Tanglewood Care Services Limited

Cedar Falls Care Home

Inspection report

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Cedar Falls Care Home is a residential care home providing personal and nursing care to up to 93 people. The service provides support to adults of all ages, some of whom may be living with dementia, a physical disability or sensory impairment or mental health concerns. At the time of our inspection there were 83 people using the service. The home is in a purpose-built property set over two levels with access to secure grounds. There are also a number of bungalows on the grounds for those who wish to live more independently.

People's experience of using this service and what we found
Systems to monitor the quality and safety of care provided in the home had not been effective. They had failed to identify concerns and to ensure that people received care personalised to their needs.

There were enough staff to meet people's needs and the provider had effective recruitment practices which ensured staff were safe to work at the home. However, staff lacked the knowledge of good dementia care and needed further training in this area.

The lack of dementia knowledge and training impacted on the care people received with care becoming task focused instead of tailored to people's individual needs. This meant at times people's dignity and privacy were not respected.

Medicines were not managed safely. Some medicines administered "as required" were not given in line with the prescription and where medicine had to be hidden in food and drink there was not always advice from a pharmacist to ensure it did not affect the efficacy of the medicine.

People were supported to eat and drink safely and to maintain a healthy weight. However, more could be done on the dementia floor to ensure people had a positive mealtime experience.

Most risks were identified, and care was planned to keep people safe. However, risks relating to people living with dementia becoming distressed had not been identified and staff had no guidance to support them to care for people safely. Activities were not used effectively to support people living with dementia.

Staff had not always followed the provider's policies to minimise the risk of infection. Some furniture needed attention to reduce the risk of cross infection. The maintenance of the home and not been completed to ensure it was a pleasant environment for people to spend time in.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. The provider's policies were in place, but staff had not followed them to support people's rights.

We raised all these concerns with the provider during and after the inspection. They took immediate action to begin to rectify the concerns.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 7 October 2019 and this is the first inspection.
The last rating for the service under the previous provider was good (published 10 September 2019).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to the management of medicines, infection control, the maintenance of the environment, respect of people's privacy and dignity and failures in the oversight of the home at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Cedar Falls Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of 2 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Cedar Falls is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Cedar Falls is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a manager in post who had completed their application to be registered. They became registered during our inspection period.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 10 people living at the home and 7 family members. We also spoke with the managing director, the registered manager, 2 deputy managers a care home assistant practitioner, a care worker and two housekeepers.

We reviewed a range of records. This included 8 people's care records and multiple medication records. We also looked at a variety of records relating to the management of the service, including policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
• People were not always protected from risks associated with their care and support or the environment. People's care plans did not always contain information on supporting people to keep safe. Some people were living with dementia and, at times, became distressed and disoriented. This would lead to them becoming agitated and putting themselves and others at risk of harm. Relevant guidance was not in people's care plans for staff to follow when people were in distress.
• Systems were not enforced to ensure visiting contractors worked safely in the home. One contractor had left a bag with sharp implements in the foyer where people, who may not be able to keep themselves safe, were able to access. We raised this with the registered manager who took immediate action to ensure the area was safe.
• Risks in the environment were not mitigated. For example, wardrobes had not been fixed to the wall to stop them falling if pulled. This was important as people living with dementia may not recognise the harm that could come to them pulling on wardrobes.

Using medicines safely
• Medicines were not always managed safely. Protocols were not always followed by staff giving people medicines prescribed to people to be taken as required. We found 2 people had been given their medicines outside of the protocols. The registered manager told us they would investigate these concerns. After the inspection, they contacted us to confirm action had been taken to address the concern. This included reviewing staff training around medicines.
• Records showed staff were crushing people's medicines into people's food or drink without approval from a pharmacist when they needed medicines covertly. Covert administration of medicines is when people receive their medicines without knowing. The registered manager was in the process of getting guidance from a pharmacist on the safest way to administer the covert medicines.

Preventing and controlling infection
• Staff did not always work to minimise the risk of infection. Coloured mops were not always used correctly to reduce the risk of infection. For example, we observed two staff members using coloured mops in the wrong area. The staff we spoke with knew the need to use different coloured mops. We raised this with the registered manager. After the inspection, they confirmed they spoke with the staff involved and ensured they followed the provider's infection control policy.
• We found staff in ancillary roles were not always complaint with the government regulations on the use of personal protective equipment in care homes to reduce the spread of COVID-19. Staff in the kitchens and laundry were not wearing masks. We raised this with the registered manager who told us they would ensure

guidance was followed in all areas of the home.
• Some equipment and furniture in the home was an infection control risk. For example, we saw some toilet frames were rusty and so would be unable to be cleaned effectively. Some wooded furniture was worn to bare wood and again would not be able to be cleaned effectively.

