties. We witnessed that at least two medication morning rounds were only finished at 11:30am close to the next medication round and that on at least three occasions one person has not been given their paracetamol due to 'timing', meaning the previous dose was too close to the next dose. Therefore this person did not receive their prescribed pain relief.

We found some concerns relating to the management and recording of risk. The home consisted of four units. These units which had previously been separated by a locked door had been opened up, meaning that people could access different parts of the home freely. In addition people living on all four units were

mixed, meaning some were less mobile and potentially more vulnerable than others living around them. Whilst the opening of the units had increased people's freedom and independence in some cases, in others, it had exposed people to risk. One staff member told us; "Mixed units have altered things. It upsets the status quo and people shouting causes friction". The Care Quality Commission had been notified of incidents of people accessing each other's bedrooms and engaging in behaviours which were potentially harmful. This was particularly concerning where people were not independently mobile and could not always summon help from staff in an emergency. We observed that some people who were not able to mobilise without staff support did not always have a call bell within reach. The risk of people accessing each other's bedrooms was partly reduced by the presence of "stair gates" which were used as a barrier and were present on many people's bedroom doors. Whilst this provided some protection, we were advised by staff, that some people were able to open these gates. In addition, not all the bedrooms had these gates in place, meaning some people were not protected. This was highlighted to the registered manager during the inspection, who told us that they were looking at potential ways to reduce risks which might include some people moving to other areas of the home. This was to be discussed with people and families. In the meantime, we were assured that call balls would be within reach of those able to use them.

One person's care records contained a risk assessment which indicated they were at risk of harming themselves by wrapping ligatures around their neck. The risk assessment indicated that items such as leads such be kept out of reach. We visited this person in their room and found a call bell mat with a lead attached, within reach of the person. We highlighted this to the registered manager who told us that the risk was historical and that the care plan needed to be amended to reflect this. We noted however that it had been recently reviewed and staff had signed to say that it was still relevant. This meant that staff might not always have been providing this person with the correct support to meet their needs and keep them safe.

We had some concerns relating to the kettles which were on the worktop of each of the unit kitchens and accessible to people. We observed that there was not always a member of staff in the kitchens. Meaning that these potentially hazardous items were left unattended. This may have posed a risk to people who were unable to operate electrical appliances safely. For example, due to the risk of burning or electrocuting themselves, and to others, should a person become agitated and use the item as a weapon. This was highlighted to the registered manager and the kettles had been moved by the second day of our inspection.

We also found an inconsistent approach to the recording of people's wishes in relation to resuscitation. Some people had a do not resuscitate (DNR) form in their care records. In some cases, the DNR had been left blank, in others it had been completed and in others a line had been drawn through it saying that the person did wish to be resuscitated. This inconsistent approach could have led to uncertainty in the event of emergency resuscitation and may have placed people at risk of not receiving care and support in the way they wanted or required.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although there appeared to be enough care staff on duty to meet people's needs in an unhurried way throughout our inspection, staff, people and relatives commented that the service sometimes appeared short of staff. Some staff felt that the nurses appeared rushed and were often interrupted during their nursing duties, including medication rounds. Comments from relatives included; "I don't think they have enough staff at weekends" and "There's not usually enough staff when I am here visiting my relative." The service was actively recruiting staff at the time of the inspection. The registered manager told us about some of the difficulties they had experienced in recruiting and retaining staff.

People told us they felt safe living at Cedar Grange. Comments from people included; "I feel safe because I get on well with the staff" and "I feel safe because I can talk to the girls about anything".

Some people living at the service could become agitated and distressed. Staff had received training on managing this behaviour and there was guidance in people's care plans for staff on how to help them stay calm. For example, one person's care plan stated that if the person became agitated, staff should try using distraction, such as looking at old photographs, laying tables, folding napkins and talking to the person about their loved ones. Another person's record stated; "please ensure [person's name] has her bag with her at all times, being without it makes her anxious". Some people living at the service required the use of low level restraint techniques in order to keep themselves and staff safe whilst care was provided. Some staff had completed training in restraint and only those who were trained used the techniques.

People were protected by staff who knew how to recognise signs of possible abuse. Staff said reported signs of abuse would be taken seriously and investigated thoroughly. Staff had completed training in safeguarding adults and this was regularly updated. The training helped ensure staff were up to date with any changes in legislation and good practice guidelines. Detailed policies and procedures were in place in relation to abuse and whistleblowing. Staff knew who to contact externally if they thought concerns had not been dealt with appropriately within the service.

