Your Health Limited

Cedar Court Nursing Home (Dementia Unit)

Inspection report

Cedar Court Care Home
Bretby Park
Bretby
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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected Cedar Court Nursing Home (Dementia Unit) on 7 January 2016 and it was an unannounced inspection. They were last inspected in December 2013 and were fully compliant against the standards we reviewed. The home provides accommodation for people who require nursing care and are living with dementia. There were 45 people living there at the time of our inspection. The accommodation was separated into two units with one unit providing accommodation for 18 male residents.

The home had a registered manager in place. 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.

Medicines and the risks associated with them were not effectively managed to keep people free from harm. When some people were given covert medicines a capacity assessment had not been completed and there was no record how this decision had been made in the person's best interest. Some medicines were not securely stored and the stock of some medicine did not match the records. There were not always clear instructions to staff how to administer medicines and some recording lacked detail.

Other risks had not been effectively assessed, monitored or actioned to reduce them. We saw that there were hazards in the environment which could cause people harm. Some of the care that we observed was not in line with the recommended support agreed and put people at risk of harm.

The quality assurance processes in place were not always effective because they did not highlight the risks that we observed. We saw that audits were infrequent and that an action plan had not been put in place to check that improvements had been made. Also, when relatives of the people who used the service completed surveys and suggested where improvements could be considered this did not lead to action.

We saw that there was an inconsistent approach to assessment of a person's capacity to consent to care. Some assessments were in place, but other important decisions were not supported by a capacity assessment or a best interest decision. The principles of the Deprivation of Liberty Safeguards had been applied within the home to protect people's human rights.

We saw that there were enough staff to meet people's needs safely. However, they were allocated to different communal areas during the day and this meant that it was difficult to respond to people on a personal level or spend time supporting people to pursue their interests or activities. Some of the environment did not have signs or decoration to support people living with dementia.

When staff did interact with people it was in a caring, considerate way. They were skilled and had received training and line management support to assist them to be effective in their job. We saw that people had their privacy and dignity respected. They were aware of how to protect people from abuse and knew how to

report any concerns. Recruitment procedures had been followed to ensure that staff were safe to work with people.

People were supported to maintain a balanced diet and care was given to ensure that meals were prepared to meet people's assessed need. People were monitored and referrals were made to relevant healthcare professionals when needed to ensure they maintained good health.

People knew who the registered manager was and stated that they were readily available and supportive. Staff told us that they were supported through regular supervision and appraisal. Systems were in place to receive feedback on people's experiences.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe
Medicines were not always stored safely and some medicines were not administered safely. Where risk to people's health and wellbeing had been assessed the recommended actions were not always followed. There were sufficient staff to meet people's needs throughout the day. Staff were aware of how to protect people from abuse and knew how to raise concerns.
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Is the service effective?

Requires Improvement

The service was not consistently effective
The provider was not always meeting the requirements of the MCA. People who were unable to make decisions for themselves did not always have their level of capacity assessed or decisions made and recorded in their best interest. Staff received training to provide them with the skills to care for people effectively. People were encouraged to have a balanced diet. Advice was sought from healthcare professionals whenever specialist support was required.

Is the service caring?

Good

The service was caring
We saw that staff had caring, supportive relationships with people and respected their dignity and privacy. People were supported to make choices in a way that suited their needs.

Is the service responsive?

Requires Improvement

The service was not consistently responsive
People did not always receive support which met their needs. Some people had limited contact with staff. Some of the environment was not designed to assist people living with dementia. There was a complaints procedure in place which was followed.

Is the service well-led?

Requires Improvement

The service was not consistently well led

The quality assurance systems in place were not effective in identifying risk or where improvements were necessary. They did not lead to an action plan which would drive improvements.
Staff felt supported by the registered manager and said that they were approachable.

Care Quality Commission

Cedar Court Nursing Home (Dementia Unit)

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.

Two inspectors, an expert by experience and a specialist adviser completed this inspection on 7 January 2016. The expert by experience had personal experience of using or caring for someone who used a health and social care service. The specialist adviser had professional expertise as a nurse with older people living with dementia. The inspection was unannounced.

