Caring Homes Healthcare Group Limited

Cedar House Nursing and Residential Home

Inspection report

Cedar House
Church Road, Yelverton
Norwich
Norfolk
NR14 7PB

Tel: 01508494207
Website: www.caringhomes.org

Date of inspection visit:
14 April 2016

Date of publication:
13 May 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 14 April 2016.

During our last inspection of the home in November 2015, we found that the provider was in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activities) 2014. These were in respect of the management of risk and cleanliness and infection control, treating people with dignity and respect, providing person centred care and good governance. We sent the provider a warning notice in respect of the breach of regulation in respect of good governance. We told them that they had to meet this regulation by 1 February 2016.

In respect of the other breaches of regulation, the provider sent us an action plan and told us they would be meeting these by 1 February 2016. At this inspection, we found that the necessary improvements had been made. Therefore, the provider was no longer in breach of these regulations. However, improvements were required to make sure that people consistently received care that provided them with enough stimulation to enhance their well-being.

Cedar House Nursing and Residential Home is a service that provides accommodation and nursing care for up to 26 older people, some of whom may be living with dementia. On the day of the inspection, there were a total of 14 people living at the home.

There was a registered manager employed at the home. 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 and associated Regulations about how the service is run.

The provider had systems in place to protect people from the risk of abuse and risks to people's safety had been assessed, with actions being taken to reduce their risk of harm. The home and equipment that people used was clean.

There were enough staff to meet people's care needs safely and people received their medicines when they needed them. The staff had received appropriate training and supervision to provide them with the necessary skills and knowledge to provide people with effective care.

People were treated with dignity and respect by staff who were kind and compassionate. People were asked for their consent about their care and the staff understood how to support people who were unable to consent to this themselves.

People received enough to eat and drink to meet their individual needs and timely action was taken by the staff when they were concerned about people's health.

People's individual care needs and preferences had been assessed. However, some people did not receive adequate stimulation to enhance their well-being.

The staff were happing working in the home and felt supported in their role. They were clear about their individual roles and responsibilities and were valued by the registered manager.

Any complaints or concerns that were raised were listened to and dealt with and there were effective systems in place to monitor the quality and safety of the care provided.

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

The service was safe.

Risks to people's safety had been assessed and actions taken to reduce the risks of people experiencing harm.

The home and the equipment people used was clean.

Systems were in place to protect people from the risk of abuse.

There were enough staff to meet people's needs and to keep them safe.

People received their medicines when they needed them.

Is the service effective?

Good

The service was effective.

Staff had received training and supervision to provide people with effective care.

Staff understood their legal obligations on how to support people who could not consent to their own care and treatment.

People had a choice of food and drink and they received enough to meet their needs.

People were supported by the staff to maintain their health.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and treated people with dignity and respect.

People and their relatives where required, were involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's individual needs and preferences had been assessed. However, people did not always receive adequate stimulation to enhance their wellbeing.

The provider had a system in place to investigate and deal with complaints.

Is the service well-led?

Good

The service was well-led.

There were effective systems in place to monitor the quality and safety of the service provided.

The registered manager listened to people living in the home, their relatives and the staff and acted on any feedback they gave about the running of the home.

Cedar House Nursing and Residential 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 inspection took place on 14 April 2016 and was unannounced. The inspection team consisted of two inspectors, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us and additional information we had requested from the local authority quality assurance team and the clinical commissioning group.

During the inspection, we spoke with six people living at Cedar House, three visiting relatives, three care staff, a nurse, the chef, the registered manager and the provider's regional manager. We observed how care and support was provided to some people who were not able to communicate their views to us. To do this, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The records we looked at included three people's care records, five people's medicine records and other records relating to people's care, three staff recruitment files and staff training records. We also looked at maintenance records in respect of the premises and equipment and records relating to how the provider monitored the quality of the service. We asked the registered manager to send us confirmation after our visit that they had assessed the risk in relation to exposed pipework within people's rooms. This information was

received promptly.