People were protected by safe and thorough recruitment practices. Records confirmed all employees underwent the necessary checks prior to commencing employment to confirm they were suitable to work with vulnerable people.

The service was visibly clean and free from adverse odours throughout and there were suitable levels of PPE (Personal Protective Equipment). Staff had received training in infection control and we observed good hand hygiene practices. Throughout the inspection, deep cleaning of certain areas was taking place.

Health and safety standards within the building were satisfactory. For example, the boiler and gas appliances had been tested to ensure they were safe to use. Equipment such as hoists had been tested and were satisfactory. There were regular fire drills and alarm tests. Environmental audits and maintenance plans helped ensure the environment was safe and fit for purpose. People had personal evacuation plans (PEEPS) in place, which detailed the level of support they would need to evacuate the building in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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. People had a mental capacity assessment within their care files. This detailed in what areas individuals had (or lacked) capacity. Where appropriate Deprivation of Liberty Safeguard (DoLs) applications had been submitted to the local authority. Staff had received training on the MCA.

Some people were prescribed medicines covertly. Covert medication means the administration of any medical treatment in disguised form. This usually involves adding medication to a person's food or drink. Where covert medication was prescribed, there was an agreement in the person's records by the person's doctor. However, we saw no evidence of a best interest process for these people, considering which less restrictive options were considered before medicines were given in this way. We reviewed the home's medication policy which read; "The decision to administer covertly must not be considered routine but rather as a contingency to an emergency and regular attempts are to me made to encourage a client to take medication in a usual manner". During the inspection, one person had become agitated. A member of staff administered some medicines covertly to help them to settle. Whilst this appeared to help the person, there was no evidence that they had first tried to offer this person the medicine and obtain their agreement, or that other options to help the person remain calm, such as distraction had been considered.

People's consent had not always been accurately recorded within their care records. We saw examples were a relative, without a Lasting Power of Attorney had signed to say they consented to elements of a person's care. Nobody can consent to an adult's care without a Lasting Power of Attorney (LPA). If there is no LPA, a documented best interest decision must be made in line with the principles of the MCA. This was explained to the provider who said that this would be addressed and care records and practices would be amended to reflect this.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did however observe staff seeking consent at other time during the day, prior to assisting people with everyday tasks. For example, asking; "Where are you going? Can I walk with you?" and "Can I take you into the lounge?"

People's health care needs were generally effectively monitored at the service. For example, some people who were at risk of developing pressure areas required regular re-positioning. We saw evidence that body maps and photographs were used to record pressure areas and to show progress. Turning charts were regularly completed and people were reviewed regularly to ensure their needs were being met. However, there were some inconsistencies in the completion of food and fluid charts by staff. Some records were completed well, whilst others contained gaps. We saw examples where the food and fluids charts were completed but lacked target intakes and summarising volumes at the end of the day. This meant it was not always possible to know if the person had taken enough fluid/food. This was highlighted to the nurse in charge who said it would be discussed with staff.

People were supported by staff who had received a range of training in order to meet their needs effectively and there was a system in place to remind them when it was due to be updated or refreshed. One staff member said; "There is always plenty of training on offer here". Staff had received training on subjects identified by the provider as being mandatory such as moving and handling, infection control and health and safety as well as training which was more specialised to their role, for example, dementia awareness and restraint. One person told us, "The staff here are spot on! They know what they are doing".

Staff who were new to the service received a thorough induction which including shadowing more experienced members of staff. Staff who were new to care underwent the Care Certificate. The Care Certificate is a nationally recognised set of standards for care staff. Staff were provided with on-going support in their role by face to face supervision sessions and an annual appraisal.

People's bedrooms were personalised with their own belongings, such as furniture, photographs and ornaments, to help them feel at home. Some people had chosen the colour and decoration of their bedroom door in order to help them orientate themselves. The environment was dementia friendly with areas painted in different colours to help people remember where they were. People's bedrooms had specialised lighting which would come on if they got out of bed at night, in order to help prevent falls.

We saw from people's care records that they had access to a range of health care professionals including GPs, speech and language therapists (SALT), district nurses, and chiropodists. On the day of the inspection a number of professionals such as a social worker and dementia liaison nurse were attending a best interest meeting at the service in relation to someone who's care needs had changed.