On this occasion the provider was not asked to complete 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. However, we gave the provider the opportunity at the inspection to provide us with any relevant information. We looked at information received from the public and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We spoke with one commissioner about their experience of working with the provider. Commissioners find care and support services which are paid for by the local authority.

We spoke with seven people who used the service and four relatives about their experience of the support they received. Some people were unable to speak with us about the care and support they received. We used observation to help us understand their experience of care. We also reviewed the care plans for nine people to consider whether the information in the records assisted staff to meet peoples' needs safely.

We spoke with eight members of staff; including the registered manager, a nurse, a team leader and five carers. We reviewed four staff files to see how staff were supported to fulfil their role and to check that recruitment procedures were followed to make sure that staff were suitable to work with people.

We spoke with three healthcare professionals who worked closely with the home about their experience of the support that people received. We also looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement.

Requires Improvement

Is the service safe?

Our findings

People were not always protected because medicines were not managed safely. We saw that some prescribed creams and nutritional supplements were not stored correctly, but kept in a communal bathroom, which could cause harm to people. We saw a large number of nutritional supplements were kept in a bin bag on the floor in a bathroom. We saw that cream was stored in a communal bathroom and it was prescribed to 'all residents at Cedar Court'. This is not suitable as all medicines and creams should be prescribed to an individual.
Two people were receiving their medicine covertly, this means without their knowledge. Medicines can be given covertly if the person does not understand that they are essential to maintain their health and wellbeing. We saw that only one person had their capacity assessed and that a best interest meeting had not been held for either person to support this decision. There were no plans in place to describe how the medicines should be administered, whether it was safe to do so and no review of the covert medicine was planned.
There were no written protocols available for some medicines given on an 'as and when required basis', known as PRN medicine. We saw that a person was given PRN medicine to calm them when they were distressed. There was no protocol for this medication and no reasons or outcomes recorded for its use, other than 'agitation'. The medicine was given by an agency nurse who did not work permanently at the home. We saw one written record in one care plan which had minimal information to guide the administration but stated that it should be given for 'agitation and restlessness'. This meant that there was a risk to people who may be given medicine inappropriately.
This evidence represents a breach of Regulation 12 of the Health and Social Care Act 2008. (Regulated Activities)

We saw that risks to people were not always managed to protect people from harm. Risk assessments had been completed but they were not always being followed. For example, one person was assessed to need pressure relieving equipment to protect their skin and also to be repositioned every two hours. We observed that they did not have this equipment in place and were not supported to move for over three hours. The risk assessment that had been completed stated that they were very high risk of damage to the skin. Another risk assessment stated that the person could stand to be assisted to move. However, we saw that when the two members of staff followed this guidance they manually lifted the person who did not bear their own weight. The risk assessment had not been reviewed which put the person at risk. Assessments had been completed for emergency situations when evacuation of the home may be required. We found the assessments did not always provide the correct information. For example, one person needed equipment to assist them to move but this was not recorded in their individual plan. Some aspects of the environment presented a risk to people's safety. For example, we looked at five bathrooms and saw that they were used for storage. There were cleaning liquids and a sharps bin stored in an unlocked bathroom cupboard. The bathrooms were accessible to people, which meant that they were at risk of harm.
This evidence represents a breach of Regulation 12 of the Health and Social Care Act 2008. (Regulated Activities)

We saw that people's needs were met to keep them safe. However, one relative told us, "There are not

always enough staff". During the day we saw that people spent time in three communal areas. We saw that people were left unsupported in one lounge. A member of staff we spoke with said, "There need to be three staff in the small lounge and not two because sometimes two staff will need to provide support to someone leaving no one to monitor the lounge". Another member of staff said, "There are not enough staff during the night because of residents needs and the layout of the building". We asked the registered manager if they used a dependency tool to assist them to plan staffing levels and they said that they did not. A dependency tool provides guidance on the numbers of staff in relation to the number of people at the service, their needs and the layout of the building.
Records that we reviewed showed that pre-employment checks were completed before staff were able to start working in the home. The registered manager confirmed that these checks were completed as part of the recruitment procedure. This demonstrated there were recruitment checks in place to ensure staff were suitable to work within the home.

