Parkside Care Limited

Cedar House Care Home

Inspection report

3-4 The Cedars
Ashbrooke
Sunderland
Tyne and Wear
SR2 7TW

Tel: 01915655385
Website: www.parksidecare.co.uk/cedarhouse

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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 took place on 18 and 21 July 2016 and was unannounced. We last inspected the service on 23 November 2015 and found the provider was meeting the regulations we inspected against.

Cedar House Care Home provides residential care for up to 31 people, some of whom are living with dementia. At the time of our inspection there were 28 people living at the home.

The home had a registered manager. 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 provider had breached the regulation relating to providing person centred care. Some care plans lacked details about people's personal needs and preferences. This included the specific support people needed to ensure their needs were met consistently.

You can see what action we have asked the provider to take at the back of the full version of this report.

People were happy with their care. People and relatives told us staff were caring and treated people with respect. One person told us, "I couldn't say a wrong word [about staff]". One relative told us, "They [people] are treated well. They're lovely with them, treated like their own."

Staff had a good understanding of safeguarding adults and whistle blowing. They knew how to report concerns and said they would not hesitate if needed. One care worker said, "If I had any concerns I would I would raise them without any hesitation."

Medicines records supported the safe administration of medicines. Medicines administration records (MARs) were completed accurately and medicines were stored safely. People confirmed they received their medicines when they were due.

People, relatives and care workers all said there were enough staff on duty. One person said, "They're always about." One relative commented, "Yes, [my relative] gets lots of attention." Effective recruitment checks were carried out before new care workers started their employment. These included requesting and receiving references and checks with the Disclosure and Barring Service (DBS).

Health and safety checks were carried out regularly to help keep the home safe, such as checks of fire safety systems and the water, gas and electrical supplies. Procedures were in place to ensure people received appropriate support in an emergency.

Incidents and accidents were investigated and action taken to help keep people safe.

Staff were well supported and received the training they needed to fulfil their caring role. Regular one to one supervisions and appraisals were carried out.

People gave positive feedback about their meals. Staff supported people to have enough to eat and drink in line with people's assessed needs.

The provider followed the requirements of the Mental Capacity Act (MCA) 2005. Deprivation of Liberty Safeguards (DoLS) were in place for people who were unable to consent to their placement in the home. Staff had a good knowledge of how to support people with making their own choices and decisions.

Records confirmed people had regular input from professionals in line with their needs, such as community nurses, consultants, GPs and a chiropodist.

Three care workers had recently completed additional training in relation to meaningful activities for people. The activity programme as being redeveloped to reflect people's needs. We observed people had regular one to one with staff and activities were taking place when we visited.

People knew how to complain but they told us they did not have any concerns about their care. Two complaints had been thoroughly investigated and resolved.

People said the home was well-led and had a good atmosphere. The provider carried out regular quality assurance checks which had been successful in identifying areas for improvement.

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.

Medicines were managed appropriately.

Staff had a good understanding of safeguarding and whistle blowing, including how to report concerns.

There were sufficient staff on duty to meet people's needs. Effective recruitment checks were in place to ensure care workers were suitable for their role.

Regular health and safety checks were carried out and emergency procedures were in place.

Is the service effective?

Good

The service was effective.

Staff received regular supervision and appraisal. Essential staff training was up to date.

The provider followed the requirements of the Mental Capacity Act (MCA) 2005 including the Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were met appropriately.

People had access to the health care services they needed.

Is the service caring?

Good

The service was caring.

People were happy with the care they received.

People told us care workers were kind and considerate.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans lacked detailed information about people's needs and preferences.

The activity programme was due to be updated following additional training for three care workers.

Complaints were dealt with in line with the provider's agreed procedure.

Is the service well-led?

Good

The service was well led.

People said the registered manager provided good leadership.

Relatives commented the home had a good atmosphere.

The provider carried out regular quality assurance checks.

Cedar House 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 inspection took place on 18 and 21 July 2016 and was unannounced.

