Care UK Community Partnerships Ltd

Cedrus House

Inspection report

Creeting Road East
Stowmarket
Suffolk
IP14 5GD

Tel: 03333211987

Date of inspection visit:
04 July 2016

Date of publication:
02 September 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 4 July 2016, and was unannounced.

Cedrus house provides accommodation, nursing and personal care for up to 70 people. At the time of our inspection there were 58 people living in the service. There are six individual units within the building. Each floor is divided into two suites, with each suite having its own dining room and living area.

There was a registered manager in post. 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.

Our previous inspection of 13 and 22 October 2015 found that improvements were needed in how the service completed assessments to accurately reflect individual needs and risks. There was also concern that clinical governance systems were not effective. The provider wrote to us and told us how they were addressing these shortfalls. During this inspection we found that some improvements had been made.

There were processes to monitor the quality and safety of the service provided and to understand the experiences of people who lived at the service. This was through regular communication with people, surveys, spot checks on staff during the night, and a programme of other checks and audits. However, some audits could be used more effectively to implement further learning and change. Whilst the management team had made continued progress in addressing more effective systems and procedures, some were not yet fully embedded in practice, and we found that clinical guidance was not consistently followed.

Staffing numbers were assessed against and reflected people's dependency needs, and we saw that staff responded to people in a timely manner. Staff took their time with people when delivering their care, and people were not rushed. However, we received some comments which indicated that the management team should review its current provision to ensure people's needs are met at all times.

Care plans and risk assessments contained clear and detailed information which supported staff to meet people's needs. There was opportunity to improve care plans further by developing a more person-centred approach which focusses on a person's whole life, including their emotional and social care needs.

Staff received the necessary training and support to enable them to do their jobs. The service had introduced monitoring tools which checked staff knowledge and understanding once training was completed.

Procedures were in place which safeguarded the people who used the service from the potential risk of abuse. Staff understood the various types of abuse and knew who to report any concerns to.

Staff understood the principles of the Mental Capacity Act (MCA), and gained people's consent before they provided care. People told us they were encouraged to make choices about their daily lives. There were procedures in place to ensure that people who could not make decisions were protected, and we found assessments had been completed.

Staff respected people's privacy and dignity at all times and interacted with people in a caring, respectful and professional manner.

Safe recruitment procedures were in place, and staff had undergone recruitment checks before they started work to ensure they were suitable for the role.

Systems were in place to ensure people's medicines were managed in a safe way, and people received their medicines in a timely manner. People were supported to maintain good health and have access to relevant healthcare services.

We saw people received a good choice of food and drink, and people's individual food requirements were well catered for.

A complaints procedure was in place. People's concerns and complaints were listened to and addressed in a timely manner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were knowledgeable about how to safeguard people from risk of harm.

Risks were identified and reviewed in a timely manner.

Staffing levels were calculated and provided to ensure that people's needs were met.

People received their medicines in a safe and timely manner.

Is the service effective?

Good

The service was effective.

People were asked for their consent before any care, treatment or support was provided. Staff were knowledgeable about their responsibilities in line with the principles of the MCA.

People's nutritional and hydration needs were assessed and monitored.

People were supported to maintain good health and had access to healthcare support in a timely manner.

Is the service caring?

Good

The service was caring.

People were treated with respect and their privacy, independence and dignity was promoted and respected.

People were supported to see their relatives and friends.

Is the service responsive?

Good

The service was responsive.

Care plans provided staff with clear guidance on how to meet people's individual needs. There was opportunity to develop

care plans further by reflecting people's emotional and social care needs more fully.

Complaints were recorded and responded to in a timely manner. The service acted on feedback received from people and their relatives.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Clinical guidance was not consistently referred to by all staff when determining action that needed to be taken.

Quality assurance systems were in place which monitored the safety of the service, but not always sufficiently robust to identify where improvement was needed.

The service had a positive, person-centred and open culture.

There were opportunities for people and staff to express their views about the service.

Cedrus House

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.

The inspection took place on 4 July 2016, was unannounced and undertaken by three inspectors, one specialist advisor who had knowledge and experience in nursing care, and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider completed a Provider Information Return [PIR]. This is a form which asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law.

During the inspection we spoke with 19 people living at the service, 10 relatives, and three health professionals. We spoke with the registered manager, deputy manager, regional support manager, and 14 members of staff including care, catering and domestic staff. We also observed the interactions between staff and people.

