Cedar Court (Cranleigh) Care Limited

Cedar Court Care Home

Inspection report

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Cranleigh
Surrey
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Date of inspection visit:
13 January 2016

Date of publication:
10 March 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Cedar Court Care Home is a purpose built care home that provides accommodation and nursing care for up to 75 people. There were 51 people living in the home on the day of our visit. It has a designated unit that specialises in the provision of care for people living with dementia. Accommodation is arranged over three units. Albert unit provides nursing care for 30 people, Edinburgh unit provides care for 29 people living with dementia and Alexander unit provides support for 16 people who require residential care.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was enough improvement to take the provider out of special measures.

The home is located close to Cranleigh Village and within easy access to local amenities and facilities. Bedroom accommodation is arranged over two floors. A passenger lift provides access to the first floor. Bedrooms are single occupancy and all have en suite facilities. There is a large garden to the side and rear of the service and a large car park is available at the front.

This inspection took place on 13 January 2016 and was unannounced.

The home was run by a registered manager, who was present on the day of the inspection visit. 'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were treated well by staff who were kind and caring. People's privacy and dignity was now being respected.

People were now protected from abuse because staff were able to recognise the signs of abuse and had undertaken training regarding safeguarding adults.

Staff now understood their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). DoLS authorisations had been submitted where restrictions were imposed to keep people safe. However one person's best interest had been considered when they needed support to make decisions.

Assessments were now in place for identified risks, which had improved following our last inspection. .

Care planning had improved although one care plan was inconsistent with the person's care needs. People were now encouraged and supported to be involved in their care.

People's bedrooms had been decorated to a good standard and were personalised with their own possessions.

People were supported to keep healthy. People were registered with a local GP who visited the home weekly. Visits from other health care professionals also took place.

People had sufficient food and drink, although the lunch time meal was a little disorganised at times on the dementia unit.

We looked at the medicine policy and found all staff gave medicine to people in accordance with this policy. Medicines were managed safely.

Previously there were not enough staff working in the home to meet people's needs and people had to wait for care. There were now sufficient staff available to support people and adequate ancillary staff were also employed to enhance the care provided.

Staff recruitment procedures were safe and the employment files contained all the relevant checks to help ensure only the appropriate staff were employed to work in the home.

Staff supervision and appraisal were now taking place and staff now received regular formal supervision from their line manager.

People had access to a range of activities which were overseen by an activities coordinator. People on the dementia unit required more support to engage in activities and this was disorganised at times on the morning of our visit.

The standard of cleanliness was an issue at the last inspection and the service was in beach of our regulations. During this visit we found the service was clean and fresh and people were satisfied with the general cleanliness throughout the service. Infection control audits were in place and there was a nominated person deployed in the service to undertake these audits as part of their clinical role.

People had been provided with a complaints procedure and knew how to make a complaint. We noted two complaints received since our last inspection had been resolved using the complaints process. .

At our last inspection the service was not being well managed. People and staff felt unsupported by the lack of leadership in the service. Since then there was a new registered manager in post and the service was now being well managed. Feedback from people included they felt listened to and the manager spoke with them every day.

The standard of record keeping had improved since our last visit and records relating to the care of people and the management of the home were kept up to date.

Staff were aware of the home's contingency plan, if events occurred that stopped the service running. They explained actions that they would take in any event to keep people safe. The premises provided were safe to use for their intended purpose.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was safe.

Risks to people were managed well to protect people from harm.

There were enough staff available to safely meet people's needs.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of the safeguarding adult's procedures.

Medicines were managed safely, and people received their medicines in a timely way as prescribed.

Staff were recruited safely, the appropriate checks were undertaken to help ensure suitably skilled staff worked at the service.

The standard of cleanliness was good and systems were in place to monitor infection control.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider and staff had an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. DoLS applications were in place for people who required these.

Staff received regular training to ensure they had up to date skills and knowledge to undertake their roles and responsibilities. They also had regular one to one meetings with their manager.

People were supported to eat and drink according to their choice and plan of care.

People's health care needs were being met.

Is the service caring?

Good

The service was caring.

People were well cared for and their privacy and dignity was maintained.
We observed staff were caring and kind and treated people kindly and with respect.

Staff were professional, patient and discreet when providing support to people.
There were some comments regarding the communication skills of some staff and English not being their first language. The provider gave us their reassurance this would be addressed.

Is the service responsive?

