Care Quality Commission

Care UK Community Partnerships Ltd

Cedrus House

Inspection report

Creeting Road East
Stowmarket
Suffolk
IP14 5GD

Tel: 03333211987
Website: n/a

Date of inspection visit: 21 August 2015
Date of publication: 21/10/2015

Ratings

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

Overall summary

We carried out this inspection on the 21 August 2015. It was unannounced. The service has not been previously inspected before as it is a new location. We brought forward a planned comprehensive inspection because of concerns received. At the time of our inspection there were thirty four people using the service on the ground and first floor, the top floor has not yet opened.

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

People were protected from avoidable harm and abuse that may breach their human rights. There were sufficient staff on duty and staff had received the training they

Summary of findings

required to care for and keep people safe including safeguarding people. The service had emergency plans in place and carried out regular tests of equipment for example fire doors.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines safely.

There was a robust recruitment procedure in place and staff were supported through supervision.

Staff understood how the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) protected people to ensure their freedom was supported and respected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty.

People had access to a range of health care professionals to help maintain their health. A varied and nutritious diet was provided to people that took into account their dietary needs and preferences so that their health was promoted and choices could be respected.

People told us they could speak with staff if they had any worries or concerns and felt confident they would be listened to. We saw staff care for people with kindness and respect.

There were systems in place to monitor and improve the quality of the service provided, but had not fully taken account of all areas to be monitored. The service was using both a paper based and electronic recording care system. We saw that notes were made regarding peoples care on each shift, but we could not see how this related to the care plan. We also saw a number of care plans that had not been updated. Although staff were knowledgeable about the people in their care there were inconsistencies in recording of peoples weights and what they had eaten and had to drink over a period of time.

We saw people participated in a range of daily activities both in and outside of the home which were meaningful and promoted independence.

Regular checks and audits were undertaken to make sure full and safe procedures were adhered to. People using the service and their relatives had been asked their opinion via surveys, the results of these had been audited to identify any areas for improvement.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe

Staff had received training and were aware of how to use the safeguarding and whistle-blowing procedures.

There were sufficient staff on duty with regard to the dependency levels of the people

People's medicines were administered by staff that had been trained and were knowledgeable about the reasons why the medicines had been prescribed

Good

Is the service effective?
The service was effective

Staff felt well supported and completed an induction and training to provide care for people using the service prior to providing care.

People's health care needs were documented and staff helped to promote people's health by ensuring they were seen by the relevant health care professional as required.

People's needs were documented and where people lacked capacity to make decisions about their care and welfare this was recorded to ensure they were appropriately supported.

People were supported to eat and drink in sufficient quantities and they were given adequate choices.

Good

Is the service caring?
The service was caring.

Staff were caring and spent time with people which promoted people's well-being.

People were treated with dignity and respect.

Good

Is the service responsive?
The service was not always responsive.

Staff knew people's needs well but records were not completely up to date which could compromise the care provided.

There were enough activities to help keep people stimulated and promote their mental health.

The service had complaints policy and procedure in place.

Requires improvement

Summary of findings

Is the service well-led?

Good

The service was well-led.

The manager was approachable and hands on and everyone felt they responded to their needs.

There were systems in place to measure the effectiveness and quality of the service provided. This included feedback from people using the service to enable to provide them a service they wished to receive.

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 the 21 August 2015 and was unannounced. It was undertaken by two inspectors and was in response to some concerns raised anonymously about the service.

We met and spoke with five people living in the service, two relatives and a visiting professional, (Dietician). We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the registered manager, deputy manager, chef, a team leader, three care staff and two ancillary staff.

We looked at six people's care and support records and care monitoring records, twelve people's medicine administration records and documents relating to the management of the service. These included the staff training matrix, three staff recruitment files, medicine audits, meeting minutes, training records, maintenance records and quality assurance records.

Before our inspection, we reviewed the information we held about the service. This included information about incidents the provider had notified us of.

Good

Is the service safe?