The inspection was carried out by one adult social care inspector 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, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR as well as all the information we held about the service including notifications of significant changes or events. Notifications are changes, events or incidents the provider is legally required to let us know about. We also contacted the local authority commissioners for the service, the local Healthwatch and the clinical commissioning group (CCG). Healthwatch is an independent consumer champion who promotes the views and experiences of people who use health and social care services.

We spoke with seven people who used the service and six relatives. We also spoke with the registered manager, a senior care worker and four care workers. We observed how care workers interacted with people and looked at a range of care records which included care records for four people, medicines records and recruitment records for four care workers.

Good

Is the service safe?

Our findings

People and relatives told us the home was a safe place to live. One person said that the home was "good, safe and comfortable". People told us if they felt unsafe there were people they could speak with. One person said, "I could go to [registered manager]." Another person said, "I could speak to anyone here." One relative commented there was "security on windows and doors" and "staff were on hand".

When we spoke with care workers they demonstrated a good understanding of safeguarding adults, including how to report concerns about people's safety. They could readily identify the various types of abuse they might encounter in their role and the potential warning signs to look out for. Two previous safeguarding concerns had been dealt with following the agreed procedures. This included making appropriate referrals to the local authority safeguarding team and the Care Quality Commission where required. Care workers were aware of the provider's whistle blowing procedure. One care worker advised us they had not needed to use the procedure whilst working at the home but would not hesitate to do so. They said, "If I had any concerns I would I would raise them without any hesitation."

Medicines records we viewed supported the safe management of medicines. Trained staff, whose competency had been checked, administered medicines to people. Medicines administration records (MARs) were completed accurately which meant medicines given to people were accounted for. Where medicines hadn't been given codes were used to confirm the reason, such as a person refusing or medicines not required. The MARs we viewed showed no gaps or discrepancies in recording. We saw audits were conducted regularly and any concerns identified were acted on. Medicines were stored securely in locked medicine trolleys which were then stored in a locked treatment room. Other medicines records, such as for the receipt and return of medicines and the medicines fridge temperature checks, were up to date. People we spoke with during the inspection told us they received their medicines on time.

People were assessed to help protect them from a range of potential risks. This included risks associated with poor nutrition, skin damage and mobility. Where potential risks had been identified a risk assessment was carried out and action taken to keep people safe. For example, one person had lost weight for two consecutive months. In order to keep the person safe additional monitoring was in place to check on the person's nutritional intake. The registered manager confirmed the person did not require input from a dietitian unless they lost further weight. Other health and safety related risk assessments had also been carried out. For example, a fire risk assessment was in place. There were other risk assessments for the use of bed rails for people who were at risk of falling out of bed and for community outings with people. These were up to date and identified the controls needed to help keep people safe.

People and relatives felt there was enough staff to care for them safely. They also told us staff responded to their needs quickly. One person said, "They're always about." Another person told us, "[Staff] come as quickly as possible, they do everything." One relative commented, "Yes [my relative] gets lots of attention." Another relative said, "I can always find someone when I need them." Staff also confirmed there were enough staff. One staff member said, "Staffing is really good. A lot of the girls have been here a long time. We can see to people's needs quickly." The registered manager monitored staffing levels to ensure they were

sufficient to meet people's needs and dependencies. A dependency tool was used to calculate staffing levels. The tool considered people's dependencies as well as other information such as falls in the home. Actual staffing levels provided were always in excess of those as determined by the dependency tool used.

The provider carried out effective recruitment checks to confirm new care workers were suitable to work with vulnerable people. These included various pre-employment checks, such as requesting and receiving references and checks with the Disclosure and Barring Service (DBS). DBS checks were carried out to confirm whether prospective new care workers had a criminal record or were barred from working with vulnerable people.

Records confirmed incidents and accidents were logged and investigated including details of any action taken to help keep people safe. We saw action had been taken to keep people safe, such as seeking medical attention when required. Incidents and accidents were analysed and monitored to look for trends and patterns. For example, referrals had been made to specialist health professionals for advice and guidance where people had experienced repeated falls.