Learning lessons when things go wrong
• Analysis of incidents and accidents was not always effective. The provider's analysis of incidents was done for the whole home, but the system had not identified a high level of incidents on the upstairs dementia floor. Therefore, appropriate action was not always being taken to improve the quality of care provided.
• Staff did not always learn from incidents. For example, the upstairs of the home was dedicated to people living with dementia. Some people could be verbally or physically aggressive. Such incidents were not monitored or analysed to see how people's care could be altered to meet their needs.
• We discussed these concerns with the registered manager and the provider's wider management team. They told us they would ensure that they recorded all incidents and would use the information to improve the safety of the care provided.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection to address the concerns we raised.

• Care plans had identified risks and care had been put in place to keep people safe. For example, where people were at risk of developing pressure sores, equipment was in place to reduce the possibility of them developing.
• Staff supported people to take their medicines on time. A person said, "The care and staff are good. I get my tablets at the same time every day." The provider had implemented an electronic medicine recording system which had inbuilt monitoring to improve the safety of medicines administration.

Visiting in care homes
• Friends and relatives were supported to visit in line with government guidance.

Systems and processes to safeguard people from the risk of abuse
• People were protected from the risk of abuse. Staff had received training in how to keep people safe from abuse. They told us they were confident to raise concerns within the home. However, they were not always knowledgeable on how to raise concerns outside of the service.
• The registered manager raised concerns with the local safeguarding authority. They investigated any safeguarding concerns and took action to keep people safe.

Staffing and recruitment
• There were enough staff employed, however staff were not always deployed effectively to ensure people's safety. Staff were not always present in communal areas when they were supporting people in other areas of the home. Although the provider had assessed people's needs to identify required staffing levels for the home, records showed several unwitnessed falls in the lounge when staff were not present. This increased the risk of injury to people.
• People told us they were happy with the staff who looked after them. A person told us, "'I'm getting on okay, the staff are good and nice to me." Another person said, "The staff are really nice, I've no worries."
• The provider had systems in place to ensure staff were safe to work with vulnerable people at the home. They had gathered references, proof of identity and completed Disclosure and Barring Service checks.

Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Adapting service, design, decoration to meet people's needs
• The premises had not been maintained to provide a welcoming environment for people. For example, some of the bay windows leaked when it rained. Windowsills were in need of repair and decoration. Other areas of the home were also in need of decoration. For example, the flooring in the sluice room was lifting creating a trip hazard.
• There was a lack of signage on the first floor, therefore people living with dementia may have found it difficult to orientate themselves and move independently around the home.
• We raised these concerns with the registered manager. They told us an environmental audit was planned for the next day. Following the inspection, the registered manager sent us the action plan from the audit identifying all areas for improvement in the home. These included all the areas we identified.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Care plans showed that recognised good practice tools had been used when completing the assessments. For example, people's risk of developing pressure areas had been assessed using the Waterlow tool. The provider had policies and procedures in place to ensure that up to date guidance and legislations was available to staff. However, as discussed in the safe section of this report, care plans did not contain guidance on how to support people when they became distressed.
• People received an assessment of their needs so that safe care could be planned. Where people had long term conditions the registered manager identified best practice guidance in supporting people with their specific conditions and ensured that this information was available to staff in people's care plans.

Staff support: induction, training, skills and experience
• People were supported by staff who did not have all of the training needed to provide high quality care. Staff received an induction when they started work at the home. This included training in how to support people to move safely and how to recognise and report abuse. In addition, new staff shadowed an experienced member of staff to gain knowledge and experience. Ongoing training was provided for staff to ensure that their skills remained up to date. Records showed that the registered manager had a system in place to monitor when training became due so that they could ensure staff's skills remained safe and effective.
• However, the care provided to people living with dementia did not support people's needs. We raised this with the registered manager who told us they had also identified this as an issue and that more training was planned.
• The provider was developing a role of a Care Home Assistant Practitioner. This provided more training for

senior care staff so that they were able to provide more support to colleagues and take a lead role in how the care and culture in the home developed.