Good

The service was responsive.

Care plans were well maintained and included people and their families.

Staff were knowledgeable about people's needs, their interests and preferences in order to provide a person cantered care.

There were activities provided for people who chose to participate.

Complaints were monitored and acted on in a timely manner.

Is the service well-led?

Requires Improvement

The service was well led.

Quality monitoring feedback surveys had just been introduced to gain an overview of the service and identify where improvement could be made.

The provider had systems in place to monitor the quality of the service provided.

The registered manager had maintained accurate records relating to the overall management of the service.
Staff told us they felt supported by the registered manager.

Cedar Court 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 13 January 2106 and was unannounced. The inspection team consisted of three 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. The expert had experience in caring for someone living with dementia and older people.

Before the inspection, we reviewed all the information we held about the provider. This included information sent to us by the provider in the form of notifications and safeguarding adult referrals made to the local authority. Notifications are information about important events which the provider is required to send us by law. We did not ask the provider to send us a provider information return (PIR) before this inspection as we were undertaking this inspection within six month of our previous visit. The PIR is a form that askes the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider sent us an action plan following our last inspection outlining how they had planned to make improvements following

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with 12 people, eight members of staff, the registered manager, the head of care, the nominated individual, the dementia champion, twelve relatives, the chef and five health care professionals.

We spent time observing care and support being provided. We read people's care plans medicine administration records, recruitment files for staff, supervision records for staff, mental capacity assessments for people who used the service and other records which related to the management of the service such as training records and policies and procedures.

The last inspection of this service was 4 June 2015 where we found the service was in breach of several regulations and we rated the service inadequate. The service was also placed in special measures. This

inspection was to check to make sure that improvements had been made.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and did not have any concerns. One person said "I feel safe living here and I worry about nothing." Another person said "Absolutely I feel safe. I came here because I was unable to look after myself at home. I definitely made the right move and I feel safe." A relative said "This is a safe place for my family member to be."

At the last inspection on 4 June 21015 we identified a continued breach of our regulations regarding safeguarding people from abuse. People had gates on their bedroom doors to prevent people from wandering and staff were unsure how to safeguard people. At this visit we found these gates had been removed and people could walk about freely. People were kept safe because staff understood their roles with regard to safeguarding people from abuse. Staff had a good understanding of what constituted abuse and the correct procedures to follow should abuse be identified. For example, one member of staff was able to describe the different types of abuse and what the local authority safeguard protocols were. They said, "I would report anything to the registered manager or the nurse in charge." There was a safeguarding procedure in place and staff we spoke with were familiar with this procedure. This also provided staff with contact details of the local authority should they require this. All staff had undertaken training regarding safeguarding adults and this was updated regularly.

At the previous inspection we found that there were not enough staff to meet people's needs. Although staffing levels had increased the registered manager told us they were still using agency nurses and carers to ensure there were enough staff on each shift. People's comments regarding staffing levels varied for example one person said "Things are definitely better and we get good care." Another person said "Bells can be either hit or miss depending on the time of day." We noted call bells were answered promptly during our visit. Some people told us there were always enough staff available to help them. Another person told us "There were too many agency nurses working in the home." The registered managed told us they calculated staffing levels according to the number of people in the home and their assessed needs. These levels fluctuated according to people's changing or increased needs. The registered manager was aware of the impact agency staff were having on the continuity of care being provided and they shared their recruitment plan with us which detailed their ongoing efforts to establish a permanent staff team. We spoke with an agency member of staff and they told us they were regular and knew people's needs and the routine of the home. We confirmed this throughout the day by observing their interaction with people and their capability to undertake their role.

People's needs were being met because there were sufficient staff deployed in the home. We looked at the staff duty rota for the previous four weeks. The rota revealed staffing levels were consistent across the time examined. There were two care staff allocated to Alexander Unit, five care staff one qualified nurse and a head of care allocated to Edinburgh Unit and three care staff, one qualified staff and a head of dementia on Albert Unit. Six staff were deployed in the service to cover night duty. There was also kitchen, domestic administration, maintenance and activity staff employed to support the provision of service.

The provider had undertaken appropriate recruitment checks to ensure staff were suitable to work in the

service. We examined staff files containing recruitment information. We noted criminal record checks had been undertaken with the Disclosure and Barring Service (DBS). There were also copies of character references, proof of registration with the Nursing and Midwifery Council (NMC) and Home Office checks regarding eligibility for staff to work in the UK.