Our findings

People told us they felt safe, because the staff looked after them. One person told us, they could speak with any member of staff if they were worried about anything and they were confident their concerns would be taken seriously and acted upon. One person told us. "I feel very safe here."

A person told us about their welcome pack which they had received from the service upon moving in. They were pleased with the layout which was clear and gave them information they needed in their new home. They also told us that they found the staff helpful and friendly.

Staff received a handbook which gave information about bullying, whistle-blowing and harassment and what to do in those circumstances when they commenced employment. This was then reinforced in their induction training. Two staff confirmed this and knew who to contact if they needed to report abuse. They gave us examples of poor or potentially abusive care which demonstrated their understanding of abuse and how it could be prevented. They were confident any abuse or poor care practice would be quickly spotted and addressed in the service. There was safeguarding and whistleblowing information available for staff. A member of staff told us they were confident that the management of the service would keep people safe and act appropriately on information reported to them. They were also aware that they could report matters directly to the safeguard team if they ever had concerns that were not addressed.

Care plans showed each person had been assessed before they moved into the service and again on admission. Any potential risks to people's safety were identified. The risks included the risk of falls, skin damage, challenging behaviour, nutritional risks and moving and handling had been assessed and actions to mitigate the risk put in place. Records also highlighted conditions such as diabetes.

Risks to people's safety had been documented. We saw that people at high risk of falls had specialist equipment such as beds which could be lowered, crash mattresses on the floor and pendant alarms. The alarm call system could be monitored to see how long it took staff to respond to a person's call bell and how long they were with the person. The manager monitored the information so they could discuss any resulting issues identified.

The service had an emergency evacuation plan written in March 2015 which had been reviewed in July with regard to the service as a whole and individual people that had moved to the service. We saw that further reviews were planned. The fire alarms were checked weekly and any issues which had been reported had been acted upon promptly.

The service carried out a falls analysis and had recorded subsequent actions to reduce the risk of further falls. This was also the case for accidents and incidents.

We spoke with people who told us staff responded very promptly to their call bells, day and night. One person said, "It is answered in a minute or so." We observed staff responding promptly to people's needs.

We asked people about staffing levels and they told us there were enough staff. One person said, "Yes they [staff] joke with me and I them, we get on very well." Another person told us. "You have to get used to a lot of staff, but they are all really nice. I don't mind male staff and I have been asked if I mind." We asked the manager about the rotation of staff as staff told us this was common practice. There was nothing to tell people which staff were on duty on any day and this might be helpful to people. A staff member told us, they absolutely loved their job but did say they were asked to work at different units which meant there was not always continuity of care. This was being addressed as the service was fully operational so that staff would work with people on more regular basis.

Staff told us staffing levels were alright. One staff member told us that it became busier around tea time and staffing levels reduced by one in the afternoon, as there were more staff on duty in the morning. The manager told us that they would keep the staffing compliment under review and in line with people's needs as the service increased in the number of people to which it provided a service

Staffing levels matched those that the manager said they needed. They told us that staff recruitment was going well and they were fully staffed and not using agency staff. However they said it was difficult to recruit night staff and day staff were rotating between day and night shifts. Staff were familiar with people's needs and had spent time with some people at their previous locations.

We saw the recruitment policy used by the manager and recruitment records. The procedure was divided into five steps which included completing an application form, an

Good

Is the service safe?

interview and checking the person's references and criminal records check, with the disclosure and barring service. These measures were in place to enable the service to employ staff suitable to work with the people living at Cedrus House. One staff member told us about how they were recruited. They were pleased that they had been given training and had time to get to know the people they cared for.

We asked several people about their medicines. One person said, "Yes they watch me taking my tablets." Another person confirmed this. Another said, "I get giddy, they make sure I take my tablets on time." We spoke with two staff that were involved in the ordering of medicines. They told us about the system in use of how medication was booked into the service and how medicines that were not required were returned. We looked at the recording of the controlled medicines and the stock balances we saw agreed with the service records. We looked at medication records and each had been completed correctly. A member of staff told us about the medication training they had completed and the competency checks that were in place for staff to follow in order that people received their medicines safely.