Good

Is the service safe?

Our findings

At our previous inspection in November 2015, we found that risks to people's safety were not being managed adequately and that some areas of the home were unclean, which increased the risk of the spread of infection. We also found that the provider's recruitment processes were not robust. This meant that there had been a breach of regulations 12 and 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider told us they would meet these regulations by 1 February 2016. At this inspection, we found that the required improvements had been made and that the provider was no longer in breach of these regulations. Risks to people's safety had been assessed and actions taken appropriately to mitigate these risks. Staff were recruited using robust processes to make sure they were safe to work within care.

The people we spoke with told us that the staff understood what care they needed to keep them safe. Most risks to people's safety had been assessed. This included risks associated with poor eating and drinking, from falls and from developing pressure ulcers. There was guidance within people's care records for staff about how these were to be managed and minimised. We saw that actions had been taken to reduce these risks. For example, where people were at high risk of developing pressure ulcers, pressure relieving equipment was in place and people were being regularly re-positioned throughout the day.

These assessments of risk had been reviewed regularly and when people's needs had changed. For example, we found that one person's ability to weight bear had deteriorated. Their assessment of risk and plan of care had been updated to show that two staff were now required to assist the person to move and transfer.

In respect of the premises, we saw that fire doors were kept closed and the emergency exits were well sign posted and clear of any obstacles. Testing of fire equipment and the fire alarm had taken place regularly. Staff demonstrated to us that they knew what action to take in the event of an emergency such as a fire. They confirmed that they had received training in how to use 'evacuation sledges' if these were needed to move people from the first and second floors to a place of safety.

At the last inspection, we found that the emergency alarm was not loud enough to alert staff throughout the building that their attendance to an incident was required. Since then, the provider had installed a new alarm system. The staff and registered manager confirmed that when the alarm was activated, it could be heard across the home.

However, on checking six people's rooms, we found that two of them had exposed piping within their en-suite toilets. The pipes in one of these rooms were hot to the touch. We brought this to the registered manager's attention. They were aware of the exposed pipes within one of the rooms. They explained that the en-suite had recently been re-decorated and that the pipes were to be 'boxed' in shortly. They agreed to immediately risk assess all of the rooms and cover any pipes that were deemed to be a hazard. After the inspection visit, we received a copy of the provider's action plan in respect of this. This confirmed that the risk to individual people had been assessed and that action had been taken where a risk to their safety had been identified.

Any accidents or incidents that took place were recorded by the staff and investigated by the registered manager. This information was sent to the provider for analysis so that any patterns could be identified. The registered manager explained that from their investigation of these incidents, they had found that one person had experienced a number of falls in quick succession. In response to this, they had contacted a team of healthcare professionals who specialised in preventing falls for advice. The person had been provided with a sensor mat by their bed to alert staff when they were trying to get out of bed. The staff could then intervene promptly if necessary. Since this had been put in place, the person had not experienced any further falls.

The communal areas of the home were clean and we saw staff taking appropriate precautions to reduce the risk of the spread of infection. This included wearing protective clothing such as gloves and aprons when providing people with personal care. We checked six people's rooms, bedding, mattresses and en-suite bathrooms and found these also to be clean. A schedule was in place that gave the domestic staff clear instruction on what items required cleaning and when. This included people's rooms, mattresses, curtains and the equipment they used.

The staff files we viewed showed that the relevant checks had taken place before the staff member commenced their employment. This was to make sure they were safe to work with the people who lived within the home.

All of the people we spoke with told us they felt safe living at Cedar House. The relatives we spoke with agreed with this. One person told us, "They [the staff] are all okay, they certainly look after me." Another person told us, "I've never seen anyone ill-treated here." A relative said, "I feel that [family member] is safe. My reassurance comes from developing a rapport myself with the staff."