At our previous inspection we found that risk assessments were either not in place, not being followed or were out of date. Risk assessments had now been put in place following our last inspection. Where risks had been identified plans were in place to manage these which were detailed and contained information for staff to follow around what the risks were and the measures needed to be taken to reduce the risk of harm. Staff followed these guidelines. Some of the risk assessments we looked at included moving and handling, skin care, personal care, communication needs, medication management, continence management or social activities. These were constantly updated either routinely or when needs changed to ensure people's needs were met. Two people told us they had been having frequent falls and as a result of this they both wore alarm pendants around their neck to summon help if they fell again. One person said "It's a jolly good idea and gives me independence."

At our last inspection people were not protected from the prevention and control of infection. General cleanliness in the home had been an issue and there was no infection control lead.
Since our last inspection a series of joint Clinical Commissioning Group and Surrey County Council quality assurance team monitoring visits have been taking place focusing on infection control improvement in the home. A tool developed by Public Health had been used to monitor infection control. During this inspection we found the home was clean and hygienic and there were no unpleasant odours. The home now had a head of care as the infection control lead who ensured that people were being cared for in a clean environment. People told us there had been a marked improvement in the standard of cleanliness and that their rooms were cleaned daily. The laundry was organised and there was no backlog of dirty laundry which was the case at our previous visit. Wash hand basins were now kept clear so they could be used for hand washing to reduce the risks of cross infection. We saw audits of infection control monitoring were being maintained monthly and staff had received training regarding this.

People's medicines were managed safely. We asked how medicines were acquired, administered and disposed of. We examined the medicine administration records (MAR) charts. We also observed the dispensing of medicine and examined the provider's medicine management policy. We were told the provider conducted regular direct observation of staff administrating medicines. Our examination of documentation confirmed this.

The administration and management of medicine followed guidance from the Royal Pharmaceutical Society. Staff locked the medicine trolley when leaving it unattended and did not sign MAR charts until medicines had been taken by the person. There were no gaps in the MAR charts. These charts contained relevant information about the administration of certain drugs, for example medicine used for heart disease and for pain management. Staff were knowledgeable about the medicines they were giving. The provider carried out regular audits of medicine management and also facilitated yearly audits from an external provider. Any issues identified as a result of these audits were addressed in order to maintain the safe and effective management of medicine.

All medicines were delivered and disposed of by an external provider. The management of this was safe and effective. Medicines were labelled with directions for use and contained both expiry date and opening date. Creams, dressings and lotions were labelled with the name of the person who used them and safely stored.

Other medicines were safely stored in trollies. There was a dedicated lockable room for the storage of medicines. A fridge was provided for medicines that require to be refrigeration and was not used for any other purpose. A patch tracker was used for people who had their medicine in patch format. This was to prevent patches being applied to the same area and prevent people's skin from becoming sore.

Accidents and incidents were recorded and acted upon. For example when falls had been recorded the registered manager met with the qualified nurses to discuss common themes and trends and implemented an action plan to manage this. This took into account staffing, the time of the accident and any other issues such as medicine to ensure people were safe.

The premises were safe for people who lived in the service. Radiators were covered to protect people from burns. Fire equipment and emergency lighting were in place and fire escapes were clear of obstructions to help people get out of the house in an emergency. Windows had the appropriate and safe restrictors in place to prevent falls. People had PEEPs (personal emergency evacuation plans) in case of fire or emergency. This is a plan that is tailored to people's individual needs and gives detailed information to staff about supporting people's movements during an evacuation.
The registered manager told us the home had an emergency plan in place should events stop the running of the service. Staff confirmed to us what they would do in an emergency.

Requires Improvement

Is the service effective?

Our findings

A relative told us that staff appeared to be trained and felt staff knew what they were doing. People said they were well cared for and staff understood them and their needs. One person said "I have seen a lot of change here and staff seems more efficient."

At our last inspection the service was not providing staff with the skills and qualifications required for them to undertake their roles efficiently and effectively.

People were now supported by staff with the skills and knowledge to meet their assessed needs. A staff member told us they had attended several training days and felt they had the knowledge to undertake their roles. One member of staff said "The manager makes sure we know how to do things, and she is always checking us."