The provider carried out a range of health and safety checks to help keep the home safe for people to live in. These included checks of the fire safety systems, the water safety, gas and electrical safety and the environment. Records we viewed confirmed these were up to date when we visited the home. Servicing and checks were up to date for specialist equipment used in the home. This included checks of moving and assisting equipment to help people mobilise.

Procedures were in place to deal with emergency situations. The business continuity plan had been recently written. This included the measures in place to deal with a range of emergency situations such as loss of utilities, staff and the building. Personal emergency evacuation plans had been written for each person, which detailed each person's support needs in an emergency.

Good

Is the service effective?

Our findings

People and relatives felt staff had the relevant skills and knowledge to meet their needs. One person said, "Oh yes they seem to know [what to do]." On relative said the staff were "very knowledgeable, more than at the hospitals".

Care workers told us they received good support to enable them to carry out their role effectively. One care worker commented, "I have never had a problem. I have never felt that I wouldn't be supported." They went on to confirm they received regular one to one supervision and appraisals. Records confirmed supervision and appraisal were carried out regularly. Some of these supervisions had been themed around important areas relating to care delivery including dignity in care and skin care.

Essential training for all staff was up to date. This included moving and assisting, first aid, fire safety, safeguarding and infection control. The provider kept a training matrix so that completion of training courses could be monitored and planned in to maintain staff member's knowledge.

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 so that they can 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. DoLS authorisations had been agreed for 25 out of 28 people, a further two applications were being assessed and one person had been assessed as having capacity. An independent advocate had been involved with one person who lacked capacity in relation to their DoLS assessment. Where people lacked capacity to make their own decisions staff described how they supported people to make choices. This included showing people pictures, holding up objects to choose from and looking at care plans to understand people's likes and dislikes. All of the people we spoke with confirmed staff asked them for permission before providing support.

All the people we spoke with gave complimentary feedback about the meals. They said they were given choices and there was sufficient to eat. Although some people felt there was too much to eat. One person said, "If you don't like it you can get something else." One relative commented about the chef, "He's just lovely with the elderly, he just loves them and is really good." People told us snacks and drinks were available outside of mealtimes. One person said, "The trolley is always on the go." One relative told us about how their family member was "eating better than at home". They went on to tell us, "They [person] get all sorts to eat and it's the best." We saw the chef spoke with each person every morning to help them make their meal choices. A food questionnaire had also been completed for each person which recorded details of

their likes and dislikes. People had eating and drinking care plans which detailed the support each person needed to meet their nutritional needs. People at risk of poor nutrition were weighed either weekly or monthly depending the level of risk. In this way the provider could identify quickly whether any additional support was required.

We observed during the lunch time meal to help us understand how well people were supported. We found prior to people being brought into the dining room, tables had been set with table cloths and cutlery. Drinks were available for people when they arrived in the dining room. People were sat at tables in small friendship groups of three to four people. Where people required assistance with eating their meal, staff provided this without any interruptions. Special diets were catered for in accordance with people's dietary requirements, such as pureed meals.

People were supported to access the health care they needed. Some people received regular visits from community nurses who visited the home most days. Care records showed people had regular input from health professionals, such as community nurses, consultants, GPs and a chiropodist.

Good

Is the service caring?

Our findings

People were happy with the care they received at the home. They told us staff were kind caring and considerate. One person said the staff were "nice enough". Another person told us "I couldn't say a wrong word [about staff]". A third commented the staff were "just natural, family-like". They went on to describe how there was "lots of humour and laughter in the home". A fourth person said, "They [staff] are as good as gold."

Relatives spoke highly of the care staff. One relative told us, "They [people] are treated well. They're lovely with them, treated like their own." Another relative said staff were always "laughing and carrying on". A third relative felt the home was very "homely". They commented, "It's nice that she's in the same kind of atmosphere as at home."

People felt staff listened and explained things to them appropriately. One person said "They chat to you, they're kind." Another person commented, "They [staff] talk to you like they've known you for years." A third person told us they could just speak with "any staff, they're all good". Relatives also felt involved in their family member's care. They said they were kept informed on a day to day basis if anything happened to their family member. Another relative described how the provider kept them informed. They felt the provider "wouldn't do anything without our say so".

