QH The Cedars Limited

The Cedars Care Home

Inspection report

Sudbury Road
Halstead
Essex
CO9 2BB

Tel: 01787472418

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 28 November 2017. The inspection was unannounced, this meant the staff and provider did not know we would be visiting.

The Cedars is a 'care home'. People in care homes receive accommodation and personal care under a contractual agreement. CQC regulates both the premise and the care provided and both were looked at during this inspection. The Cedars accommodates up to 63 people across two separate units the meadows and the main house, which have separate adapted facilities. At the time of our inspection 42 people were using the service.

This service has been recently acquired by a new provider and a new manager has been appointed and had taken up 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.

The service needed to provide activities for people to take part in taking into account people's interests and hobbies. People needed further support to be given opportunities to take part in meaningful activities.

We recommend that the activity co-ordinators have training to be able to support people living with dementia to take part in activities meaningful to them and in the use of dementia friendly sensory aids.

People spoke positively about the service and the care that was provided. They told us they were listened to and staff were kind and caring.

People told us that they felt safe. Staff were clear about what was abuse and the steps that they should take to protect people. Risk's to people's daily life's had been assessed.

There were adequate systems in place for the safe administration of medication and people received their medicines as intended.

Checks were undertaken on staff suitability for the role and there were sufficient numbers of staff available to meet the needs of the people living in the service.

Staff received an induction to prepare them for their role and additional training was provided to support their learning and development. However, we recommend staff have access to more face to face training especially in supporting people living with dementia.

Staff had an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

The provider was looking at ways to improve the mealtime experience for people as one dining room had limited lighting with no windows.

People were supported to eat and drink enough to maintain a balanced diet and referred to other healthcare professionals when their health needs changed.

Care plans were written in a person centred way and were regularly reviewed to reflect people's individual care and support.

The manager was new in post and feedback from people and staff were they were open and approachable. Staff were supported by a manager they liked and respected.

The provider had worked hard and prioritised people's safety since taking over the service.

The provider's quality monitoring system included regular reviews of people's care plans, checks on medicines management and staff's practices. Accidents, incidents falls and complaints were investigated and actions taken to minimise the risks of a re-occurrence.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

Staff understood their responsibilities to safeguard people from the risk of abuse.

Medicines were well managed and people received their medicines as intended.

Staff were only employed after all essential pre-employment checks had been satisfactorily completed.

The service was clean and there were good systems in place to reduce the risk of cross infection.

Is the service effective?

Requires Improvement

The service was not always effective

People were supported to have a balanced diet. However, peoples dining experience needed improving.

Parts of the environment needed attention to ensure it was fit for purpose and suitable for peoples assessed needs.

People were supported to maintain their health by visiting professionals such as chiropodist, dentists and GP's.

Staff supported people lawfully and sought their consent before providing treatment and care.

Is the service caring?

Good

The service was caring.

People were treated with respect and their privacy and dignity was maintained.

Most of the staff were kind and considerate in the way that they provided care and support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People needed to be offered and supported to take part in meaningful activities.

The service took into account people's feedback and had an established complaints procedure and quality assurance process.

People received good quality, compassionate end of life care.

Is the service well-led?

Good

The service was well-led.

The management team were supportive and accessible and lead by example.

Systems were in place to assess and monitor the quality of the service provided.

There was clear oversight of the service.

The Cedars Care 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place 28 November 2017. It was unannounced 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 service.

We reviewed all the information we had available about the service, including notifications sent to us by the provider. A notification is information about important events which the provider is required to send us by law. We used this information to plan what areas we were going to focus on during our inspection. We also reviewed the information the provider had given us in their 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 the improvements they plan to make.

During the inspection we spoke with five people that used the service, four relatives, and six staff including the chef. We spoke with the registered manager, operations manager and the provider.

We used a method called Short Observational Framework for Inspection (SOFI). This involved observing staff interactions with people in their care during the inspection. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed how staff interacted with people who lived at the home. We observed how people were supported during meal times and during individual tasks and activities.