There was now a formal induction programme in place which all new staff undertook on commencement of employment. The programme was structured around allowing new staff to familiarise themselves with the service policies, protocols and working practices. Staff worked under the supervision of a senior staff member and were assessed as competent before they undertook their duties unsupervised. We noted the provider had introduced the Skills for Care Certificate training as part of staff introduction. This provided staff with an identified set of standards that health and social care workers adhered to in their daily working life.

People were being cared for by nurses with the skills and qualifications to provide appropriate and effective care. We examined the 2015/2016 training records and found that training had been provided and further training was planned including refresher updates. This included infection control, health and safety, moving and handling people, food hygiene, and caring for people with dementia. Qualified staff were also provided with training specific to their roles and for professional development in line with the Nursing and Midwifery Councils (NMC) Code of Professional Conduct. For example catheterisation, wound management, medicine awareness and taking blood.

Staff told us they were now receiving formal supervision with their line manager every two months. They said it provided them with opportunity to discuss their training and development with their line manager and to identify any concerns or areas for improvement. They also said objectives and goals were discussed and set for the coming year. We looked at staff supervision records which confirmed this. Yearly appraisals were partly in place. These were in the process of being reviewed and brought up to date by the registered manager who had only been in post since the last inspection and had not implemented these fully yet.

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 interest and as least restrictive as

possible. We noted that the provider had made improvements in relation to the management of mental capacity assessment since we made a compliance action at the last inspection.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.
People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes is are called the Deprivation of Liberty Safeguards (DoLS). People who required them had DoLS authorisations in place that had been authorised by the local authority. However we found some of these were generic and not always specific to individual needs. For example we saw staff moved a person about in an arm chair with wheels when their mobility plan said they could walk. However there was no evidence that a mental capacity assessment or best interest meeting had taken place or a DoLS application had been made to support this need.

We recommended the service should review how they were moving this person.

The registered manager had spoken with staff collectively regarding the MCA to ensure they were aware of this and what it meant to them in their everyday roles. Some some staff had undertaken training in MCA and more staff were due to have this training on various dates during 2016. Staff told us "It's all about getting people's consent I would never undertake a procedure before asking the person first." We noted written consent was sought and obtained from people or their representative with regard to the use of bed rails, photography for identification purposes and sharing of information with other agencies. One person's mental capacity fluctuated, which meant their ability to make decisions for themselves varied from day to day. This person's mental capacity was regularly assessed to monitor this. The mental capacity care plan also contained steps staff should take to maximise the person's ability to make decisions for themselves whenever possible.

People were supported to keep healthy, and had access to appropriate health care professionals when needed. Care records showed people's health care needs were monitored and action taken to ensure these were addressed by appropriate health care professionals. People were registered with a local GP who visited the service weekly or more frequently if required. One person said "I am very pleased with the support I get from my doctor." People had access to dental care, a chiropodist, and an optician regularly. Specialist input from a tissue viability nurse (TVN) was sought when a person developed a pressure ulcer. There was one application in progress for TVN support for a person who was recently admitted to the service. Community psychiatric nurses (CPN) and a continence advisor were also available to support people. We noted advice and guidance given by these professionals was followed. We spoke with two health care professionals who made positive comments about the care provided. They said "I have noticed a big improvement in the home now they have qualified staff employed." Another comment was "Having a clinical lead person to manage the care has changed things for the better." Appointments with consultants or specialists were made by a referral from the GP. We saw records were kept in care plans of visits from health care professionals. This included any changes to medicine or new treatments prescribed.

We saw people had a nutritional care plan in place which outlined their dietary needs. It identified if people required a high calorie diet, a low fat diet, a soft or pureed diet, if they were diabetic, vegetarian, required low sodium due to heart disease or had a cultural requirement. These plans were supported by action plans for staff to maintain adequate nutrition and hydration. This included monitoring people's weight. Although most people's weight was recorded we saw one person refused to be weighed which caused concern to their family. Staff had involved the community psychiatric nurse and the dietician for support. This was

reviewed regularly to ensure this person was getting enough to eat and drink.

The chef who told us they were provided with people's choices daily but did not have a list of people's dietary needs. They also said they were not aware of people's allergies and did not offer a choice of pureed food. We ecommended the chef was provided with a list of people's dietary needs to ensure people were eating the correct diet.