When people had known health needs or risks associated with their diet, plans were in place to support them and keep them safe. One person had been at risk of choking and a prompt referral had been made for a SALT assessment. Staff had identified that another person had gained weight. A risk assessment had been undertaken which indicated that they were at risk of developing health issues as a result. The person's weight was being carefully monitored and recorded each month. There was a clear care plan in place to assist them in losing weight. It contained guidance for staff, such as encouraging healthy snacks, and splitting their meal into two portions, as the person had dementia and would often forget they had eaten, and request another meal.

We observed the lunch time experience in three of the four lounges. People were supported by suitable staffing levels to assist them promptly if required. People were given plate guards and specialist cutlery if required to help maintain their independence whilst eating. The service was operating a trial of having the main meal in the evenings instead of at lunchtime. This pilot was being used across Cornwall Care services (The company that own Cedar Grange). The provider had decided to trial this change as it was felt that people may be more tired after a big meal at lunch time and would be more responsive after a lighter meal. There was also a query as to whether this might reduce falls. Most people and relatives we spoke with did

not support this change and some had raised complaints. This was being monitored by the registered manager. One person said; "The food is very good. I just prefer my main meal for lunch."

People told us they enjoyed the meals at Cedar Grange. One person said; "The food is wonderful". We observed that the food appeared varied, plentiful and appetising. There were a range of alternatives on offer. Comments from relatives included; "My wife is a vegetarian so they cater well for her" and "I've never heard my relative complain about the food, she has a good appetite."

People did not contribute to the menu plans, but they were able to request items if they wished. People's dietary needs were known by the cook and recorded in the kitchen. Some people had their food pureed. We observed the pureed meals to be well presented and resembling the food in its original form. Any changes to people's dietary needs were communicated with the kitchen staff

Good

Is the service caring?

Our findings

People and their relatives told us the service was caring. Comments from people included; "The staff are very caring" ; "The staff are always popping their head around the door to see how I am, even the cleaners pop in"; "They are always giving me a cuddle, they are wonderful"; "The staff are very caring, can't do enough for me" and "I love it here, you can't get more caring people."

Comments from relatives included; The staff here are second to none"; "The staff here are always smiling and friendly and everyone is well known to them" and "It's a pleasant, homely atmosphere." Relatives confirmed they were involved in care planning and in making decisions about people's care.

Staff were kind and committed to providing a caring service. Comments from staff members included; "To get that smile, that thank you when you have helped someone is the best part of the job"; "It's rewarding to know you have given the best care you can and you have made someone feel happier"; "I always know I can go home and think, I've done my best" and "If I've made them smile then I've done my job". One person told us that when her husband had been alive, he would always give her a hug in the morning when she woke up. A staff member had heard about this and now gave the person a hug in the mornings if they visited their room. The person told us this brought them a lot of comfort.

Staff were warm and cheerful and put people at ease. We observed staff singing to people and paying them compliments. One staff member noticed a person walking in the corridor and appearing lost. The staff member put their arm around the person supportively and asked; "What do you want? How about a cuddle? You always give lovely cuddles". This made the person smile. Another staff member was heard to say to a person; "Hello gorgeous! Don't you look lovely today? I do love this cardigan, it's so pretty".

Staff were attentive and noticed if people required support. One staff member was heard to say to a person, "Isn't it cold out today? Let me get you a hot drink to warm you up". All of the staff at Cedar Grange were kind to people, including administrative staff and maintenance staff. We observed the maintenance person help to orientate a person and to get them a hot drink. We also saw a person had pulled a chair up to the desk at reception and was sitting watching the administrator and was interested in what they were doing. The administrative staff spoke to this person kindly and respectfully and was telling them about their job and the task she was completing.

Staff knew the people they cared for well. They were able to tell us about their likes and dislikes, background and histories. Staff encouraged people to get to know each other and to share common interests. One staff member told us they knew two people living on separate units enjoyed painting. They introduced the people to each other and they enjoyed painting together. The staff member said they had also done this for two other people who enjoyed knitting. The staff member commented; "If people have common passions, why not share them".

The atmosphere in the home was pleasant and calm, people were engaged in a variety of activities and appeared content and relaxed. We observed several people coming to sit in the coffee bar and admiring the

views. A staff member had brought the rabbits inside and some people were seen enjoying holding them. Another person was walking in the enclosed garden and admiring the flowers.