Good

Is the service effective?

Our findings

Everyone we spoke with was confident that the staff had the necessary knowledge and the right skills to meet their needs.

We spoke with staff who told us that they received an induction before starting work with people. Some staff had worked in the previous service which was closed and people had been transferred to Cedrus House. This meant staff were familiar with people's needs. Members of staff told us, they were shadowed by more experienced staff and received adequate support and supervision. They told us they felt well supported and able to ask for help or raise concerns.

We spoke with ancillary staff who confirmed they had a flexible job description and all staff received the same training. They told us they received all the necessary support and had regular meetings. Domestic staff were supported by a head housekeeper.

Staff had an understanding of the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals. Staff knew how to support people to make decisions and were clear about the procedures to follow where an individual lacked the capacity to consent to their care and treatment. We looked at staff training records that showed that staff had completed training in the MCA.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. The manager had made appropriate Deprivation of Liberty Safeguard (DoLS) applications for people living at the service. The manager told us about the work they had carried out thus far regarding MCA and DoLS applications and had found the local authority team supportive when discussing issues with them.

People's records showed us that where there was a concern about people's capacity to make decisions about their care and welfare, this had been assessed. Some people had fluctuating capacity and this was recorded. We could see that people were encouraged to make choices and be involved in decision making. People had been asked for their consent for different aspects of their care and welfare and had signed that they had been involved in their plan of care. Key codes were in place on the main doors but people were not restricted. One person told us they went out regularly and just had to remember to sign out. The manager assured us this was the person's choice and they did not have to book out of their own home. Doors were open between units and people were free to move about and go into the main reception area to the 'café'. Doors to the garden were open and people were sitting outside and there were no restriction.

We asked people about the food which was provided to them. One person said, "We get two good meals a day." Another said. "There's always an alternative if you want one." Another person said. "Yes it is marvellous, you can't fault it."

We carried out observations on two units over lunch time. We observed people being appropriately supported with their meal and staff giving the necessary support and encouragement to people to ensure they ate as much as they were able. Staff prompted people to drink throughout the day and we saw people had drinks in their rooms which were in reach. The service has introduced a stop for tea at three in the afternoon. At this time tea or alternatives drinks are offered and staff are encouraged to take tea with someone so they can chat.

The chef was very knowledgeable about people's dietary needs and who needed a special diet. They showed us the menu slips which were collected every day to indicate what menu choice a person wanted. There was a choice of two main dishes. However in practice people had what they wanted and we saw many different food choices given to people. The chef told us they were currently working to a set menu but had scope to order and offer people choices. They were working on the next menu and had consulted with people about what they would like on the menu and this had been incorporated. They completed food satisfaction surveys each week doing random samples. This helped them ensure people were happy with the food and their individual needs accommodated. In the kitchen was a list of people's food preferences. These were also in people's plan of care. There was also a white board with details of everyone's dietary requirements. We asked about

Good

Is the service effective?

the availability of snacks and finger foods and were shown a wide array of home -made cakes, including people's favourite sponges. There was also chocolate, crisps and other finger foods. The chef told us that they made their own jams and marmalades and had a record of each person's birthday so they could make a cake.

Where people had weight loss this was monitored and lots of people were taking supplements and fortified foods to promote weight gain. However we could not see how many people were on fortified foods, because the home did not compile this information and held it centrally. The dietician was visiting people in the service on the day of our inspection. They told us that they were there to sample records to see if changes had been implemented following training to staff on using the malnutrition universal screening tool, (MUST.) This helped staff accurately measure and identify people at risk of unintentional weight loss. We looked at a sample of records and found weight records to sometimes be unreliable because the records showed wide variations of weight recordings, some for the same month. Some of the weight recordings had been carried over from where people used to live so the manager explained it was because the scales at the previous service had been inaccurate. However without a central weights record for each person it was difficult to see how this was closely monitored.