We observed lunch being served during our visit. On Edinburgh Unit (dementia unit) we saw people who were unable to communicate verbally or who required their food to be pureed were not offered a choice of either food or drinks. Food was pureed separately but this did not look very appetising. We found the lunch time experience was not very well organised as the staff member who was most familiar with people's dementia needs was attending a review meeting which impacted on the mealtime experience fpr people. People who were able to communicate verbally were given a choice of meals and drinks. People who required help to eat were supported by staff in a kind and patient manner. Plate guards and spoons were provided for people to help maintain their independence.

The lunchtime experience for people who ate their meals on the other two units was pleasant and sociable. The tables were nicely laid with laundered table cloths, condiments and glass wear.
People chose who they sat with and there was good interaction between people. The food was served by the chef from a heated trolley to ensure food was served at the right temperature. Staff supported the chef to serve and had a list of people's dietary needs, likes and dislikes. Menus were displayed outside the dining room and were planned over a four week period. These were varied and offered people a range of wholesome home cooked food. People said they had enough to eat and that the food was good. They were offered a choice of meals and if they did not fancy what was offered the catering department organised a lighter option. We saw one person refused all food offered to them. Staff supporting them provided them with two hot puddings instead of a main meal which they enjoyed. The member of staff told us "This is not unusual for this person so we give them what they ask for." People were also offered a glass of wine with their meal.
We observed some people had their meals in their rooms either by choice or they were confined to bed. Staff took meals to people in their rooms on trays and plates were covered with plate covers. The chef ensured food was served at the correct temperature before it left the trolley. When people required to be fed their food was kept in the trolley until staff were free to support them. A relative told us they came every day to feed their family member and the food always looked appetising and wholesome.

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offered a choice of meals and if they did not fancy what was offered the catering department organised a lighter option. We saw one person refused all food offered to them. Staff supporting them provided them with two hot puddings instead of a main meal which they enjoyed. The member of staff told us "This is not unusual for this person so we give them what they ask for." People were also offered a glass of wine with their meal.

We observed some people had their meals in their rooms either by choice or they were confined to bed. Staff took meals to people in their rooms on trays and plates were covered with plate covers. The chef ensured food was served at the correct temperature before it left the trolley. When people required to be fed their food was kept in the trolley until staff were free to support them. A relative told us they came every day to feed their family member and the food always looked appetising and wholesome.

Good

Is the service caring?

Our findings

People told us staff were "Kind" and "Caring." One person said, "I think the staff take care of me really well." Another person told us "I am satisfied with the care I get." A relative said "Staff are really terrific and you just can't fault them." Another relative said "Things have improved here lately which is good."

Staff were caring and attentive to people's needs. There was good interaction between people and staff and staff took the time to inertact with people either when passing or working with them on a one to one basis. Staff consistently took care to ask permission before undertaking care or assisting. We heard a member of staff ask if a person was alright and they replied "I would like the toilet." We then saw the person being taken to the bathroom by staff who engaged in conversation and took their time with them. Another member of staff gave a person their newspaper and took the time to make sure they also had their reading glasses. A member of staff was serving coffee and we heard them say to someone who had a drink on the table "Let me put that closer to you so you can manage better." There was a high level of engagement between people and staff. When staff had a moment they stopped beside people and took an interest in what they were saying. For example one person had a visit from their family and when they left staff spoke about the visit and how their family were.

People had been involved in their care planning and told us staff had consulted about things that mattered to them. For example how they wanted their care to be undertaken, their choice of diet, and when they liked to go to bed. When people were unable to participate in their care plan relatives told us they had been consulted in their behalf.

At our last inspection we reported staff were task orientated and had to take on additional duties like washing up and cleaning floors, which had an impact on the care provided. This had now changed as housekeeping staff had been employed to undertake cleaning duties.

People's privacy and dignity was maintained and people received personal care in the privacy of their bedrooms or in bathrooms provided with lockable doors. If people wished to have gender specific staff to undertake personal care this could be accommodated in order to promote dignity. This was not provided at our last inspection due to lack of staff. People who required had continence assessments in place and adequate continence wear was provided accordingly. This had been a dignity issue at our last inspection

We observed staff calling people by their preferred names and knocking on bedroom doors before entering. We noted each persons care plan contained a section which specifically addressed issues of dignity and privacy.

We spoke with the head of care who had responsibility for promoting care standards in the home. They told us one of their roles was to educate and raise awareness of relevant issues which included dignity and respect amongst staff and promoting good practice. We saw staff were respectful and spoke to people

kindly and in a dignified way throughout our visit.
Staff ensured when people used hearing aids that these were in good repair and had batteries that worked. Staff also ensured that people who wore dentures had these cleaned daily and wore them to eat.