We reviewed six people's care records, six staff recruitment records, medication charts, staffing rotas and records which related to how the service monitored staffing levels and the quality of the service. We also looked at information which related to the management of the service such as health and safety records, quality monitoring audits and records of complaints.

Good

Is the service safe?

Our findings

Since the provider had taken over this service in April 2017 they had prioritised people's safety. This had included replacing kitchen equipment which was not fit for purpose as well as sourcing improved cleaning products and new milk dispensers. Another priority was ensuring people's risk assessments had been reviewed and updated.

There were policies and procedures regarding the safeguarding of people. Staff knew how to keep people safe and understood their roles and responsibilities to recognise respond to and report any incidents or allegations of abuse, harm or neglect. It was evident from our discussions with them staff had a good awareness of what constituted abuse or poor practice, and knew the processes for making safeguarding referrals to the local authority. One staff member told us, "If I had any concerns I would go straight to the manager." Their records showed that the manager was aware of their responsibilities with regards to keeping people safe, and reported concerns appropriately.

Risk assessments were in place and had all been reviewed and evaluated in order to ensure they were relevant and gave up to date information in order to keep people safe. The risk assessments included risks specific to the person such as for mobility, personal safety, and pressure area care. For example, we observed staff moving residents in wheelchairs and using hoist to transfer them from a chair to a bed and from a wheelchair to a fixed chair. These were all used appropriately and safely with the correct equipment, and risk assessments clearly documented accurate information.
People we spoke with told us they thought there were enough staff to meet their needs. Comments included, "They do answer the buzzers promptly, even at night. I do feel safe", "There is always someone around to help me if I need them to."

Throughout the day our observations showed there were enough staff available to keep people safe from harm and meet their needs. However, staff feedback was that on occasions in one of the units because of people's mobility needs they sometimes struggle to accommodate people's personal care needs in a timely way. We discussed this with the management team who told us they would review each person's dependency level and then allocate staff according to the needs of people on each unit.
We saw that there were processes in place to manage risks related to the operation of the service. For example, the manager arranged for the maintenance of equipment used including hoists, fire equipment and electrical appliances and held certificates to demonstrate these had been completed. There were appropriate plans in place in case of emergencies, for example evacuation procedures in the event of a fire.

We found that medication was safely managed. We observed the medication round as part of our inspection, and noted it was undertaken safely. The senior carer ensured people had a drink, and gave them time to take their medicines. However, some medication was given out whilst people were eating which distracted them from their meal and also meant a senior member of staff was then not available to support with the mealtime period. We discussed this with the management team who agreed to look into this.
People were protected by safe systems for the storage, administration and recording of medicines. Medications were kept securely and at the right temperatures so that they did not spoil. Medications

entering the home from the pharmacy were recorded when received and when administered or refused.

The medicine trolley was kept locked when unattended, and the member of staff signed the medication administration charts after the medicines had been taken. We checked samples of medication as well as Controlled Drugs and saw that they were appropriately signed for and the quantities in stock tallied with the controlled drugs register. Staff recorded when they administered PRN medication such a pain relief. We saw forms completed to say that the medication had been audited on a regular basis. One person told us, "The staff give me my medication and I know what to take and what it is for."

Staff recruitment files demonstrated that the provider operated a safe and effective recruitment system. The staff recruitment process included completion of an application form, a formal interview, the provision of previous employer references, proof of identity and a check under the Disclosure and Barring Scheme (DBS). This scheme enables the provider to check that candidates are suitable for employment. People could be assured that their needs were being met by staff that had been assessed as safe and competent, with the necessary skills for the job role they had been employed for.

The service was clean throughout and there were sufficient arrangements in place to help ensure the cleanliness of the service. Staff were observed following good infection control practices to help reduce the spread of infection, including regular hand washing and wearing aprons to protect their clothes. All areas of the service were subject to daily cleaning and deep cleaning as required. Infection control policies and audits were in place to help ensure standards were maintained and staff received training in infection control. This helped to ensure they were following policy and had a good understanding of how to minimise infection.