People were protected from harm by staff who were knowledgeable about the signs of potential abuse. One member of staff said, "I would talk to my manager if I was concerned". Staff confirmed they had received training in safeguarding. The registered manager had followed their safeguarding procedures and notified us of any actions taken as required.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides the 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 capacity to take particular decisions, any made on their behalf must be in their best interests and least restrictive as possible. We saw that there was an inconsistent approach to assessment of a person's capacity to consent to care. Some capacity assessments had been recorded for specific decisions. However, other areas where people lacked capacity to make decisions were not assessed, reviewed or supported by a best interest decision. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We saw that nineteen people had their liberty legally deprived as they had DoLS granted. Further applications had been made and were awaiting a decision. Staff we spoke with demonstrated some understanding of MCA. They were able to say who had capacity and knew about asking people for consent. One member of staff said, "It is important to ask people's permission before we assist them".

We saw that people were supported by skilled staff who had completed training that was relevant to their role. A relative we spoke with said, "I am impressed with the staff, they know what they are doing". One member of staff we spoke with said, "All of us are encouraged. I have done my level two [nationally recognised qualification] and am going to ask about doing my level three". Another member of staff said, "I have recently done some specialist training which helped me focus on people's needs". Staff said that they felt encouraged by their manager. A member of staff that we spoke with said, "I have grown in confidence here and feel competent and independent about the work I do. I really enjoy it, I have been well-supported". The registered manager said, "Training is really important and we have recently re-introduced classroom based learning for important topics like dementia". They also said that they had links with organisations that provide guidance in best practise; for example, the end of life care team and dignity champions.

We observed effective communication between staff. One member of staff we spoke with told us that they had communication systems in place which helped them support people by having up to date information. They said, "We all have a hand over at the beginning of the shift and there is a handover book that we use to remind us of anything we need to know"

We saw that people were supported to maintain a balanced diet. We saw a choice of meals was offered and one relative we spoke with said, "The food is very good". People who had specific dietary requirements were provided with food which met their needs. If people needed support with eating, we saw that it was provided in a patient, caring way by staff. Risks to people's health associated with eating and drinking were assessed and additional professional support was requested when it was needed. For example, we saw that when people lost weight they were referred to healthcare specialists to provide guidance.

We saw that people were supported to maintain good health through access to healthcare professionals. One member of staff we spoke with said, "There have been a lot of changes and we now have better

community links such as with the physiotherapy teams". We saw that there were visits from healthcare professionals on a regular basis and in response to the staff team alerting them. Health professionals we spoke with confirmed this. One said, "We work really well with them, the nurses are knowledgeable and the information they provide is reliable". Another said, "I have no cause for concern, they contact us if there are any changes to patient welfare".

Good

Is the service caring?

Our findings

We saw positive, caring relationships between staff and people who used the service. One person we spoke with said, "The staff are excellent. I can't speak highly enough of them". A relative we spoke with said, "The staff are so caring, they are very good". Another relative described how staff supported them to celebrate the person's special occasion. They said, "I am really impressed with the staff". We saw staff supporting people patiently and reassuring them when they were distressed. For example, we saw one member of staff sit beside someone and speak gently to them while holding their hand until they were happier. A healthcare professional we spoke with also said, "They are a really caring group of staff who know the residents well".

We saw that people made some decisions about their care and were encouraged to make choices. For example, we observed people being asked where they wanted to sit, or what they would like to do. We also saw people who had difficulty communicating were supported to make choices, for example, a member of staff helped somebody choose which chocolate they wanted by pointing and describing the sweet to them. One person we spoke with said, "I like to come where it is quieter. I can get up when I feel like it and I am free to do as I like". We saw some people had support from an advocate. An advocate is a person who is independent of the home and who supports a person to share their views and wishes.

We saw that people's privacy was respected by staff. People were supported with their care needs discreetly and spoken with quietly. Relatives told us that they were able to visit when they wanted to. One relative said, "I am always welcomed". Another relative said, "There is open visiting and I come every day". We observed relatives being included and offered refreshments. Another relative told us, "When I visit I have a meal with [my relative] which is really good".

