The Cedars Healthcare (CF) Ltd

Cedar Falls

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Cedar Falls is a residential and nursing home providing personal care and accommodation for up to 39 people. Older people were living in the home, and some were living with dementia. People have access to their own bedroom along with communal spaces including lounges and gardens. At the time of our inspection there were 27 people living in the home.

People's experience of using this service and what we found
The systems in place were not effective in identifying areas that required improvement. Feedback had been sought from people, however this had not been used to make improvements. Lessons were not consistently being learnt in the home. There was no evidence to show people and those important to them were involved with their care or the reviewing of this.

As people's care was not always reviewed, care plans and risk assessments were out of date and in some instances not in place. Improvements were needed to ensure all people received their medicines as prescribed. Advice from professionals was not always followed as needed.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The home environment required updating, however it was clean and infection control procedures were in place and followed.

There were systems in place to ensure there were enough suitably trained and recruited staff available for people. People were happy with the care they received and felt they were supported with dignity and respect.

People enjoyed the food and were offered a choice. People told us they were happy with the activities provided in the home. There was a complaints policy in place, and this was followed. Staff felt supported by the manager and provider and were able to raise concerns. We were notified by the manager or provider of significant events as they are required to do.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 25 February 2022, and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels, risk management,

leadership, infection control issues and an incident that had occurred in the home. A decision was made for us to inspect and examine those risks.

Enforcement and Recommendations
We have identified breaches in relation to how risks are managed in the home, how the provider assessed and monitored quality to ensure improvements were consistently made when required. We identified concerns with capacity and following the Mental Capacity Act and that people's communication needs were not always fully understood.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

The service was not always safe.
Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.
Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.
Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.
Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.
Details are in our well-led findings below.

Cedar Falls

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 2 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.

Service and service type
Cedar Falls is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had recently started working in the home. The manager planned to register with us.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since our last inspection, including notifications the provider had sent to us and information we had received from the public. We also gathered feedback from the local authority.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 3 people and 9 relatives or friends. We spoke with the manager, the area manager, the clinical lead and 5 care staff. We also spoke with the nominated individual, who is also the provider. We looked at the care records for 11 people. We checked the care people received matched the information in their records. We looked at records relating to the management of the service, including audits carried out within the service and staff recruitment checks.

The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management. Learning lessons when things go wrong

- Individual risks to people were not always assessed, monitored and reviewed. For example, a serious incident involving 1 person had occurred within the home in February 2023, we had been notified by the provider and the safeguarding team about this. There were no care plans or risk assessments put in place identifying this risk after the incident had occurred. There remained non in place at the time of our inspection. There was also no guidance for staff to follow should this reoccur. When we asked the manager, who was not working in the home at the time of this incident, they not aware of this taking place and the risks associated to this. This placed people and others at risk of harm.
- Care plans were out of date and not reflective of people's current needs. For example, one person had a series of falls so an alarm had been put in their room with their consent to alert staff if they fell. The care plans and risk assessments did not reflect this alarm was in place and it was documented the person had declined this. This placed people at risk of inconsistent care.
- When people were displaying periods of emotional distress there was no guidance in place for staff to follow during these times. This placed people and others at risk of inconsistent care and potential harm.
- The provider and manager were unable to consistently demonstrate how they used information to ensure lessons were learnt when things had gone wrong. When incidents had occurred previously in the home there was no evidence to show any learning had been identified.

Individual risks to people were not assessed, monitored and reviewed. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The new manager was aware that care plans and risk assessments were out of date and not reflective of people's current needs. They had plans in place outlining how they would address these concerns. They had also started to consider how lessons could be learnt in the future, they had started to review incidents including falls and they had considered this as part of these reviews. We will review this as part of our next inspection.

Using medicines safely

- Medicines were not always consistently managed. For example, one person had been prescribed medicines to be given 4 times a day. However, we found staff were not following the prescribers instructions and were instead offering the person the medicine when they requested this. This meant we could not be assured all medicines were administered as prescribed. The nurses told us they would discuss this with the persons' GP as they did not need this medicines prescribed regularly.

● People told us they had their medicines when needed, and we saw these were administered to people in a safe way. One person said, "Every morning with my breakfast, very prompt."
● When people were prescribed 'as required' medicines, there were protocols in place to ensure staff had the information to administer these medicines when people needed them. The nurses we spoke with knew people well and when to administer these medicines to them.
● Staff administering medicines had completed training and a competency check to ensure they were safe to administer medicines.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of potential abuse.
● There were procedures in place to ensure referrals had been made to the local safeguarding authority when needed.
● Staff told us they had received safeguarding training and were able to tell us the actions they would take to protect people from potential abuse.