Supporting people to eat and drink enough to maintain a balanced diet
• People's mealtime experience varied depending on which floor they resided on. People on the ground floor who were more independent had a pleasant mealtimes experience. On the first floor, where people needed more help, lunchtime was a more chaotic experience for people.
• Staff did not follow good practice when supporting people to eat and did not support independence. For example, when people left the table and returned later they were given cold food. Staff did not engage people with the food while supporting them. In addition, food was mashed together so that it was not appetising. We observed a member of staff holding a person's hand so they could not touch the food on their plate.
• People told us they were happy with the food provided. A person said, "There's a choice of two meals and an alternative if I don't like either." Another person told us, "I enjoy the meals, there's always a good choice."
• People's ability to eat and drink safely were assessed. Where needed their diet was modified so their choking risk was minimised. For example, some people required their food to be fork mashable, while others needed their fluids thickened. People were therefore protected from the risk of choking.
• People's ability to maintain a healthy weight was monitored. Where there was a risk of people not maintaining a healthy weight, their weight was recorded and tracked monthly. Any concerns were raised with the GP. Where needed people were prescribed fortified drinks to help them maintain their weight. These actions supported people to remain healthy.

Ensuring consent to care and treatment in line with law and guidance
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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

• People's rights under the MCA were not fully respected. Where people may lack the capacity to live at the home the registered manager had submitted applications for them to be assessed under the Deprivation of liberty safeguards. Where conditions were in place, for example around covert medicines staff worked in line with the condition.
• Where people lacked capacity, staff were required to make decisions in people's best interest taking into account the views of health and social care professionals and people's relatives. This had not been completed in a way which minimised the restrictions on people. For example, one person was unable to have their belongings in their bedroom There was no mental capacity assessment completed and no best interest decision had been recorded. This did not respect their rights. Following the inspection the provider confirmed the person now had their belongings in their bedroom.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

• The staff had built relationships with healthcare professionals to improve the care provided to people. Records showed that healthcare advice and support had been sought for people when necessary.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

• People's privacy and dignity was not respected. People were allowed to wander into other people's rooms. For example, one person came out of a bedroom which was not theirs with another person's belongings. Staff were not aware that they should be protecting people's privacy and belongings.

• People's dignity was not respected. For example, two people had bedrooms next to each other in an alcove off the main corridor. One of people would often become distressed and would manage those feeling by becoming destructive in both bedrooms. The other person was deprived of personal objects and clothing from their own bedroom. The clothing was kept in a storage room with other equipment in another part of the home. We raised this with the registered manager, following the inspection they confirmed the person had moved rooms and now had their belongings in their bedroom.

• Another person who was having one to one care to keep them safe, walked into the communal area to sit down. They had wet trousers. The member of staff with them did not support them to maintain their dignity.

• People in a shared room were required to share a wardrobe. This meant neither person's belongings were private.

• At times staff were task focused. For example, a member of staff administering medicines interrupted a person while they were eating. They offered the person their medicine mixed in with yoghurt. This was not appropriate as the person was eating a main course. Staff did not stop to consider that it was not appropriate to offer the medicine in yoghurt while the person was eating a hot meal.

• People told us staff did not always respect their views. For example, a relative told us, despite making it clear that their relative only drinks tea or water, it took nearly a year before staff stopped leaving jugs of orange squash or blackcurrant in their room. They told us, "Sometimes we don't feel listened to." Another family member told us that they had not been involved in planning their relatives care.

The provider had not ensured people's dignity was respected and supported. This was a breach of regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People told us they were happy with the staff and care provided. One person said, "The staff are really nice." Another person said, "The staff are okay and the care is good." A relative said, "The care is excellent."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

• There was a difference in the level of activities offered between the floors. On the ground floor staff were supporting people to be entertained. For example, a member of staff was playing dominos with a person. A monthly church took place in the downstairs lounge.

• People living with dementia on the first floor did not always have opportunities to engage in activities to promote their well-being and stimulation. During the inspection, we did not see a large central activities area being used. In addition, we saw a number of instances where a lack of activities had a negative effect on people. For example, people walking around the home and becoming distressed when interacting with other people.