Preferred priorities of care were in place for some people which documented what people's end of life wishes were and, Do not resuscitate forms were in place on the files we looked at.

We spoke with staff during the inspection including at meal times and the staff on duty were aware of people that were receiving care in bed on that day. They were aware of the reasons for this, the care they required and the food and turning charts were up to date and in order.

One person had received support and counselling due to high levels of anxiety which was associated moving from one home due to close to another. The manager said a number of people who had been poorly on admission were beginning to improve and their weights were increasing. The home had referred people to relevant health care professionals as required. The practice nurse visited weekly and routinely followed up on any health care concerns. The home had one main GP practice they used but said alternative GP practices could be used if people preferred. The manager told us the GP had a contract with the Contract Commissioning Group CCG and as part of this contract the GP undertook annual health care reviews and medication reviews as well as responding as required and the weekly visits from the nurse.

The manager said they had a domiciliary dentist but did encourage people to retain their own dentists. They had a local pharmacist who also carried out their own medication audits as part of the service level agreement. The manager said they had regular chiropody visits and vision call and spec savers for people's eye tests. People's records documented their health care needs and how they were met, including links with the Parkinson's disease nurses and diabetic nurses.

Good

Is the service caring?

Our findings

One person told us. “I love it here, it is home, the staff make it what it is.” People told us they were happy about the care provided. One person said. “The staff are lovely and work really hard.” Another person said, “The staff are nice and I am treated with dignity and respect” We saw that in each bathroom a curtain had been installed, so that if someone opened the door by mistake, the curtain protected the person’s dignity.

One visitor said. “I think it’s very good here, we have no complaints and I know that is the case of my [relative], they would tell me if anything was wrong.” They explained there are no restrictions on when we could visit. People and their relatives said that people’s privacy was respected and they were treated with dignity. One person said. “The staff respect my privacy; they always knock before they enter my room.”

Staff interactions with people were considerate and the atmosphere within the service was welcoming, relaxed and calm. Staff demonstrated affection, warmth, compassion and kindness for the people they supported. For example staff made eye contact and listened to what the people were saying, and responded accordingly. One person told us they felt listened to because, “I can’t chew certain foods very well, the cook knows this and is always able to make me something that I can eat.” One person became distressed and staff reassured them and stayed with them until they were settled. When staff supported people to move they did so at their own pace and provided encouragement and support. Staff explained what they were going to do and also what the person needed to do to assist them.

People told us that they had been consulted about moving home by the staff of the new provider.

One person told us. “I liked the old place but this is better.” They said they liked their room and amenities and the staff had helped them. They thought they would sleep better if there bed was in a different position; this had been done as they said. “No bother” by the staff and all had worked out well.

We observed people’s care and saw that staff were kind and attentive in their interactions with people. One person was distressed upon admission which had happened recently. Staff spent a great deal of time with this person and helped them focus on more positive experiences whilst acknowledging their distress. We observed this person being reassured and comforted by staff.

During the day we saw people were well dressed, and had appropriate foot wear. Some people had blankets over their knees and staff protected people’s dignity whilst transferring them using a hoist. People were encouraged to be as independent as possible. One person used their walking frame to come into the lounge. Staff were very patient with them as it took them along time and staff stayed with them at all times to make sure they were safe, offering constant reassurance.

We observed staff helping people reconnect with their pasts and staff took time to sit with people, chat with them and find out about their interests. One person had a disability which staff discussed with them and how it impacted on them and their ability. Staff said they would record such information to help them care more effectively for people.

Family reviews were held every six months and people told us they were consulted about their needs and told us their needs were met in the way they wished them to be. For example one person, said they got up and went to bed when they wished and there were no restrictions placed on them. Another person said they went out during the day and showed us some of the plants they were cultivating in the garden.

Requires improvement

Is the service responsive?