People looked well cared for. Their clothing was clean and fresh and colour coordinated which meant staff had taken the time and effort to support people with their personal care. Their was a hairdressing salon where people could attend which included a nail bar where people could have their nails painted. We heard people comparing the colour of their nails in the small lounge during afternoon tea which made good conversation.

People were encouraged and supported to make choices regarding their daily living routines. People could have their breakfast in bed or in their room according to how they felt on the day. People had the choice how they wanted their personal care undertaken. For example if they liked a bath or a shower and if they preferred this in the morning or the evening. They also chose where to spend their time and what activities they participated in.

People had single en suite bedrooms that were well decorated and furnished according to individual taste. People were encouraged to bring some personal possessions with them into the home to help make their personal space individual to them. One person said they were more than happy with their accommodation and the home in general. Another person said "I am very comfortable here and look at the lovely view I have." A relative said they had been encouraged to bring personal items of furniture that were important to their family member to help make it homely.

Relatives told us they could visit their family member at any time and always found them well cared for. They could visit their relative in the privacy of their room or there were private areas throughout the home that people were able to use.

People's cultural and spiritual needs were observed. Regular visits from local clergy were arranged and people were able to have Holy Communion when they wished. There was a church service taking place in the lounge on Albert unit during our visit.

One person was celebrating a special birthday. The activity coordinator and chef had arranged a birthday lunch for them and seven relatives which they all thoroughly enjoyed. Relatives said it was a kind and thoughtful way of responding to such a special event.

Good

Is the service responsive?

Our findings

People had needs assessments undertaken before they were admitted to the service in order to ensure the service had the resources and expertise to meet their needs. Relatives told us the manager had made them aware of the previous inspection report before they made a decision about whether they moved into Cedar Court Care Home.

At our last inspection we found care plans were unclear and did not reflect care being undertaken. At this visit we saw one care plan which contained contradicting information for example one section said the person could walk and somewhere else it stated they required help of two care staff, another section said the person could feed themselves and it stated somewhere else they required help to eat. The entire care plan was inconsistent. The registered manager gave us their reassurance his would be addressed and a further assessment of needs would be undertaken immediately.
Care plans had been reviewed and restyled into various sections which made them easy to follow and find information more easily. People's choices and preferences were documented and staff said they were encouraged to read these. Care plans were legible, person centred and up to date. They contained information about people's care needs, and an action plan for staff to follow on how to meet this need. For example how someone was to be moved and how many staff this required, if a lifting aid was needed. The care plans also contained detailed information about personal histories and likes and dislikes. People's choices and preferences were also documented. The daily records showed that these were taken into account when people received care, for example their choice of food and drink. Care planning and individual risk assessments were reviewed monthly to ensure they contained relevant and up to date information. The registered manager told us they had introduced a new care review system. People with a birthday in the current month had a review of care and their relatives were invited to attend. There were two such reviews taking place during our visit.

People had access to a wide range of activities. There was an activity plan in place that was overseen by an activities coordinator. People and relatives spoke positively and enthusiastically about the activity coordinator and the impact they had on people's social activity. They were supported by the dementia champion to ensure people were able to take part in activities of their choice which includes art and craft, music and exercise, board games, reading clubs, entertainment by external musicians and visits from local schools. Trips out were also arranged and people spoke very favourable about their trips to Wimbledon Tennis Museum, Brookland, and Guildford Cathedral Carol Service.

People gathered in the lounge on the dementia unit during the morning for a music and movement session that had been previously organised. The dementia champion who was due to facilitate this activity was otherwise engaged in a meeting. Staff were unsure what to do and people sat around for half an hour waiting for something to happen when eventually the activity began. This had a negative on people as they became restless waiting. There was a volunteer taking part in this music session to help support people and they gave encouragement to people to participate in this activity.

One to one activities were also organised for people who chose to stay in their rooms to prevent them from becoming socially isolated. This included hand massage or reading to people individually. Relatives told us they were included in organised events like summer fates and the Christmas party.

The provider was responsive to the mobility needs of people and made adaptations as required. Assisted bathing facilities were provided, raised toilet seats, grab rails in bathrooms and a ramp to access the garden were all provided to help ensure people were encouraged to keep as independent as possible.