Staffing and recruitment
● There were enough staff to support people.
● One person said, "There are enough staff, I don't have to wait when I need someone." A relative commented, "There always seems plenty of staff on duty." We saw there were enough staff available for people and they did not have to wait for support.
● There was a tool in use to calculate the required staffing levels. The manager told us they were working above the current amount of staff needed as staff had felt this was not enough at key times such as lunch. They told us they would review this as needed.
● Staff suitability to work with people had been checked prior to them starting employment. This included a Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● There were no restriction placed on visiting and visitors could access the home freely.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection since this service has been registered with us. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law 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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The principles of the MCA were not always followed. When required people did not always have capacity assessments or best interest decisions in place. For example, one person's care plan referred to them as not having capacity in areas such as the management of their falls or their personal evacuation plan. There were no capacity assessments or best interests' decision in place for this person.
- Another person received their medicines covertly. This is when people's medicines are disguised in food or drink. There was no capacity assessment in place for this which meant the provider had failed to comply with the MCA and we could not be assured this person was taking this medicine lawfully.
- Some people had DoLS authorisations in place. However, when new restrictions had been implemented such as sensor alarms, these had not been considered as part of this process., This meant people may have been restricted unlawfully as there was no evidence to support the necessity of the sensor alarm being put in place.
- Although staff told us they had received training, there was a lack of understanding around capacity and consent.

The principles of MCA were not always followed. This placed people at risk of harm. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live

healthier lives, access healthcare services and support
● Advice from health professionals was not always followed. We saw one person had been reviewed by a specialist nurse. They had advised this person's blood pressure needed to be monitored. There were no records confirming this was being completed and the registered nurse confirmed it was not.
● Another person was not receiving water each day in line with their water regime. Records we reviewed showed they received less than the recommended amount. Staff we spoke with were not aware of this and had not taken any action to resolve. This placed this person at an increased risk of dehydration.
● When people had diabetes their blood sugar levels were not always effectively monitored. Care plans in place were not reflective of people's current needs. For example, one person's diabetes medicines had been changed and the care plan did not reflect this. It was also unclear what people's blood sugar levels should be. For one person this was not documented anywhere. For another person their recordings were sometimes high. Although the nurse could provide an explanation for this, no action had been taken to resolve this.

Advice from health professionals was not always followed. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● People's oral health care was considered and there were plans in place identifying the level of support they needed.

Adapting service, design, decoration to meet people's needs
● The home environment looked tired, and areas were in need of repair. For example, the ceiling was stained where there had been a flood. A relative told us, "The home is clean. It is tired looking and some of the furniture requires updating."
● Further improvements were needed to ensure the home was more dementia friendly. For example, there were limited signs or pictorial guidance to offer guidance or support to people who were living with dementia.

Supporting people to eat and drink enough to maintain a balanced diet
● People's nutritional and dietary needs had been assessed by health professionals when concerns had been identified; there was guidance in place for staff to follow. Improvements were needed to ensure individual care plans were put into place for people. During our inspection, we saw people were supported in line with professional advice. (Apart from the 1 person who wasn't getting enough fluids and we have reported on)
● People enjoyed the food and drink available. One person said, "The food is very good, always hot."
● There was a choice of meals available for people. We saw people were verbally asked what they would like and when they chose different options, this was made available for them.
● People had hot and cold drinks available on tables beside them.

Staff support: induction, training, skills and experience
● People and relatives felt staff had the skills and knowledge to support them. One person said, "They know me and how to help with my needs, they are all trained."
● Staff received training that was relevant to their role. Where gaps had been identified with staff training the manager had recognised this and training was planned.
● An induction process was in place for new staff members, this included classroom-based training and then shadowing more experienced staff members. This gave staff the opportunity to get to know the people they would be supporting.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were assessed, however information recorded was not always accurate. New assessments had been introduced but information recorded was not reflective of people's current needs, for example when people were using alarms in their rooms. The manager was aware of this and had acknowledged this prior to our inspection.

● It was unclear how people and those important to them were involved with this process.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection since this service has been registered with us. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care

- People's care plans were not always reflective of their individual needs. Care plans were often not reviewed when changes occurred or were not in place.
- There was no evidence to show how people or those important to them had been involved with their care planning or reviews. We received mixed views from relatives. Although they felt they were updated when something happened in the home, some felt they were not always involved with the care planning and reviews.
- Staff told us they offered people choice when offering support. One staff member said, "We always ask people, what we can, where they want to sit, what they want to eat or drink." People confirmed to us and we saw people were offered choice throughout the inspection.