We spoke with three staff about their training to enable them to recognise and respond to abuse. Each of them confirmed that they had received this. They were able to tell us what might lead them to be concerned that someone might be at risk, for example unexplained bruising. They were clear about their obligation to report any concerns. The registered manager had reported any incidents of alleged abuse to the local authority safeguarding team as is appropriate. We were therefore satisfied that the provider had systems in place to protect people from the risk of abuse.

We received mixed views from the people and relatives we spoke with regarding the current staffing levels at Cedar House. One person told us that the staff did respond in a timely way when they used the call bell for assistance. Another relative said, "When I visit there seems enough staff. Today three staff asked [family member] before lunch if they needed their hands cleaning." However, two people told us that on occasions they had to wait for assistance with personal care. Both of these people said that this happened most often in the evenings. A visiting relative told us that they had noticed occasional problems with staff assisting people in a timely way on a Sunday.

The staff we spoke with said they felt there were enough staff to meet people's needs in a timely manner. On the day of the inspection, we observed that this was the case. The staff responded quickly to people's call bells and their requests for assistance.

We advised the registered manager of the feedback we had received from people regarding the time it took for staff to sometimes help them with personal care. They told us that the staffing levels had remained the same based on when the home had full occupancy. The registered manager agreed to investigate into these concerns to see if adjustments needed to be made to the deployment of staff during the evenings and at weekends.

The registered manager told us that any unplanned staff absence was covered by existing staff, or agency staff when needed. The home had one vacancy for a care staff member that they were currently advertising for. Once in place, the registered manager advised that the home would have the required number of permanent staff that it needed.

People's medicines were stored securely so they could not be tampered with and for the safety of the people who lived in the home. We checked some people's medicine records to make sure they had received their medicines as intended by the person who had prescribed them. The records we looked at confirmed this. There was clear information in place to guide staff on how to give people certain medicines and regarding whether people had any allergies that needed to be taken into account. We were therefore satisfied that people received their medicines when they needed them.

Good

Is the service effective?

Our findings

At our last inspection in November 2015, we found that staff did not have a good understanding of their legal obligations when supporting people who could not consent to their own care and treatment. We told the provider that improvements needed to be made within this area. At this inspection, we found that the necessary improvement had been made. The staff knew how to support people who were not able to consent to their own care and the principles of the Mental Capacity Act 2005 (MCA) were followed when doing this. Any actions taken by the staff were made in people's best interests.

The 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA.

The registered manager told us that since our last inspection, the staff had received further training in the MCA and DoLS. The staff we spoke with confirmed this. They were able to demonstrate to us the importance of seeking consent from people before they offered support. For example, they told that if someone refused assistance with personal care, that they would return later and ask again. They recognised that sometimes people would accept assistance from a different member of staff so they would try to gain people's cooperation in that manner.

We observed that staff asked people for their consent before delivering care. For example, people were asked before assistance was given to cut up food. We also saw that someone who needed assistance to transfer to an arm chair, using the hoist, were asked if they were ready for help. Another person was offered an apron ready for them to eat their meal. They told the staff member, "I don't want that on. I'm not having that on." The staff member explained that it was to help keep their clothes clean but respected the person's decision and removed the apron.

Assessments of people's capacity to consent to certain decisions had been made when felt necessary. For example, one person received their medicines covertly (hidden in food or drink) in their best interests. The records we viewed clearly showed this decision had been made in line with the principles of the MCA. We noted that applications had been made in accordance with the DoLS where this was considered appropriate.

However, although staff understood the importance of seeking consent, people's ability to make informed decisions about their care was not always well documented within the care records we viewed. We found that documentation was not specific to individual decisions, for example about receiving personal care, support with their health, or medicines. Although not clear about specific and individual decisions, we did

note in records seen, that people's ability to retain and understand information was taken into account. We spoke to the registered manager about this. They advised that they were aware that the information regarding people's capacity required improving and that plans were in place to complete this.