Requires Improvement

Is the service responsive?

Our findings

We saw that care was not consistently responsive to people's needs. For example, we saw the call button was not accessible to somebody when they were in bed. The person told us that they had to shout for attention. A member of staff we asked about this said, "I don't know why they haven't had one before". One relative we spoke with said, "There is not much stimulation". We observed one lounge for one hour and during this period some people had no interaction with staff. . For example, one person was distressed from losing a personal item but could not articulate this to staff and the staff did not know because they had not been near the location when it happened. Staff that we spoke with said that they would like to spend more time with people. One member of staff said, "There could be more staff because we all love the time we get to be with residents at the end of the shift". Another member of staff said, "I would like more time with the residents".

We saw there was a member of staff who focussed on developing activities with people and we observed some interaction with people. For example, we saw that people had the newspaper read to them and someone had a manicure. However, this was across a large building and many people did not receive this individualised interaction. We saw that the largest communal area did not have signage or decoration that could stimulate people living with dementia. For example, people didn't have belongings that could provide comfort to them or stimulate a conversation; bedrooms had names on them but no photos or memories. This could disorientate and isolate people living with dementia. In another area of the home there had been attention to the environment to support people, in partnership with a local college, for example, murals of famous people on the wall. The registered manager said, "We used to have signage downstairs but people pulled them off the wall".
Staff we spoke with knew people well and were able to describe their likes and dislikes. However some of the records that we reviewed did not contain enough information about the person. For example, a lot of the actions in the care plans were generic with the word 'resident' crossed out and the person's name written in. When there were changes to a person's support needs the plan did not clearly reflect the change. For example, one person's wound care plan had not been updated to show progress in its management. This meant that new staff could be providing care that was not up to date and therefore not meeting people's needs.
We saw that there was a complaints procedure in place and the registered manager told us how they had responded to previous complaints but there hadn't been any since the last inspection. Relatives that we spoke with told us that they had raised concerns with the management team and had received a response, for example about the care of the person's laundry.

Requires Improvement

Is the service well-led?

Our findings

We saw that the quality assurance systems were not fully effective to assess, monitor and improve the quality. For example, there had been three audits completed for the management of medicines by the registered manager in the past year. Each of the audits had identified errors. There was no action plan in place to address the errors or a system to ensure they were resolved. For example two medicine errors were reported to the safeguarding authority at the end of last year but monthly medicines audits had not been instigated by the registered manager to ensure the errors were not repeated. The registered manager said, "I know that three medicine audits were not enough and we will do monthly audits this year". We saw that improvements were needed in the safe management of medicines which were not known to the registered manager. For example, we reviewed the auditing of one medicine and found an error in the numbers of medicines recorded and the actual stock. This meant that there were medicines missing which were not accounted for, which could present a risk to people. We also saw that guidance for staff to administer and record medicines were not always in place. For example there was no guidance for staff to know where to apply cream to a person and the administration of this was not recorded. This demonstrated that the audits were not effective and did not reduce the risks to people associated with medicines.

A survey was sent to relatives annually and there had recently been a relatives meeting. However, the feedback that they gave was not used to improve the service. The information was collated and a report was written but no changes were made as a consequence to drive improvement.
This evidence represents a breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities)

Staff we spoke with felt supported by the registered manager and had regular meetings as an individual and a team. One member of staff said, "Management are very supportive, firm at times but fair". Another member of staff said, "I have supervision and we talk my progress and ask my views. We also have team and the minutes are sent to everyone even if they hadn't attended". People's relatives knew the registered manager and said that they were approachable. One relative we spoke with said, "They have been marvellous and have really taken the time to help me to resolve our situation". Another relative said, "I know the manager and they are always available". The registered manager sent us information about significant events in the home. This showed that they were aware of and adhered to the requirements of their registration with us.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe care and treatment (g) The proper and safe management of medicine. The procedures in place for the safe management of medicines and the risks associated with them were not effective. Safe care and treatment (a) and (b) Assessing risk and doing all that is reasonably practicable to mitigate it. The systems in place to assess risk and reduce its likelihood were not effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Good Governance The quality assurance processes in place were not effective.