• We raised this with the provider. After the inspection they contacted us to say they had reviewed their activities programme and discussed with people and their relatives the type of activities or interests they had. They were using this information alongside dementia training to support people living with dementia.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• Care provided for people living with dementia did not always support their needs. As discussed above activities were not used to keep people settled and entertained and because of this the atmosphere on the dementia floor was unsettled. For example, one person had a negative interaction with another person. Staff were aware that the person was unsettled as their family had been unable to visit for a few days. However, no extra care or support had been put into place to help the person remain calm and content.

• Where people had been diagnosed with conditions care plans contained information on concerns for staff to monitor. For example, when a person had diabetes, their care plan recorded what insulin the nurses were administering. Care plans had been reviewed on a regular basis and this information supported staff to act quickly in an emergency and to help prevent the need for hospital admission.

• Systems were in place to ensure that any changes in people's needs were shared with staff. The registered manager attended the daily handover when information was passed between shifts. This allowed them to identify any concerns or action that was needed to keep people safe.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

• The service identified people's information and communication needs by assessing them. Staff understood the Accessible Information Standard. Care plans recorded the support people needed to access written or verbal information. For example, they noted who needed glasses to read. These needs were shared appropriately with other health and social care professionals.

Improving care quality in response to complaints or concerns
• The registered manager had investigated complaints in line with the provider's policy. Records showed people were happy with the outcome of complaints.
• Complaints were also reviewed on a monthly basis to see if any themes occurred where action could be taken to improve the quality of care provided.

End of life care and support
• People's wishes for the end of their life had been recorded in their care plans. For example, if people wanted to stay at the home instead of being admitted to hospital.
• The staff worked with healthcare professionals to ensure that people had dignity at the end of their life. Where needed anticipatory medicines were in place. These are medicines to manage symptoms and make a person more comfortable at the end of their life.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The governance processes in the home had failed to identify the concerns we found. There were audits in place, but they had failed to fully identify the concerns or to drive improvements.
• There had been a failure to identify and address issues related to the safe management of medicines and the internal environment and infection control. The care for people living with dementia was not in line with best practice guidance and did not support people's need for dignity and independence.

Systems established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service had not been effective. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection and submitted an action plan to show how they were going to improve.

• The provider had recently employed a person to oversee the governance of the organisation. They were currently based at Cedar Falls Care home and their priority was to improve the care for people living with dementia.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• Relatives said at times it was difficult to get information on their loved one's health. One person said, "I can't get any information at weekends. One Saturday [Name] was poorly when I visited, and I rang on Sunday to see how they were and when the phone was eventually answered they couldn't find anyone to give me an update."
• Most people told us they knew the staff and registered manager and felt confident to approach them. A person told us, "I see the manager every day and know all the nurses' names." And a relative said, "I see [deputy manager] daily, she does floor walks."
• On the day of our inspection the registered manager and some of the provider's senior staff were holding an open day. This was where people and their relatives could pop in to talk to someone about the care provided and any concerns they had.
• The provider understood their duty of candour responsibilities to be open and honest with people and

relatives about incidents which happened. Records showed the registered manager had contacted relatives when a serious incident had occurred and had kept them up to date with their family member's care and the action they were taking to keep their family member safe.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• The provider had surveyed people living at the home and their relatives to gather their views of the care provided. They used the information to drive improvements in the home. For example, after the latest survey they changed the menu and updated the outside area.

• The registered manager also ensured people and their relatives were invited to regular meetings to keep them informed of what was happening in the home. One relative told us, "We have relatives and resident meetings and issues get addressed."

• Staff told us they felt supported and were happy to raise issues with the management. One member of staff told us, "[Deputy manager] has been very easy to speak to and never makes me feel that I am pestering them."

Continuous learning and improving care; Working in partnership with others

• The registered manager ensured lessons learnt from accidents, complaints and safeguarding were shared with the whole staff team so that everyone knew what went wrong. This decreased the risk of similar incidents reoccurring. However, more work was needed to ensure all incidents were recorded and action taken to improve care.

• The provider worked collaboratively with health and social care professionals to ensure that people received care which met their needs.

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 10 HSCA RA Regulations 2014 Dignity and respect People's dignity and privacy was not respected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines prescribed to be taken as required and those given covertly had not been safely managed. Staff had not followed infection control processes. Risks for people living with dementia had not been effectively assessed or mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Management systems had not identified concerns in the home and had not driven improvement in care.