We saw lessons had been learned and improvements made where required and these were on going. For example, it had been identified that the administration office was not situated in an appropriate room it meant that visitors had to sit in the lounge area which invaded people's privacy. Therefore a new office had been made available that was situated in the entrance hall of the service.

Requires Improvement

Is the service effective?

Our findings

Our observations of the dining experience for people were that some improvement was required. One of the dining rooms did not have adequate lighting as there was no window and only limited lights there was also no tablecloths or serviettes. We discussed this with the management team and they told us of their plans to put a false window along one wall of a mural to brighten the room up they also told us they would look at putting some additional lighting in the room. Some table cloths and serviettes had already been ordered and they were waiting for them to be delivered. People started to assemble into this dining room at 11.45 but the meal was not served until 12.30 therefore they were kept waiting rather a long time. People were offered a choice of foods and some people had a different meal to what was on the menu. The manager told us they were in the process of having picture menus in place and people would be offered 'show plates' to help the people living with dementia make an informed choice. Our observations showed that some people were confused about the choice of foods and would benefit from additional visual aids.

The dining experience in both dining rooms as well as in the communal lounge was not a social experience there was limited verbal interaction between staff and the people during the meal. Although people were supported with their meal if required there was no verbal encouragement and not enough staff to support people effectively. We discussed this with the registered manager who agreed to make the lunchtime period 'protected time' this would mean that all of the staff in the service would be available to assist with mealtimes and therefore people could have more support and staff would have the opportunity to speak to people and offer conversation or verbal encouragement.

We saw that the service thoroughly assessed people's needs. The management told us they had to re-assess people when they took over the service as information in existing care plans was incomplete and did not give the complete picture of the person. For example, one person was keen on a particular sport and talking about this sport or watching it could calm them down if they became agitated. Staff who had worked in the service for a long time knew this but this had not been recorded previously in the persons care plan.

Staff confirmed that when they commenced employment at the service they had received an induction. Records showed that the staff's induction was in line with the 'Care Certificate'. Staff confirmed that opportunities were given whereby they had shadowed a more experienced member of staff for several shifts before they were deemed competent to work on their own.

Members of staff told us they felt supported by the new registered manager. Records we looked at of formal 1:1 supervisions demonstrated they were being carried out on a regular basis. Staff told us, "We have regular team meetings and also have shift handovers."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best

interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager had made the appropriate referrals to professionals for assessment when people lacked capacity and needed constant supervision to keep them safe. This met the requirements of Deprivation of Liberty Safeguards (DOLs). People told us that they had a say in how they were supported and we saw people being offered choices.

The service had appropriately assessed people's nutritional needs and the Malnutrition Universal Screening Tool (MUST) had been used to identify anyone who needed additional support with their diet. Support form Speech and Language Therapist (SALT) had been sought where a risk of malnutrition had been identified as well as swallowing difficulties. Staff had received guidance within support plans and associated risk assessments in supporting people identified to be at risk.

People told us their day to day health needs were being met and they had access to healthcare professionals according to their specific needs. People told us that staff took appropriate action to contact health care professionals when it was needed. One relative told us, "They get the GP out if necessary." We saw in people's records details of appointments and the outcomes.

The registered manager told us they had to refer people to healthcare professionals which on some occasions took a long time because although they had glasses or a walking frame they had no further details in the original care plan to explain why this person required glasses or a walking aid. As some of the people were living with dementia they were not always able to understand the reasons for their aids. We saw clear documentation in people's care plans which showed referrals had been put through to the appropriate healthcare professionals.

The environment was suitable for people in regards to safety and cleanliness. The provider told us of their plans to make the environment brighter and to enhance the décor to make it suitable for people living with dementia. This included people having a recognisable 'front door' to their bedrooms. The bathrooms were also going to be refurbished in the near future. The management team informed us they were in the process of looking at ways to make the environment more 'homely'. This had already been identified on audits we were shown. We were assured the management team were committed to ensuring the environment was enhanced to support and promote people's independence.