People were made to feel special, valued and important. Special occasions were celebrated and relatives were involved. People had a cake on their birthday and were able to choose to do something special to mark the occasion. One staff member told us; "There are lots of ways we make people feel special. It's the small things like keeping them looking smart. Some people like a nice shave and wearing a tie. We try to keep them looking like they did at home". Another staff member said; "Some of the ladies love a bit of pampering and one to one. It's things like making sure they have their jewellery and a bit of make up if they choose".

People's independence was promoted wherever possible and they were encouraged to lead full and active lives. One person went out into the local town without staff support. This had been risk assessed and a missing person's protocol was in place to ensure the person remained safe whilst still enjoying their freedom and autonomy. One person had expressed a wish to have a holiday abroad and this was being explored and considered by staff. A staff member said; "It may be very nice here, but coming to live in residential care doesn't mean you should never have a holiday". Two rabbits had recently been purchased to live in the enclosed garden. People had been involved in helping to care for them and to clean their rabbit hutch. Staff told us they had really enjoyed this. People were also involved in gardening and tending to the flower beds. During our inspection, some people were being supported to bake biscuits in one of the unit kitchens.

We saw that in most cases people's privacy and dignity was promoted and respected. People's confidential information was securely stored in a locked office. We saw staff knocking on people's doors before entering. Staff said they promoted people's dignity by closing curtains and doors when providing personal care and allowing people space and privacy when they requested. However, we saw some aspects of the environment did not always promote people's privacy, dignity and independence. For example, there were incidents where people had accessed each other's bedrooms without consent. This did not promote their privacy or dignity.

Good

Is the service responsive?

Our findings

People's care records provided personalised information about their background, history, likes and dislikes. This helped staff to understand the person and to provide care and support to them in the way they preferred. Care plans were detailed and gave staff the correct level of detail required in order to meet people's needs. Care plans were regularly reviewed and where possible, people and their relatives were involved in developing the plans. People's records were well organised and easy to navigate.

People were given the opportunity to participate in a range of activities inside the home. There were three activity coordinators and the service had its own minibus to transport people to social events and appointments. There were regular days out to the beach, for pub lunches and to local places of interest. There had been a recent men's day out, where several male residents took a packed lunch and went to the RAF base to look at the aeroplanes. There was a suggestions board in the reception area where staff and people could put forward ideas for future days out. One person had been encouraged to pursue their hobby of painting. Materials were supplied by the service and the person was encouraged to display their work around the home. The person said; "I love doing my paintings and I have put some up in my room".

There had been a recent project at the service, celebrating 100 years of Winnie the Pooh. People had enjoyed honey sandwiches, and staff had taken poems and extracts from the book which people sat and read. This had been extremely popular with people and the photographs of the event displayed around the service reflected this. There was also regular entertainment at the service, such as singers, storytellers and musicians. On the day of our inspection a singer had visited the service and a large number of people were up singing and dancing and clearly enjoying themselves.

The service made use of assistive technology to enhance the lives of people living with dementia. For example, portable DVD players had been purchased which people were able to watch dementia friendly DVDs on. The service was working with Falmouth university, using technology to help prevent falls, several items had been ordered to trial in the home. A staff meeting had been scheduled for staff to undertake training on operating these items.

There was a hairdressing room and a pampering room where people could go to receive beauty treatments and massages. One person told us; "The hairdresser is coming in today, I love having my hair done". There was also a vintage tea room where people could enjoy afternoon tea and cakes. Another room had been decorated to create a "pub feel" this was called the Cedar Arms. The Cedar Arms had its own games machines, a pool table and a bar. Staff told us the room was used for film nights as well as parties and celebrations. There was also an enclosed garden with flower beds which people were seen to access. One relative told us; "My wife goes out in the garden with the activity coordinator and plants some flowers, she enjoys her gardening". One person commented; "In the summer I go out in the garden and have a glass of wine".

Staff were committed to forging links with the local community and to ensuring people remained active

outside Cedar Grange. One staff member told us, whenever they had errands to run, they would take people with them, for example, to the local supermarket. They would make this a sociable experience, stopping for coffee. Creating links with local schools and universities was promoted. Children had visited the service to sing and to perform their nativity play at Christmas. Staff would sometimes visit people on their day off and bring their own children, so they had the opportunity to enjoy the company of younger people. One staff member told us; "We have a good relationship with the local church. We go weekly to the church hall for bacon sandwiches, residents love it". Staff also brought their pets to the service. During the inspection, one staff member had dropped in on a day off, to show people their new puppy.