Ensuring people are well treated and supported; respecting equality and diversity

- People were happy with the staff that supported them. They felt they treated them with respect and were caring towards them. One person said, "I like the staff they are all very kind." A relative told us, "The staff know my loved one well they know their likes and dislikes the staff are friendly." Another said, "I would say the atmosphere of the home is welcoming and good interaction from the staff to residents."
- Staff we spoke with knew about the people they supported, this included their background and any preferences they had. We saw people were supported in line with these preferences.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was encouraged and promoted. One person told us, "I would say they respect me." Staff gave examples of how they supported people, including closing door and curtains when people were being supported in their bedrooms or in bathrooms.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs. This is the first inspection since this service has been registered with us. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People did not always have control over their lives as people were not always encouraged to express opinions around their care.
- Care plans introduced were not always detailed or reflective of people's current needs.
- When care plans were in place, they had not been updated and were not reflective of people's preferences, including their likes and dislikes. This meant that staff did not always have the information they needed to be able to care for people inline with their preferences.

Meeting people's communication needs Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs were not always understood. For example, one person had multiple mental capacity assessment in place that identified they lacked the capacity to make decision for themselves. There was no medical reason identified as to why this person may lack capacity. It was recorded the decision was reached as this person did not have verbal communication. We interacted with the person who used facial expressions to communicate. This meant this person's communication needs had not been considered or understood.
- Other people had communication plans in place however they lacked details and were not up to date.

People's communication needs were not always fully understood and considered, people did not always have control over their lives. This placed people at risk of harm. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider and manager were aware of the Accessible Information Standard and told us information was available for people in other forms should they need it.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People had the opportunity to participate in activities they enjoyed. Throughout the course of our inspection, we saw people had access to newspapers, some people enjoyed completing crosswords, others participated in group games.
- Relatives felt that when their relations were in their bedrooms, they were isolated and activities did not always take place. We observed this. Feedback surveys had also identified that people felt there could be

more to do and they could go out more. The manager told us this was something they would review.
● People told us their friends and families could visit when they wanted to, and we saw this throughout our inspection.

Improving care quality in response to complaints or concerns
● People and relatives felt able to complain. One relative told us, "I have had no reason to complain if I had any concerns, I would contact the manager."
● There was a complaints policy in place, we saw when complaints had been made these had been responded to in line with the policy.

End of life care and support
● No one who was being supported with end-of-life care at the time of our inspection. However, some people's end of life wishes were identified in their records.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection since this service has been registered with us. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, Continuous learning and improving care Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Systems in place had failed to effectively monitor and make improvements to the quality and safety of care provided to people. There were no effective systems in place to identify when people did not have appropriate care plans or risk assessments as needed. This included periods of emotional distress and health needs.
- There were no systems in place to identify when people's care plans were out of date or not reflective of their current needs. This included when people had fallen.
- Incidents and accidents audits had not identified reviews were not being completed after each incident or accident had occurred. The audit had not highlighted that care plans and risks assessment had not been updated to ensure people's risks of continued harm were effectively mitigated. This placed people at an increased risk of avoidable harm.
- Governance systems had failed to identify when health professionals' referrals or advice had not been followed. For example, when a person's blood pressure needed monitoring.
- Systems in place were not identifying when the principles of MCA were not followed. For example when people did not have individual capacity assessments in place.
- The medicines audit had failed to identify when people were not receiving their medicines as prescribed.
- A satisfaction survey had been completed but no action had been taken to identify the concerns raised. The survey highlighted that people felt more could be going on in the home and they would like to go out more often but no action had been taken to address this.

Systems in place were not effective in monitoring risk at the home and identifying areas of improvement. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager had identified that the governance systems were not effective. They discussed with us the action they had started to take and planned to take in the future. We will review this as part of our next inspection.
- Staff attended meetings so that they could share their views. Staff felt supported and listened to by the manager and provider and spoke positively about the home.
- We had been notified about events that had happened within the service when needed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The systems the provider had in place did not always create a positive culture for people. There was a lack of documentation, accurate information and a lack of effective systems to identify areas of improvement. This placed people at risk of not receiving good outcomes and the support they needed.

● People and relatives were generally happy with the home. One person said, "I like it here." A relative told us, "I have no concerns when I walk into the home the residents are dressed well and look comfortable, I am always made to feel welcome."

Working in partnership with others

● The was some evidence the provider worked in partnership with health professionals. Professionals were involved with people's care and we saw people had been referred recently for support with weight loss and risks associated to eating and drinking. However, the provider had not always acted on advice from health professionals visiting the home.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Duty of candour requirements were understood and met.

● The manager and provider had been open and honest with people and their relatives and ensured they were notified of events accordingly.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People's communication need were not always fully understood and considered, people did not always have control over their lives.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The principles of MCA were not always followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Individual risks to people were not assessed, monitored and reviewed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The systems in place were not effective identifying areas of improvement.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The systems in place were not effective identifying areas of improvement.

The enforcement action we took:

We issued a warning notice.