We also saw the service had signed up to the 'PROSPER' initiative aimed at improving health and wellbeing of people living in care homes. The registered manager told us they had identified a 'prosper' champion who would be responsible for liaising with other healthcare professionals and supporting staff with this initiative.

Good

Is the service caring?

Our findings

Prior to the inspection we received a number of concerns implying that the atmosphere was not caring within the service. However, when we inspected the service our observations showed that most staff were kind and caring. However, some staff were task focussed. We discussed our findings with the management team. Despite our concerns the service had done all they could in ensuring that all staff were supervised and this was on going to ensure good practices. New staff had been recruited whom we observed on the day of inspection and they showed kindness, empathy and understanding. They had been recruited in a supervisory role and were responsible for supporting and advising the rest of the staff team and feeding back to management any concerns. The initial focus had been on ensuring the service was a safe place to live and this had also been the focus for staff. The management team told us they would now be focussing on ensuring all of the staff team had the knowledge and understanding to enable them to support people in a kind and caring manner. Further training was also being arranged for staff in supporting people living with dementia.

People were generally happy with their care and told us that staff were kind and caring. One person told that, "It's all nice here, and it is very much improving. I like the way the girls talk with me and have a laugh they seem to have a different approach now which is nice", "The staff here are all very nice and the manager is a really nice lady very friendly. We often see her around the home checking we are all ok." One relative who was visiting on the day of our inspection told us, "This is my first visit; the staff seem very friendly and welcoming."

During the inspection although at times staff were busy we observed staff interactions with people were positive. They were kind and considerate; the atmosphere within the service was welcoming, relaxed and calm. Most of the staff demonstrated affection, warmth and compassion, for the people they were supporting. For example, they made eye contact by kneeling or sitting next to them and listened to what people were saying, and responded accordingly. However, some staff were task focussed and although they were caring for people and responding to their needs they did not take time to talk to them and interact. When we spoke with the staff some of them did not have the communication skills to communicate very well with people with communication needs. The registered manager was aware of this and was working hard to improve this with supervision and mentoring. .

We looked at six people's care plans and saw that they contained information about people's likes and dislikes and their personal history. New staff told us they were in the process of learning about people's care needs and the things that were important to them in their lives.

People needed further encouragement to make day to day choices, and to be as independent as possible. The registered manager was aware they needed to focus on supporting people with this as in the past people had not been encouraged to make their own choices or to be independent.

We saw that staff knocked on bathroom doors and waited for a response before entering, this showed us that people were treated with respect. We observed people being spoken to discreetly about personal care

issues so as not to cause any embarrassment. However, whilst one person was eating their meal a staff member gave them their medication at the table in front of other people therefore, they had to stop eating. This person did not then continue to eat the rest of their meal as they had been distracted. This meant they prevented them from enjoying their meal. We discussed this with the management team who told us they would look into this to ensure in future medication was given in a more timely way.

People were supported to maintain relationships with others. People's relatives and those acting on their behalf visited at any time. Relatives confirmed this and told us they were able to visit their relative whenever they wanted and at a time of their choosing.

Resident meetings were being implemented and 'feedback Friday' introduced. This was a time for the manager to speak with people to encourage general discussions of any improvements required or what people wanted to change in the future.

Requires Improvement

Is the service responsive?

Our findings

On the day of inspection we were told the activity co-ordinator was off sick. The registered manager told us they had recruited an additional two activity staff that would be starting as soon as possible and would be covering the full seven days for activities.

It was evident from our observations that staff did not have the time to offer or support and encourage people to do a meaningful activity. Most people sat in arm chairs dozing off for much of the day. When we spoke to a staff member and asked them if any activities would be taking place they replied, "No we do not have time." However, we did on occasions throughout the day observe some staff trying to engage people looking at a book or magazine however, this was for a very limited time as they were quickly called away to help with a care task.