People were cared for by staff who knew their needs well and supported their choices. One person said, "They all know about me". People said they could choose where to spend their time during the day. One person explained how they spent their mornings in the lounge and then went to their room in the afternoon. They went on to explain how this was their choice and staff supported them to do this. Another person explained they spent time relaxing and chatting with staff. They told us they "like to get my hair done and have chats with the gardener". One relative said, "[My relative] can do as they want". Staff demonstrated they knew people well. One staff member introduced us to one person and explained how they liked to spend their day. They described how they liked to spend time together chatting and looking at books or other memorabilia.

Relatives told us privacy and dignity was maintained in the home. One relative described how "doors are kept shut" and "two staff support [my relative] with personal care". Another relative explained how staff approached and explained things as they attended to their relative. Staff gave us examples of how they provided care in a dignified and respectful way. This included encouraging people to be as independent as possible, explain what they were doing at all times and supporting choices.

People had input from independent advocates when needed. Two people using the service were registered with an advocate and had regular visits to assist with reviews and significant decisions relating to their care. Information on local advocacy services was available to people within the service user guide. Leaflets and posters were also displayed in communal areas.

Requires Improvement

Is the service responsive?

Our findings

Care plans were not always detailed enough to reflect the personalised needs and preferences people had. For example, one person's needs had changed so that they were now cared for in bed. We had no specific concerns about the person's actual care as community nurses were visiting very regularly to check on the person. However, their care plans did not detail the person's current needs. For example, the person had been prescribed medicines to help manage a specific medical condition. We found their care plan made no reference to this medicine or the support required from staff to take this medicine safely. This meant there was a risk some people might not receive the personalised care they required to meet their individual needs.

Another person's communication care plan stated the person had difficulty with communication but staff were aware of the person's wishes through understanding their 'body language.' However, the care plan did not then go on to detail what body language the person used and what they were wanting to communicate. The person's eating and drinking care plan identified the person was unable to make meal choices but did not identify any preferences the person had to help staff make informed choices for them. Also the care plan did not detail the specialist equipment and support the person needed to help them eat independently. We observed the person over lunchtime and saw staff provided the person with the required specialist crockery. The crockery was a bright yellow colour to help the person identify and locate it easily on the table. However, on both days of our inspection staff placed these items on a yellow table cloth which meant the person had difficulty. We saw the person was often "spooning" the tablecloth rather than their meal.

We saw other examples over lunch where people's preferences were not fully met. For example, we heard one person asking for their lunch to be cut up before it was served. However, the meal was served without this being done and was cut up at the table. Another person preferred their meal items served separately but the meal arrived with the gravy already on. This meant some people did not always receive care and support in line with their personal preferences.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although care plans lacked detail, other care records contained information about people's preferences, such as what time people preferred to get up on a morning and what time they preferred to go to bed. There was also some good examples of 'life history' work using photos from people's early life to tell their story. Life histories are important as they help staff to develop a better understanding of people's needs. We found people's needs had been assessed shortly after admission to the home.

The provider was responsive to requests from people and relatives. Relatives told us they felt involved in their family member's care. One relative gave us an example of how they had asked for their relative to have a change of room which had been accommodated. We found the provider had redecorated another person's room as they were unhappy with the colour scheme which had been used.

People gave us mixed views about the activities available at the home with some people telling us there wasn't much activity. One person said, "There's not much to do." They went on to say there were "occasionally singers or entertainers". Another person said they had been out for fish and chips recently. Other than that they had been watching TV because "there's nothing else to do". The provider had invested in training three staff to lead on the activity programme in the home. They had just completed training in a programme called 'Oomph' (our organisation makes people happy). This is a specific themed exercise and activity programme delivered by trained care staff. This was to be rolled out across the home imminently.