People knew how to make a complaint or to comment on issues they were not happy about. People and their relatives were provided with a copy of the complaints procedure when they moved into the home. These was also a copy of this displayed in the main entrance.
People were supported by staff that listened to and responded to complaints. One person said "I have not had to make a complaint and if I had any issues I would talk to the manager who would solve them immediately." People were provided with a complaints procedure when they were admitted to the home and there was a copy of this displayed in the reception area. The complaints policy included clear guidelines on how and by when issues should be resolved. It also contained the contact details of relevant external agencies such as the Care Quality Commission and the local authority. There had been two formal complaints made since our last visit. The complaints had been resolved in a timely and satisfactory manner. The registered manager had written to the relevant parties with an action plan, where necessary, to prevent further issues. They also sent CQC a copy of this explaining how they resolved these issues.

Relatives were reassured that if they had to make a complaint that their concerns would be acted upon. One relative said "Things have improved greatly here recently and I can approach the manager about anything I am not satisfied with. I have not had a reason to follow the formal complaints process."

Requires Improvement

Is the service well-led?

Our findings

The home was being managed by a registered manager who had been appointed since our previous inspection when we found there was a lack of leadership in the service.

People told us they were now satisfied with the management and support in place at the home. They told us the registered manager spoke with them every day and listened to what they had to say. One person said "The difference now is what we say does not fall on deaf ears." They said since the new manager was appointed things get done. For example they said they got a new chef as the previous onehad left following ths inspection, and they had a laundry person now which addressed the vacancy. The registered manager operated on open door policy and we saw staff members were able to approach them during our inspection and were supported in open and inclusive way. A member of staff said "The manager is always available and will always assist if required. She will give us encouragement where it is due"

Relatives told us they could talk to the manager at any time. One relative said "The manager is always ready to listen if I have any worries about my family member they are in capable hands."

The registered manager had introduced "An open surgery" one evening a week when relative who worked or had commitments during the day could come and talk with them about any aspects regarding the care provided or the running of the home." The manager said "It was early days but had already proved popular."

Staff felt supported by the management arrangements in place. Some staff told us there had been an increase of staff lately and that they now had line managers in place. We saw staff meetings had been introduced on a regular basis and minutes of these meetings were retained in the service for information. This made staff feel included in matters relating to the service. One member of staff said previously they had told management of their concerns about lack of staff and "Nothing was done." Now this has been addressed and "We feel we are listened to." Another staff member said "I enjoy working here now and feel part of a team." Staff had been given specific roles and responsibilities for example there was a designated person to management medicine administration, someone to manage infection control and a dementia champion. This ensured clear lines of accountability and staff had embraced this change.

Health and safety audits were undertaken to ensure the safety and welfare of people who used the service, people who visited the service and to promote a safe working environment. We saw records relating to health and safety for example maintenance checks, utility certificates, fire safety, and equipment were maintained to a high standard by the maintenance department.
We viewed the overall business plan for the service. This addressed areas for improvement such as an ongoing programme of refurbishment and decoration and ongoing staff recruitment.

The provider had systems in place to monitor the quality of the service. The head of care undertook audits of care plans and risk assessments. Audits of medicines, infection control and training audits were also delegated to clinical staff and updated provided to monitor the senior to further enhance the care provided.

Housekeeping audits and catering audits were also undertaken and people's feedback welcomed in order to improve services. Senior staff meetings took place to identify any shortfalls following these audits and action plans introduced to address improvements. For example the appointment of an additional domestic and a laundry assistant.

People and relatives were included in how the service was managed. Residents and relatives meetings took place and minutes of these meetings were kept in the service for information. Relatives mainly spoke on behalf of people who use the service to communicate their views. People were encouraged to make suggestions and the provider took these on board. For example changing the menus in accordance with people's preferences and providing additional activities like trips to the local theatre.

The registered manager was in the process of coordinating a satisfaction questionnaire to be sent to people who use the service, relatives, staff and stakeholders to gain their feedback on how the service was preforming and to identify where improvement was required. This process had lapsed previously and the new questionnaires had only recently been reinstated.

We saw thank you letters and cards from people and relatives in appreciation of the care and kindness shown by staff and feedback about the management of the home from health care professionals we spoke with was positive. .

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The provider had informed CQC of significant events that happened in the service in a timely way. This meant we could check that appropriate action had been taken.