There was a thorough pre-admission process, which helped to ensure the service was the right place for people. The process involved visiting the person and undertaking a thorough assessment of their needs. There was a Cedar Grange welcome book which was available to people and their families considering using the service. The book showed what the bedrooms looked like as well as different areas of the home where they could either relax or keep busy. The book was intended to provide an insight into life at Cedar Grange and to help people settle in.

Management and staff recognised the importance of family and friends in people lives and there were no restrictions on visiting times. Throughout the inspection, we saw relatives visiting people and being made to feel welcome. They clearly had a positive rapport with staff members. Some visitors sat in the coffee bar area and staff were attentive to their needs, providing them with refreshments. We spoke with two relative whose parents had resided at the home. Both continued to regularly call in for a coffee and a chat and were made to feel welcome. One relative said; "The care extends to the family as well".

There was a system in place for receiving and investigating complaints. Relatives confirmed they knew how to make a complaint and felt any concerns raised would be dealt with to their satisfaction. We reviewed the service's complaints file and policy. We saw that any concerns raised had been investigated promptly and used to raise standards and drive improvements.

Requires Improvement

Is the service well-led?

Our findings

There were systems in place to monitor the quality of the service at Cedar Grange, however these systems had not identified the issues we found during the inspection in relation to the management of medicines or the administration of covert medicines. In addition, the issues with the recording of consent and resuscitation and risk management had not been identified. This meant that these systems were not fully effective. In addition, despite incidents which had occurred as a result of people accessing each other's bedrooms, the systems in place to mitigate the risks and reduce the likelihood of a reoccurrence were insufficient. For example, the stairgates used as a barrier to people's bedrooms had been opened by some people, and were not present on the doors of all people who were vulnerable.

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

Cedar Grange is owned by Cornwall Care Limited. Cornwall Care Limited runs a number of services within the county of Cornwall. There was a clearly defined management structure at the service and regular oversight and input from senior management. People and their relatives told us the service was well led and spoke highly of the registered manager. People, staff and relatives confirmed that the registered manager was approachable, visible within the service and led by example. Comments included; "My husband can go and report any worries I have to the manager, she's wonderful"; "A huge amount of effort goes into running this place" and "This place deserves my vote."

Staff told us they felt well supported by the managers at Cedar Grange, comments included; "The managers have always been really lovely to me" and "They have been flexible to my family commitments and treated me well". There were regular staff meetings which provided staff with an open forum to raise suggestions or discuss any concerns. One staff member said; "The staff meetings are good. That's the place to do it, if you want to discuss any ideas".

People were involved as much as possible in the running of their home. Residents' meetings were not always held due to the current needs of people. However, the service arranged relatives meetings and invited people living in the service to attend. The registered manager encouraged all staff to make time for people and talk and listen to people's concerns.

Feedback on the service was sought through a variety of forums. The registered manager operated a cycle of quality assurance surveys in order to gain feedback from people. The results of the most recent survey were positive. The registered manager used an independent visitor to carry out a regular audit of the service and there were comments cards located in the reception, inviting people, relatives and visitors to have their say. There was a clear drive towards continuous improvement and the registered manager was committed to trying new and innovative ways to enhance the quality of life of those living at the service. For example, working with Falmouth university to trial assistive technology to reduce falls and increase independence.

Morale at the service was good. Staff told us they were happy in their role, felt well supported by managers

and knew what was expected of them. There were a variety of incentives for staff members including access to a wellbeing scheme. Comments from staff included; "This is one of the nicest places I've worked for" and "when I drive up the hill I can see Cedar Grange and I think; I work there!" There was a staff awards ceremony which was used to recognise and celebrate the particular characteristics of staff members. Awards included; carer of the year, learner of the year and dementia champion of the year.

Staff were encouraged and supported to reflect on their practice and be clear about their role and responsibilities. Daily handover meetings took place to help ensure people were up to date with issues concerning people's care and daily support arrangements.

The service had an up to date whistleblowing policy, which supported staff to question practice. It clearly defined how staff that raised concerns would be protected. Staff confirmed they felt able to raise concerns and felt confident the management would act on their concerns appropriately.

The provider and registered manager promoted the ethos of honesty, learning from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The Duty of Candour is a legal obligation to act in an open and honest way in relation to care and treatment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent was not always appropriately recorded. It was not always possible to know whether best interest processes had been followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor the quality of the service had not always identified areas of concern.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment people's medicines were not always managed safely. People were not always protected from the risk of harm and people's care plans and risk assessments were not always an accurate description of their needs.

The enforcement action we took:

We issued a warning notice.