The people we spoke with and visiting relatives told us they felt the staff were well-trained. One person when asked said, "Yes, I do, they're always re-training someone. With new staff, they come and say hello and show them around." A relative said, "They [the staff] appear to be trained quite well, the young ones aren't left on their own very much." They added, "There are several senior staff here who can communicate with [family member] better than I can at times."

All of the staff we spoke with told us they felt they had received enough training to provide people with effective care. This included training in moving people, first aid and health and safety. A staff member told us how training had recently been arranged to enable them to better support people who were living with dementia. This training had involved staff experiencing what it was like to receive some of the care they provided to people, such as moving in a hoist. The registered manager told us this was so staff could have a greater understanding of what it was like to receive care.

The staff training records we checked confirmed that staff had received recent training. Staff's competency to perform their role had also been regularly checked. We observed that staff supported people to move in a safe way.

The staff we spoke with talked to us about support and supervision. They said that they felt well supported within the home and there was always someone to go to for advice. Two staff commented particularly that the registered manager was supportive and accessible if they needed to speak with them. We concluded that staff had received enough training and supervision to enable them to provide people with effective care.

Most people told us that they enjoyed the food and that they had a choice of meal. They also said that they were offered an alternative if they did not like what was on the menu. One person said, "We get plenty of choice. We usually get a choice of two hot things and a pudding." Another person told us, "In the morning you have eggs, bacon, tomatoes and toast. I eat it in the dining room at about seven thirty". They added, "It is good food, I feel there's enough choice. I have fish at least once a week, kippers, I ask for it."

We observed people being offered a choice of main meal at lunchtime and they were provided with regular drinks throughout the day. The staff we spoke with were aware of the importance of making sure that people drank enough. One member of staff was responsible for offering people regular drinks within the communal areas of the home and to those who chose to stay in their rooms. We observed this happening on the day of the inspection. A relative told us, "There's always liquid. [Family member] prefers blackcurrant juice for their indigestion, or tea, or water."

People's intake of drink was monitored where they were at risk of not drinking enough and staff were clear about the importance of completing the associated records. However, we noted that intake charts did not record what the 'target' amount of fluid was for each person. Having a target would help staff to assess whether the person needed to be offered drinks more frequently during the day.

People who needed support or prompting with their meals received this. However, we observed that one person experienced difficulties eating both their main course and dessert. They tried to eat these with their fingers but found they could not do this. This was because the food provided could not be picked up easily. We saw them pushing their dessert away, saying, "I don't like this. I can't pick it up." Although they were

offered an alternative main meal, this again was not food that they could easily pick up. The staff told us that this person had chosen these meals but it was noted within the person's care record that 'finger foods' were appropriate for the person. This was to help them eat their food independently. We brought this to the registered manager's attention who agreed to speak with the staff. This was to make sure the person received their food in a form to suit their needs.

Where people were at risk of not eating and drinking enough, action had been taken to address this. For example, people were offered regular snacks throughout the day and their food was fortified with extra calories. Where necessary, the registered manager had referred the person to a healthcare professional for specialist advice.

The chef was able to tell us which people needed their food fortified with extra calories and/or specialist diets. This information was displayed within the kitchen to help the kitchen staff provide people with the diets they required. The chef told us that they monitored when people had received their meals throughout the day. This included the time staff had taken each person's meal to serve to them . This system was in place to make sure that people received all of their meals and the time between them receiving their meals was not too long. We were satisfied that people's nutritional and hydration needs were being met.

The people and relatives we spoke with told us they or their family member were supported with their healthcare needs. One person told us, "A chiropodist comes round every month, my dentures feel fine. I haven't seen anyone but they do send for a dentist if you need one." Another said, "The GP comes the same day if you need them. Oh yes, the staff respond straight away." A relative echoed this. They told us, "They [the staff] called the house, and in my absence alerted other family members that they'd called the GP."