We observed during our inspection staff regularly spent one to one time with people. For example, we saw some staff sat chatting with people whilst other staff spent time with people doing jigsaw puzzles or reminiscing with old photos. We also observed a game of 'animal bingo' with eight people engaged with the activity. We saw there was lots of positive interaction between people and staff with people clearly enjoying the activity. The members of staff explained to us how they had adapted the bingo game to make it suitable for people using the service. Staff said they felt people enjoyed this game and got involved.

There were opportunities for people to give feedback. This included the provider involving people in monthly quality checks and organising specific 'residents' meetings'. We viewed the minutes from previous meetings held and found people had given positive feedback about the home. Topics discussed included activities, events, mealtimes and complaints.

People knew how to make a complaint if they were unhappy with their care. Most people said they would approach a member of the care staff or the registered manager. One person said, "Yes I would give my views and I would speak to the head one." Another person said they would let a "member of staff know what they want". Relatives said they knew how to complain and felt they would be listened to.

Complaints were fully investigated and dealt with effectively. The provider had a complaint procedure for people and relatives to access if they were unhappy with the care provided. Two previous complaints received relating to the décor in people's rooms had been fully investigated. The provider took action to improve the décor including new carpets and re-decoration and a full clean. The provider checked people were happy with the outcome before closing the complaint.

Good

Is the service well-led?

Our findings

The home had an established registered manager. The registered manager had been proactive in submitting the required statutory notifications to the CQC. People who gave a view about the management of the home said it was well-led. One person said "Most of the time everything runs pretty smoothly." Another person commented, "[Registered manager] is always around." One relative told us the registered manager was "always pleasant and approachable". Another relative commented the home was "definitely" well managed.

Staff said the registered manager was approachable and they could contact them at any time. Regular staff meetings took place, which were used to discuss important aspects of care delivery. This included equality and diversity issues, dignity and keeping people safe.

Relatives gave us positive feedback about the atmosphere in the home. One relative said, "I really like the place because it's homely, friendly and clean." Another visitor said "It's nice and clean, clothes are nicely washed." Relatives told us about how they had recently attended a garden party at the home and felt included in the home life. Staff also felt the home had a good atmosphere.

The provider carried out an annual self-assessment as part of the quality assurance processes for the home. The tool being used had been developed jointly with other care home providers and was accompanied by a detailed manual to guide staff on effective use of the tool. The self-assessment focused on four areas: 'quality of environment; quality of staff; quality of care; and quality of management and organisation'. The last self-assessment was carried out in April 2016 with the provider identifying strengths, weaknesses and areas for improvement in each of the four areas. These were then supported with an action plan. For example, areas of strength identified during the last self-assessment included the homely atmosphere in the home and the open and spacious environment. Areas for improvement identified in the action plan included commencing a bedroom refurbishment programme, new flooring and additional lighting in corridors.

There were a range of other audits in place to check on the quality of people's care. Regular checks of people's medicines were in place. These were effective in identifying issues and ensuring action was taken to investigate and deal with the issues. The registered manager told us the current system of care plan audits was being reviewed. A new system was to be introduced as the current system was not as effective as the registered manager would like.

The provider also had a system of 'monthly management reviews' as a further check on the quality of people's care. This included a check of the premises, care records, complaints and the views of people and relatives. We viewed the most recent check which had been carried out in June 2016. People and relatives included in the review all confirmed they were happy with the care provided. The action plan developed from the review included plans to update care records for two people.

People and relatives were asked to complete an 'annual quality questionnaire' to gather their views about

the home. The results were available to view from 2013 onwards and this showed a consistently high percentage (over 90%) of people were 'very' or 'extremely' satisfied' with their care. The provider sent us the results from the most recent survey which were being collated when we visited. This found 93.75% of people and relatives were either 'very' or 'extremely' satisfied with the care. Specific comments received from the feedback included: "everything is excellent"; "I know I can go home and [my relative] is well looked after"; "staff are very friendly and caring and always respond to requests"; and, "[My relative] is very happy here and receives the care [my relative] deserves." Some mixed views had been received about activities in the home which the provider was addressing through the planned improvements to the activity programme.

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 People's care was not always designed in such a way as to meet their needs and reflect their preferences. Regulation 9(1) and 9(3)(b).