One person was very good at drawing and their drawings were displayed around the service. We observed this person drawing before lunch but after lunch they did nothing and looked very bored sitting in the lounge on their own.

In the communal lounges there were televisions however, these were not on for the duration of the inspection and in the meadows lounge there was no music either. When we commented to a staff member they put a CD on but did not ask for any input from the people sitting in the lounge about what music they may want to listen to. The seating arrangements in the meadows lounge meant that the seats were placed around the room which made it difficult for people to sit in small groups and have a conversation. In the main house the seats had been placed in smaller groups to encourage conversation.

In one part of the service people were singing to music and taking part in a movement to music session for a limited time during the morning. Also the gardener/maintenance member of staff tried to interact with people and bought a pot with some pansies into one of the lounges and a few people took part in re-potting them from small flowerpots into a large one and filling them with earth this activity however did not last very long as they only had a couple of plants.

We recommend the activity staff have training in supporting people living with dementia to take part in activities meaningful to them and to use dementia friendly sensory items.

People's changing needs were identified promptly and reviewed with the involvement of other health and social care professionals where required. Staff confirmed any changes to people's care was discussed regularly at shift handovers to ensure they were responding to people's care and support needs. Therefore people had consistent up to date care given to them by all staff. A shift handover is where a discussion is held between staff to update each other on any changes before the end of a shift.

The service provided responded to people's needs. Each person had a detailed care plan in place that identified how their assessed needs were to be met. These also included information on their background, hobbies and interests and likes and dislikes. Input from family members had been sought when appropriate.

People told us they had no complaints but would speak to the manager if they needed to. The service had in place policies and procedures for dealing with complaints. We saw that complaints were dealt with and investigated and responded to in a timely way.

Care plans described how people wanted to be supported during the end stages of their life and their wishes were recorded. Staff supported people in relation to their beliefs and religion. Where people had made a decision about resuscitation a completed 'Do Not Attempt Resuscitation' (DNAR) directive was in place. Where possible people had been involved in their care plan and when this had not been possible a family member had been consulted about the care their relative needed.

Good

Is the service well-led?

Our findings

The registered manager had only been in post for a few months and had only recently been registered by the commission. They were supported by the regional manager and the provider who was present during our inspection.

The manager told us that their main priority had been to ensure the safety of people living in the service which had meant replacing items in kitchen as these were not fit for purpose. They had also prioritised the recruitment of sufficient numbers of staff to enable people to receive consistent care. Most of the things we had highlighted during our inspection had been previously picked up in an audit that the registered manager and regional manager had undertaken. We therefore had confidence that this actions would be carried out.

The manager was enthusiastic about their role and spoke passionately about their vision and what they were trying to achieve at The Cedars.

We saw minutes of recent staff meetings where the manager had set out their expectation regarding the care they wished to see delivered. When we spoke with staff they told us they felt things had improved since the new provider and registered manager were in place. Comments included, "There are more staff now the changes are good", "[Name of manager] is so approachable if I have a problem I go to [name of manager] and they will always help me. Staff also told us the provider was clearly visible in the service and took time to speak to them and ask them about any issues or any improvements they could suggest. Without exception staff told us they felt included and listened to and were happy with the provider and registered manager and could clearly see the improvements that had taken place and were aware these were on going.

Actions were taken to learn from accidents and incidents. These were monitored and analysed to check if there were any emerging trends or patterns which could be addressed to reduce the likelihood of reoccurrence. Healthcare professionals told us that they had a good relationship with the manager and that communication between both parties was very good. One professional told us, "They listen and action what we ask, they definitely want the best for people."

Quality assurance systems were in place to monitor the safety and effectiveness of the service. We saw that a range of audit were completed such as infection control, health and safety, care plans and medicine audits. Where issues were identified, the appropriate action was taken. For example, new clinical waste bins had been purchased because the existing ones were not working properly.

Relatives told us they had found the management team approachable and they were available to speak to whenever they wanted. They told us there were more staff visible and that they had been advised of the new provider and registered manager as they had received a letter form the provider informing them of the changes.