People's records showed that advice had been sought from other health professionals where this was needed to ensure people's health and welfare. We found that people were referred to their doctor promptly when they became unwell. People were also referred for advice regarding falls and we saw that advice about this had been incorporated into people's care records and followed by the staff. Where people had been identified as having difficulties with eating and drinking, advice had been taken from the speech and language therapy services. We were therefore satisfied that people were supported with their healthcare needs.

Good

Is the service caring?

Our findings

At our previous inspection in November 2015, we found that people were not always treated with dignity and respect. This meant that there had been a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider told us they would meet this regulation by 1 February 2016. We found that improvements had been made and that the provider was no longer in breach of this regulation.

Most of the people we spoke with told us that the staff were kind and caring. One person said, "[Staff member] is the main carer. They are very good. They are always busy, they're alright." Another person told us, "The staff are pretty good." A further person told us, "I do think they [the staff] are compassionate. There is a staff member here. They came in and said 'I can pop in when I'm on shift and make your bed.'

The relatives we spoke with agreed that the staff were kind and compassionate. One relative said "They [the staff] have cared for [family member] and looked after them very well." Another relative told us, "All of the staff are very attentive and caring, which is very reassuring."

During the lunchtime meal, the staff sat next to people whilst offering them assistance with their meal. This was done in a dignified way and at a pace that suited the person. When necessary, gentle encouragement was given to the person to eat the food. Staff talked to people throughout in a light hearted, conversational manner. One person, who had their eyes closed throughout the meal, responded positively to the member of staff who was both patient and cordial. This reassured the person and enabled them to relax and enjoy their meal.

We saw that one person received a card in the post during our inspection. A staff member took this to the person concerned and asked whether they wished for assistance to open and read it. They said that they would like help and the staff member sat alongside them, showing it to them and reading the content to them quietly to maintain their privacy.

Another person told us how they were happy with their room. We observed that it was personalised with a memory board on the wall. This helped the person remember past events and memories. They pointed out to us a picture of their former home, of which they were clearly very proud. Their relative told us, "[Family member] has a lovely room, it's been re-decorated."

Care records contained guidance about how to promote people's dignity when staff were delivering personal care. These outlined how staff should close people's doors and make sure people were covered as far as possible. We observed that this occurred during the inspection and the staff when spoken with, were clear what they needed to do to promote people's dignity. The care records also reflected what people should be encouraged to do for themselves when staff were supporting them with personal care. The staff we spoke with told us they were aware of this and that they followed this guidance. This contributed to people maintaining some aspects of their independence.

People were addressed by the staff using their preferred names. The registered manager told us how one person preferred to be addressed and we checked this with a member of staff. They told us how the chosen name was preferred by the person when they were assisted by male carers, but that they liked female carers to use their given name.

People told us they could make decisions about how they wanted to be cared for on a day to day basis. This included areas such as making choices about where they wanted to spend their time within the home, where they ate and what they wanted to eat. One person said, "I have my breakfast downstairs and my lunch in my room because I like to watch the news." We observed that staff respected this and offered people choice regularly. Some people chose to remain in their rooms whilst others spent time within the communal areas. People were able to eat their food in their rooms, the conservatory, dining room or lounge. The staff we spoke with were clear about the importance of enabling people to make choices about their daily lives.

The relatives we spoke with told us they felt fully involved in their family member's care. We saw that people, and their relatives if necessary, were consulted about the care to be received when the person moved into the home. Reviews of people's care also took place where their care needs could be discussed and plans to meet them changed if necessary.

Residents and relatives meetings had taken place to obtain people's views on their care. However, these had not been well attended even though the registered manager had sent relatives letters about these meetings. There was a schedule of meetings in place. The registered manager was trying to publicise to people and relatives when these meetings were going to take place to increase the attendance and people's involvement in the care provided.