Our findings

People told us there were enough activities, examples given to us were, 'bingo, dominoes, quizzes and planting seeds.' Staff told us some people went to the carnival recently. During our inspection we saw staff assisting people with personal care and spending time with them. In the morning music was being played appropriately for those wished to listen, people were reading and doing crosswords but we did not see much other activity. However staff told us several people had been to the supermarket. Some people were accessing the coffee shop and there were lots of visitors in the home. We also observed one to one interactions. Staff spent time helping a person doing some embroidery and knitting and chatting to people about their lives and experiences.

Attached to the service was a day centre which was open three days a week and this was open to members of the local community and people using the service. There was no activities coordinator for the service but the manager told us they expected activities to be provided by all staff and were not the specific responsibility of activity staff. There was a list of activities on the notice board which showed planned activities seven days a week morning and afternoon. There was also an activity room which appeared well used with lots of photographic evidence of activities and paintings.

We looked at a number of care records and found these difficult to follow. The service had carried out assessments of people's needs prior to them coming to the service and once they had moved in. The service had electronic records in which they recorded people's daily progress notes. We saw that notes were recorded on each shift but it was unclear how these related to the person's care plan. Individual care plans and risk assessments were also electronic and should have been updated monthly and as required. We saw a plan that had not been updated since the person had joined the service, some three months ago. Therefore we could not be sure of any changes to the person care needs in that time had been recognised and recorded.

Paper records were also held and did not correlate with the electronic record although staff told us the paper records were up to date. It was difficult to see why the service used two sets of records. The manager said it was because sometimes the computer would go down. We found the information presented in the two records confusing as they did not mirror each other and some of the information was unreliable. For example we saw big weight fluctuations, some recorded for the same month. We could not see a reason for this. The manager said that scales had not been calibrated at the previous service so when people were weighed on arrival to the service their weight recordings were different. On one person's records we saw one document said the persons weight was static another document indicated a recent weight loss. Staff were not aware of this conflicting information and the impact was that the response to the persons care need could be missed.

The resident of the day review was not fully complete and the monthly review indicated no changes over three months. However we were able to see this person had some high risk factors and some subtle changes of need which had not been identified as part of the review process. The person had Parkinson's disease. There was guidance in relation to their manual handling needs but not in relation to their personal care and fluctuating ability. We also noted that a number of care plans and risk assessments had not been signed by the person or indeed a member of staff.

We looked at monitoring charts for food/fluid intake and repositioning charts over a period of time. These showed large variations. We saw on the whole people were having good fluid intake but some day's fluid intake was low and the records did not tell us what actions were being taken. A nurse said food and fluid intake was recorded on people's daily notes and discussed as part of handover if there were any concerns. However there was no correlation between records. Our concern was as the service was only half full at present staffs knowledge to know people's needs and provide care lessened the impact of poor care being provided. We raised with the senior staff that the recording need to improve to take into account that the service was planned to increase and hence staff would be far more reliant upon records than their own memory.

Records were not particularly helpful in telling staff what people's needs were. The computerised record was divided into many sections so we were unable to see at a glance what their main needs were and would not help staff who were unfamiliar with people's needs. The staff we spoke with were familiar with people's needs but could not tell us where some documents were. For example not all staff were familiar with what information people would take if

Requires improvement

Is the service responsive?

they had to go to hospital. The seniors and nurses knew but gaps in staff knowledge could compromise care. There was a document, 'All about me 'which told us about people's preferences and history. This was an informative document but we found it at the back of people's files and they had not been updated since people had moved to the home. The manager said they were completing scrap books for people including photographs and some people had memory boxes outside of their room.

The service had carried out quality outcome reviews in both June and August 2015. We could not see in these reviews that attention had been given to how people received personalised care that is responsive to their needs. In the regulatory governance audit (another internal document) of June 2015 which also considered if the service is responsive. There was information for both areas and although complaints appeared to be satisfactory, the service itself had identified how the personalised care needed to improve and had rated itself as requires improvement for responsive. We were confident that work to improve had begun regarding recording and responding to personalised care.