To help us assess how people's care needs were being met we reviewed 11 people's care records and other information, including risk assessments and medicines records. We reviewed five staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

Good

Is the service safe?

Our findings

People and relatives commented on the safety of the service. One person said, "Yes I am safe, and they [staff] put themselves out to make you feel happy". A relative told us, "[Relative] is being well looked after, they are safe".

Staff told us they had received safeguarding training and understood their role in reporting any concerns they had, and were able to describe different types of abuse they may come across in their work. Staff told us that they felt they could raise any concerns and they would be escalated promptly. One staff member told us, "I have reported things before and it was sorted straight away. I know the difference between right and wrong and am up to date in my safeguarding training. I would speak up if I had to. People come first". Another said, "I wouldn't hesitate to report bad practice or concerns". They went on to tell us of the roles and responsibilities of the local authority and the Care Quality Commission. This demonstrated that staff understood how to raise a concern with the relevant professional body.

People's individual care records clearly described risks that could affect them in their daily lives, such as health conditions, mobility, skin integrity and moving and handling needs. There were weekly recordings of people's weights, monthly reviews of MUST [Malnutrition Universal Screening Tool] and Waterlow [skin integrity] and a date scheduled for the next review. This meant that risks to people were being monitored on a regular basis.

At our inspection in October 2015, we found that documentation for the use of bed rails had not been fully completed and in one case these had not been fitted safely. At this inspection we found that improvements had been made, and the provider had implemented risk assessments for each person who had bed rails in place. The maintenance person also carried out weekly checks on each bed rail to ensure they were fitted correctly and people were safe.

People lived in a safe environment. The internal and external aspects of the building were maintained to ensure people were safe. Records showed that tests on fire safety equipment were conducted by external contractors to ensure these were done by appropriately trained professionals. There were systems in place to monitor and reduce the risks to people in relation to the water system and legionella bacteria.

People, relatives, and staff commented on the staffing levels. One person said, "Usually it is ok, but sometimes in the mornings it's a busier atmosphere". A relative said, "Staff are very busy but always visible, people are safe. Lunch times are the busiest, but they always deal with what people's needs are". A staff member said, "I spoke to the deputy manager last week about the staffing and they took it to the manager's meeting. We need a 'floater' [extra member of staff] to get people showered".

We observed that staff responded to requests for assistance promptly, there was a calm atmosphere, and on the occasions when a call bell sounded, staff responded to these. We spoke to the management team about the staffing levels. They told us that they were confident they had sufficient levels of staffing to ensure the care provision, and that the levels of staff were calculated using a dependency rating tool as a guide. They

told us that the skills and knowledge of staff were also taken into account to ensure staff were deployed effectively. This was also seen in the minutes of the last staff meeting, where the registered manager asked for the team leaders not to move staff around the different units as staff were deployed taking into consideration important factors, such as if they were new members of staff, and the gender of workers [for example not having two male workers on one unit]. However, given the feedback we received, we asked the management team to review its current provision, and take into account times when two staff were attending to one person, administering medicines, or attending the handover meetings, to ensure staffing levels were sufficient to meet people's needs at all times.

People were protected by the procedures for the recruitment of staff. Staff we spoke to, and records we reviewed, confirmed that reference checks and Disclosure and Barring Service (DBS) checks [which provide information about people's criminal records] had been undertaken before new staff started work. This ensured that new staff coming to work in the service were suitable for their role.

People were supported to take their medicines safely and as prescribed. One person said, "I have several tablets to take throughout the day and a special cream at night. They [staff] never forget and I have never had to go without". A relative told us, "The staff are usually very discreet at giving people their medication. Never intrusive, and ask people if they are experiencing pain and will give them something for it if they are. They also take the time to explain to [person] what they are taking".

Staff confirmed they had received training to be able to administer medicines. They demonstrated a good awareness of safe processes in terms of medicines storage, administration and about the purpose of the medicines prescribed for people. Individual medicines profiles provided clear information for staff in terms of the purpose of each medicine prescribed for people, and the possible side effects. We also saw that medicines were stored securely, with appropriate facilities available for controlled drugs and temperature sensitive medicines.

Good

Is the service effective?