Relatives were encouraged to visit their family member. One relative told us, "I have the door code and let myself in." A person who lived in the home said, "They [the staff] make the family feel welcome." Another relative said, "Yes, very much so. You are able to come and go."

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in November 2015, we found that care and treatment had not always been designed with a view to ensuring that people's individual needs were met. This meant that there had been a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider told us they would meet this Regulation by 1 February 2016. We found that some improvements had been made and that the provider was no longer in breach of this regulation. However, improvements are required to make sure that people consistently receive care that provides them with adequate stimulation to enhance their wellbeing.

Two people told us that staff did not often have time to spend talking to them which they enjoyed. One person, when asked if this happened said, "Very, very rare, but they [the staff] don't have the time." A relative told us, "Not really, but what can you do? They [the staff] are always doing jobs and there's not always enough time to sit down." Another person told us how they sometimes wanted to go outside but this was not always catered for.

Our observations during the morning of the inspection confirmed that the staff did not always interact with people apart from when they were performing a task. The staff we spoke with told us they had limited time to spend with people in the morning talking to them or engaging them in activities due to being busy assisting people to get up.

Although staff regularly checked on two people using the conservatory in the morning, they received no interaction with staff at all for 30 minutes. For a separate period of an hour, we again saw that one of these people did not receive any interaction from the staff. We did observe however, that later during the afternoon that that person had a staff member alongside them talking to them. Staff did engage with the other person as they passed. Neither of the people had a call bell close by so they could summon assistance but we noted that one person's request for help with personal care was responded to promptly and discreetly.

We received mixed views from people regarding the provision of activities to enhance their wellbeing. One person told us, "There isn't a lot to do, they've got a new activities manager who had us making Easter bonnets. The one thing I've really been able to do is quizzes. I've managed them very well, there's several of us, it's quite popular." Another said, "I can go in the garden if I want. Staff help me outdoors." Another person told us, "I like gardening, but I have not been in the garden lately." A relative told us, "I came here a few weeks ago and there was a lady doing jigsaw puzzles and other things."

A new activities co-ordinator had recently been recruited who was responsible for providing people with stimulation and activities to complement their hobbies and interests. This staff member had been on holiday for three weeks. In the interim, the care staff had been given the responsibility for providing people with adequate stimulation but some people told us that this had not occurred. We saw limited activities occurring on the day of the inspection.

We noted that a film was put on in the main lounge for people to watch during the afternoon although the two people sitting within the conservatory were not asked if they wanted to watch this. A singer had been arranged to visit the home at the end of April 2016 and a PAT (Pets as Therapy) dog was due to visit the home the day after our inspection for people to pet.

The registered manager told us that the activities co-ordinator was to return to work shortly and that they were currently working with people in relation to activity provision to meet their individual needs. The registered manager was confident that this area would improve.

The people we spoke with told us that most of their preferences in relation to how they wanted to be cared for were met. One person told us how they liked to have their breakfast at various times in the morning and that this was catered for. Another person said, "I'm always first up, it's more or less my choice. We always have a bath or shower every day, or they give me a wash, if I want one." The relatives we spoke with echoed this. One relative told us, "The care is always timely." Another said, "They [the staff] see each person as an individual, I've always been made to feel that my [family member's] needs are paramount."

People's care needs and preferences had been assessed and there were clear plans of care in place to provide staff with guidance on the care people required. People's care records had been recently reviewed and the information within them was accurate and up to date. The registered manager had recognised that these care records contained lots of information and were cumbersome. Therefore, they had prepared a summary care record that was held in people's rooms. This provided staff with basic information regarding a person's needs. The staff we spoke with told us they found these useful but that they wanted more information within them. This was because the main care records were kept in a locked cabinet that was not accessible to them. Due to this, the staff told us they were not always aware of people's individual histories. One staff member commented to us that they did gain, '…snippets of information from people…' in general conversation.