People and visitors said they felt able to raise any concerns about the service they received. One person said. "I'd speak to [manager] if I had a complaint". A visitor told us: "I've never had to complain, but if I did I'd feel comfortable speaking to the manager." Arrangements were in place for people to inform the service of their concerns. Each person was also given a copy of how to raise a complaint in the welcome back. This set out the organisations aims and objectives and also contained information on how to make a complaint in detail. There were copies of this in the main entrance of the home. The manager told us about the policy and procedure and actions they would take upon becoming aware of a complaint.

Good

Is the service well-led?

Our findings

We spoke with a person on respite care. They told us, "Yes I know who the manager is they come and see us and ask us if everything is alright. As soon as I got here I knew it was right. They ask you, if you need anything."

One person told us about the staff, "Very helpful the smallest things are addressed. The manager is very helpful. I go to the residents meetings."

Staff told us the manager was visible and often helped out staff particularly if they were short or staff were busy. All staff told us the manager was approachable as was the deputy manager. One staff member told us. "The service is great, we are a really strong, cohesive management team."

The manager was experienced in the care sector and of managing large homes and supporting people in particular with mental health issues, and, or dementia. They had come into post in 2014 a year before the home opened and had spent time getting to know the people who would be moving into the service. The manager and people we spoke with considered this an excellent idea so they could get to know each other and plan the move between services. Most people had lived at Wade House which was due to close and people were being transferred to the new purpose built service. People told us they were involved in their transition and had time to look round their new home. The manager said staff recruitment started at the same time and staff had completed their training and induction in the months leading up to the home opening.

The manager told us that people had a chance to visit the new service before moving in which helped them settle and feel involved and included. The home included a family room and we observed many family members and visitors at the service during our visit. They were able to see their family member in private or in communal areas, including the 'café'.

The manager informed us the service had been well received by the local community and the day centre was already fully functional. They said there was a joint project between them and the local primary school opposite and they were doing an arts project. They said some people also used the local community centre. We spoke with people who were able to go to the local supermarket and into town. However some people had requested day trips further out such as the seaside. This had not yet taken place, but was being looked into by the manager. The service did not have its own transport but the manager said they would use community transport.

The home were involved in initiatives, such as dementia friends which was run by the Alzheimer's association who provided support and training to raise awareness of dementia. Once a person had attended an information session they could access other resources and could also volunteer to facilitate an information session to a community group. They were also involved in dementia action alliance which had members both nationally and locally and provided support and information to communities about dementia.

Regular resident/relative meetings took place. People were aware of these and minutes were available.

The home was well equipped and some people had assisted technology which included an alarm call system which meant that staff were alerted if people were moving about and therefore could be at increased risk of falling. This was only installed with people's permission. There were also hydraulic baths and specialist equipment as required.

There were audits in place to ensure records were appropriately maintained. Care plan audits identified gaps in record keeping but we could not always see how these were being addressed. There were night audits to ensure people's care was being delivered effectively over a 24 hour period. There were surveys to ask and capture people's experiences of care. We looked at the food audits and the forms, 'resident of the day,' each day a person's needs were reviewed and this included a full review of their needs, and if their room was clean and involved comments from the person, and other staff such as the house keeper, chef and key worker. These were quite detailed but a number of forms had not been fully completed. There were regular medication audits and audits for pressure care and ulcer management. At the time of our inspection there was no one with reported pressure sores.

The manager told us there were internal governance audits and monthly manager's audits including audits around risk factors such as falls, and urinary tract infections. These went to their managers for a final check and to ensure appropriate measures were being taken to manage risk. We saw recorded evidence that the manager had carried out

Good

Is the service well-led?

audits at night, there had been reviews of care plans. People using the service and their relatives had been asked their opinion via surveys, the results of these had been audited to identify any areas for improvement.

Communication in the home was reported to us as being good with the manager and head of departments and nurses having a handover of information at nine then another meeting at eleven am with team leaders. The meeting was then disseminated to all other staff.