Our findings

Staff received training in areas relevant to the people they were caring for, and told us they were encouraged to professionally develop. One staff member said, "Plenty of training, online, face to face, plus we also talk about the best way to do things in meetings and during handovers, which is really helpful". There was a new clinical lead staff member within the service that staff could speak with to seek advice and develop their knowledge. They were also responsible for checking that the service's policies were up to date, and that best practice guidelines were available to staff for guidance. One member of staff told us, "The clinical lead is especially supportive and you can always go to them for support". A relative said, "All the staff seem to know what they are doing, they all seem trained up".

All staff told us they felt supported and had regular supervision meetings to receive feedback on their practice and identify further training requirements. Staff confirmed they had access to a range of induction, mandatory and other training, such as dementia awareness, relevant to their roles and responsibilities.

Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

Staff we spoke with had a good understanding of MCA and DoLS. An MCA and DoLS audit had been carried out, where staff were asked to write about their understanding and test their knowledge on the subject. The audit indicated that staff had a clear understanding of MCA and DoLS legislation. We observed staff asking people for consent before providing their care. Care records showed that consent to care and treatment had been sought in line with legislation and guidance. One staff member told us how they had discussed the use of a mobility aid with a person, they said, "I offered [person] who suffers with [name of condition] the use of equipment to help with their mobility. The person said they would only use the equipment when they felt they needed it. All the staff were informed and the care plan was updated". This demonstrated that people were asked their views about their care options before staff provided it.

Applications for DoLS had been made to the relevant body, however, we saw one authorisation which was due to expire soon, and the registered manager had not yet requested a review. This is important to ensure the authorisation is still relevant. As soon as we brought this to the attention of the registered manager, they requested a review.

People were supported to eat and drink sufficiently. People were positive about the meal choice and said that they were able to make snacks and drinks independently or with staff support. For example, there was a communal café at the front of the building where people could make drinks and snacks if they wished.

We observed the lunchtime meal. The atmosphere was calm, and well organised. Staff were discreet when offering assistance, and were available at all times during the meal. Where staff assisted people with eating their food, they maintained conversation, encouraging people to eat, and asking them what their preferences were. One person said, "I have to have a special diet due to [health condition] and can only have certain foods, they do steamed fish for me, it's lovely". Another said, "If you don't want what you have asked for, they change it, the food is great and you get your choice". Some people had coloured plates; these were beneficial to people who were living with dementia as the food was more visible to them. We also saw adapted cutlery had been provided to some people to support them to eat independently.

Care records showed that people's dietary needs were being assessed and monitored. A visiting dietician confirmed that they received appropriate referrals for people in the service. We also observed a conversation between a team leader and dietician, who were discussing the most suitable nutritional supplements for people. A weekly meeting was held with staff and the chef to discuss each person's dietary needs, and the chef was advised of any dietary changes. This demonstrated that the service was regularly reviewing the needs of people.

People had access to health care services and received on-going health care support where required. Records confirmed that people had been referred to other professionals, such as GP's, dieticians, speech and language therapy, podiatry, and opticians. A visiting health professional said, "It is very nice here, very friendly and welcoming. Staff are happy to take on board my suggestions, and the residents I see seem very happy".

Good

Is the service caring?

Our findings

People told us that staff were caring and attended to their needs with understanding. One person said, "Pleased with everything. They [staff] are friendly, and smile at you from the moment they start until they finish. They work very hard and do their best by you". Another said, "Delightful place. Friendly, caring staff who are polite and decent".

We saw that people were relaxed in the presence of staff. Staff knew people well and understood their needs. Time was given to people, and we saw that interactions were not rushed. When speaking about people, we observed that staff were respectful in their language, and ensured people's wishes were communicated. We observed interactions between staff and people to be kind, compassionate, person-centred and supportive. This showed that staff attended to people's needs with care.

Records reviewed showed that people were involved in making day to day decisions about their care and support needs. We saw staff asking people what they would like to do, where they would like to sit, and how they would like to spend their day. Conversations were relaxed between staff and people, and we saw staff asking people about the weather, how they were feeling, and enquiring about their families. One relative said, "I have been involved in [relative's] care. Staff are very busy but no one is sharp, and cannot find any fault. They [staff] are always pleasant and have a chat with [relative] and me". Where people did not have any family, information relating to advocacy services was available if required. Minutes of resident's meetings that had taken place were available for review in the main foyer. These meetings gave people the opportunity to express their views and make decisions about changes that may be required in the service.