We raised with the registered manager the importance of staff having an understanding of people's individual histories and backgrounds to enable staff to be better aware of what had been important to people in their past lives. This is particularly important for people who were living with dementia.

The registered manager explained that there were plans in place to include this information within people's records in their rooms. The regional manager told us the provider was aware that the care records were large and difficult to navigate. They explained that the provider was exploring ways of how to document people's needs and preferences in a way that would help staff to find information more easily.

No complaints had been received by the home since our last inspection. The registered manager had a process in place to investigate any complaints including both verbal and written complaints. There was a book within the reception area of the home that people could record any concerns they had . We were therefore satisfied that people's complaints would be dealt with appropriately.

Good

Is the service well-led?

Our findings

At our previous inspection in November 2015, we found that the governance systems in place were not effective at monitoring the quality and safety of the care being provided or to mitigate risks to people's safety. This had resulted in some people experiencing poor care and harm. This meant that there had been a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We warned the provider about this and told them that they had to meet this regulation by 1 February 2016. At this inspection we found that the necessary improvements had been made and that the provider was no longer in breach of this regulation.

There were effective systems in place to monitor all aspects of the care and treatment people received. The methods for measuring this included audits, staff meetings, the analysis of incidents, accidents and complaints and obtaining feedback from the people who lived in the home, their relatives and the staff.

Audits had been conducted regularly by the registered manager. These has assessed areas such as the cleanliness and safety of the environment, the accuracy of people's care records and the management of people's medicines. We saw that where any shortfalls had been identified, actions had been taken to address these.

A new system had been introduced to improve the communication between the staff and the registered manager in relation to people's care needs. Each day the nurse completed a form which was given to the registered manager. On this form they recorded pertinent information regarding people's care. This included areas such as the person not eating or drinking, if they had had any accidents or who needed to see a healthcare professional. In addition to regular handover meetings held between the staff, the registered manager also held a daily meeting at 11am where staff communicated any issues or concerns. All of these systems enabled the registered manager to make sure that timely action had been taken in response to any concerns about people's health and wellbeing.

The provider's operations director had visited the home monthly and had conducted an audit in relation to the quality and safety of the care being provided. We looked at these audits and saw that they were comprehensive. They covered a number of areas including incident and accident reporting, the safety of the premises, accuracy of care records and staff training and competency. Again, we saw evidence that the registered manager had taken action where any shortfalls in the quality of care provided had been identified by the provider's operations director.

Information about important issues had been communicated by the provider to the registered manager and the staff. For example, the introduction of a new system to monitor that people received their meals in a timely manner. This had been implemented immediately by the registered manager when the communication from the provider had been received.

Plans were in place to gain the opinions of the people who lived in Cedar House about the care they received. The provider had already sought the views of their relatives on the care provided in December

2015. This information had been analysed and an action plan produced. The majority of relatives were happy with the level of care being provided. However, some had identified that improvements could be made in respect of the food on offer, communication and in relation to the décor and furnishing within the home.

The registered manager had taken on board these comments and in response, the chef had checked people's preferred choices and refurbishment of some areas of the home and people's rooms had taken place. We saw that the entrance and dining room had recently been re-decorated. The registered manager told us that some people's rooms had also been re-decorated and that this was on-going. This was confirmed by one of the relatives we spoke with during the inspection.

All of the staff we spoke with told us that their morale was good. They described the staff team as working and communicating well, across different staff roles. One staff member told us that they thought the registered manager was very supportive and that they valued the staff team. The staff said they understood their individual roles and responsibilities.

People, their relatives and the staff told us that they could raise any concerns they had with the nurse or registered manager without hesitation and that they felt listened to. They added that any concerns they did raise were acted upon in a timely manner. This demonstrated that the registered manager had established an open culture within the home.

We asked two staff whether they would be happy for a relative of theirs to be cared for within the home. They told us that they would. They said that the size of the service meant that there was a family atmosphere within the home which they liked and enjoyed.