All staff were observed to be respectful to the needs of each individual in relation to their privacy and dignity. We saw staff knocking on doors and waiting before being invited in. People who spent time in their bedrooms were asked if they wanted their doors open or shut. One person said, "Lovely charming carers, very friendly and treat me with respect". Another said, "They always knock. I don't lock my door but I could if I wanted to, I do lock the bathroom door". Discussions about people with visiting professionals were made in private; this included telephone calls to GP surgeries. This demonstrated that staff were respectful about people's personal information and the importance of protecting this.

People's records identified the areas of their care that people could attend to independently, for example, elements of their personal care. People moved about the building independently, using the lift to access the different floors. The foyer of the building had french windows which were open, and several people walked out to the enclosed garden for a walk, or to meet with relatives. The foyer area was used as a meeting place for a number of people. People could move from floor to floor independently; one person had lunch on a different floor, and one had come down to meet with a relative. This ensured that people were not socially isolated, but encouraged to meet with others throughout the day as they chose.

Good

Is the service responsive?

Our findings

People told us they received care that was responsive to their needs. One person said, "Get up early, my choice, and get dressed. Sometimes I get my breakfast myself and do tea and toast", another said, "I shave myself, shower myself, and get up at 7am to go to the dining room. I am always the first there and eat breakfast on my own and say 'hi' to the staff and get my cornflakes". People were encouraged to develop their own daily routines, and what suited them.

People's care plans contained clear information relating to health conditions, personal preferences and how people would like their care delivered. Content was regularly reviewed and updated. We saw that people and their families/representatives had been involved in the planning of their care. Care plans explained what people were able to do for themselves and provided instructions for staff on what support people required to meet their needs. We found that there was opportunity to develop care plans further to reflect a more person-centred approach, for example, some care plans we looked at focused on the risks to people and how staff should support people to be safe, and less information to guide staff on how to support people with their emotional and social care needs, which would provide a more person-centred description. The registered manager told us they were in the process of developing people's life histories. This information would provide staff with the opportunity to tailor care more fully for individuals.

People told us there were activities and events they could participate in. The list of activities were displayed in the individual units. Activities included weekly keep fit sessions, arts and craft, church services, and outside entertainers. There was also a day club in a separate building in the grounds of Cedrus House which formed part of the home. Several people attended the club, which was open three days per week. The registered manager told us that details of the activities were published in the newsletter so people knew what was happening there, and anyone was free to attend.

The service was in the process of recruiting a dedicated activities co-ordinator. In the interim, staff from the day club had been brought in to support with activity. Staff also supported people to take part in activities on the individual units. We observed people participating in a game of dominoes, and people were seen chatting and laughing with staff. During the afternoon, people were seen in the cinema watching a film, and singing along.

The service had built up positive relationships with the local school. The service took part in the 'Suffolk at Play' project which brought together different generations living in the same community to share their stories of childhood and play. Children from the local school visited the service and spent time talking with people about their memories from the past, including interacting in fun games and activities. A DVD was produced, which showed old and young people engaging positively, laughing, and singing along to old songs. This was a positive step in building and developing effective links and relationships with people in the wider community for the benefit of people using the service. The registered manager told us that they intended to build on this positive experience and maintain the link, as people really enjoyed the interactions and said they wanted this to continue.

We saw that friendships were encouraged and supported. For example, two people who resided on different floors were seen to spend time with each other during the day, and staff encouraged this. One staff member said, "It's lovely they have developed a friendship here and we help them to maintain that". They went on to tell us that when one of them was unwell, they supported the other to visit them. One person said, "I have no fear of asking staff for anything, they make you feel free to ask, they are very friendly".

The service had recently put a 'Wish tree' up on the wall. The registered manager told us that staff asked people what their wishes were and the wish was then added to the tree. So far small wishes had been added, such as food requests, and recently two people asked for a day at the beach. The registered manager told us they were in the process of organising this. The aim was to encourage people to think more about what they would still like to experience in their life, and what made them happy.

The service had a complaints process and procedure in place that identified how people could raise concerns. This was displayed in the main foyer. One person said, "No complaints, and if I did I would go to the office". Another said, "My [relative] has filled in a feedback form with our views. It was all positive". We saw that where people or relatives had complained, that a response had been made in a timely manner, and solutions put in place where possible. During our inspection we were approached by a visitor who had concerns regarding the approach of one of the care staff and wasn't sure whether to discuss this directly with one of the staff members on duty or complain officially. We encouraged them to speak to the team leader on the unit, which they did. They later returned to tell us that the team leader was dealing with their concern and was reassured by their response. The team leader also told us that they would be raising the issue with the management team to avoid a recurrence in the future. This was a positive example of the service responding to feedback and acting on it.

Requires Improvement

Is the service well-led?

Our findings

We found that the service had made continued progress in addressing the shortfalls found at previous inspections particularly in relation to the documentation of risk, and the content within people's care records. At our previous inspection of October 2015, we found that clinical governance systems were not effective, and did not ensure staff received the most up to date guidance and information, particularly in relation to diabetes. At this inspection we found that the service policy for the management of diabetes was current and had been recently reviewed. The team leader we spoke with was able to demonstrate a good understanding of the policy. The majority of staff had received training in diabetes, and for those who had not, training had been booked. Improvements had also been made to ensure staff understood the training sessions they attended, and were asked to complete an 'Evidence of learning' log, listing their five key areas of learning. This provided the management team with a level of assurance that staff had understood and learnt from the training provided.

However, we found that staff had not consistently followed clinical guidance in relation to determining what action needed to be taken for people who were at risk of developing urinary tract infections. Procedures such as these had not yet been fully embedded into staff practice, and therefore needed more time to ensure they were used and referred to routinely. The registered manager told us that they would ensure that the clinical lead continued to take an active role in ensuring the service's policies and guidance were regularly updated and disseminated to staff.

The registered manager was knowledgeable about the people who lived in the service, and the day to day culture amongst staff. They visited the individual units several times a day to carry out spot checks, and encourage feedback from staff. The registered manager was not able to be present during the whole of the inspection, and after they left we found that the deputy manager was not always sure of how to access some of the systems used, for example, the system for recording medicine errors. Improvements are required to ensure that various staff members can access systems which are used to monitor the quality of the service, and other important information which may be requested.

Regular monthly audits were carried out to monitor the quality of the service, such as meal time experience and night time checks. These audits resulted in changes which improved the experience for people, such as planning to introduce picture menus which would help some people when choosing which food they would like to have. During the night time checks, staff were asked questions relating to the safety of people in the service. This enabled the management team to assess whether staff were competent to take appropriate action during the night if this was required. Other audits included falls, medicines, MCA/DoLS, and infection control. These audits allowed the service to monitor trends and gather information which minimised risk to people living in the service. However, when we audited medicines, we found discrepancies in the medicine stock levels. The services' own medicines audit tool had not identified this issue, and therefore the service needs to ensure that the systems and processes in place are sufficiently robust to identify where improvement is needed. We brought this to the attention of the registered manager who told us that the clinical lead would follow this up.

Although these areas required some improvement, there had been significant improvement in the care for people, and the management team continued to be committed to making the service better in all areas.

People and their relatives were given the opportunity to feedback their views of the service which were listened to and acted upon. Resident meetings were held regularly which gave people and their relatives the opportunity to discuss any concerns they had, and plans for upcoming events. A monthly newsletter, Cedrus Sparkle, was produced to inform people of upcoming activities, and updates on recent events. This ensured that people were kept informed of what was happening in the service, and particular events they may wish to attend.

There was an open and supportive culture in the service. Staff worked well together as a team. They showed a good understanding of their individual roles and spoke to each other throughout the day as to what was happening and what needed to be done. Staff were clear about their roles and responsibilities and said they felt valued and supported by the management team. The registered manager told us they operated an 'open door' policy and said that staff spoke with them regularly to discuss issues which kept them well-informed about what was happening in the service. One staff member said, "I definitely feel supported by management. [Registered manager] is really great and does not panic, they manage well". Another said, "Approachable and supportive manager". People and relatives spoke positively of the management team. One person said, "As far as I am concerned I would give them 10 out of 10. The manager is a very special lady and so caring". A relative told us, "Very good, you can always find a senior person if you have a problem".

The registered manager told us they felt supported by the provider who regularly communicated with them and attended monthly meetings to discuss any issues and receive updates in relation to the organisation as a whole. They told us that the provider fully supported continued improvement plans, for example, a new sensory area was to be created, and a music-themed bar which would incorporate music therapy activities.