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Cedric House EMI Residential Care Home

Inspection report

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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?	Good

Summary of findings

Overall summary

The inspection was unannounced and took place on the 11 and 18 April 2017. The service was last inspected in April 2015 and was rated as good.

Cedric House is registered to provide accommodation to people living with dementia who require personal care and support. The service is registered to accommodate up to 20 people. At the time of the inspection visit there were 18 people living at the service.

There was a registered manager in post within the service, who had been registered with the CQC since March 2015. 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.

The registered provider specialises in supporting people living with dementia, however we found some aspects of the service that would benefit from some improvement. For example the environment would benefit from consideration around how it could be made more dementia friendly, and the use of therapy dolls needs to be carried out in line with best practice. We have made a recommendation to the registered provider around supporting people who live with dementia.

Audit systems were in place to monitor the quality of the service being provided. However an accurate record of complaints was not being maintained by the registered manager. This meant that common themes or trends in complaints could not be identified to prevent issues from reoccurring again in the future. Other aspects of the service that were audited to a good standard included medication and the management of falls.

During meal times the majority of people enjoyed the food presented, whereas some people did not appear to enjoy what had been offered. Alternative options were not always made available. However, people received special diets where needed and appropriate action was taken to refer people to the relevant health professionals where they were at risk of weight-loss. This helped to protect people from the risk of malnutrition. We raised this with the registered manager so that this could be addressed with staff.

People were protected from the risk of abuse. Staff were aware of the different signs of abuse and how to report any concerns they may have. The registered provider had a whistleblowing policy and procedure in place which staff were familiar with. This enabled staff to report concerns inside or outside the service without fear of reprisals.

Accidents and incidents were being monitored by the registered manager, and appropriate action was being taken in response to these. Where people were at high risk of falls and had experienced multiple falls they had been referred to the appropriate health professional for support.

Recruitment processes were robust and ensured that staff employed were of suitable character to work with vulnerable people. Appropriate checks had been carried out prior to new staff starting which helped the registered manager make decisions regarding the suitability of applicants.

People had been supported to take their medication as prescribed. Medication was administered safely, and staff signed medication administration charts (MARs) to show that this had been given as required. Clear instructions were available for staff around when medicines should be administered.

People's rights and liberties were being protected in line with the Mental Capacity Act 2005. We observed positive examples where staff gave people the option of making choices for themselves. The registered manager was aware of those family members who had the legal power to make decisions on people's behalf, and people's care records reflected their cognitive and mental abilities.

Staff were kind and caring towards people and positive relationships had developed between them. Family members commented positively on staff and told us that they were made to feel welcome when they visited the service. Staff acted appropriately to maintain people's privacy and dignity.

People each had an individual care record which outlined what staff needed to do to support them. These were personalised and contained information regarding their likes, dislikes and personal preferences. This helped ensure staff knew what support to provide to people.

There were activities available for people such as bingo, entertainment and arts and crafts. The local church visited the service on a Sunday so that people had the option of participating in a service and taking communion if they wished to do so.

An annual survey was carried out by the registered provider to establish the views of people using the service, their families, and external professionals. The feedback given had been positive. Where suggestions had been made to help improve the service the registered manager had acted upon these.

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 aware of safeguarding procedures and how to report any concerns they may have.

Accidents and incidents were monitored and appropriate action taken to keep people safe.

Recruitment processes were robust and helped ensure that staff were suitable to work with vulnerable adults.

Is the service effective?

Good

The service was effective.

We have recommended that the registered provider look further into best practice around supporting people living with dementia.

A majority of people had a positive meal time experience, however alternative options were not readily available.

People were supported to access health and social care professionals where required.

Is the service caring?

Good

The service was caring.

Positive relationships had developed between people and staff.

Staff acted to maintain people's privacy and dignity.

People's confidentiality was protected.

Is the service responsive?

Good

The service was responsive.

An accurate record of complaints was not kept in line with the registered provider's own complaints policy.

Care records were personalised and contained clear information regarding the support that staff should provide to people.

Activities were available for people to participate in.

Is the service well-led?

Good

The service was well-led.

An accurate record of complaints had not been kept which prevented the registered provider from identifying patterns and trends.

Quality monitoring processes were effective at identifying issues in other areas, and appropriate action was taken to rectify any issues identified.

Survey's had been completed with people and their family members to ascertain their views on the service.

Cedric House EMI Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 was unannounced and took place on the 11 and 18 April 2017.

The inspection was completed by one adult social care inspector.

Prior to the inspection we contacted the local authority who did not report any concerns.

During the inspection 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 spoke with four people who used the service and three people's family members. We spoke with three members of staff, the deputy manager and registered manager. We looked at the care records for three people and the recruitment records for three members of staff. We made observations on the interior and exterior of the premises, and looked at the records pertaining to the day-to-day management of the service, for example audit systems.

Good

Is the service safe?

Our findings

People told us that they felt safe. Their comments included, "Yes, I'm safe enough here" and "Yes I'm safe". People's family members also told us they felt their relatives were well looked after. One family member commented, "[My relative] is absolutely safe here. I am so grateful to them", whilst another told us, "This place is not bad. We've no concerns about safety".

Staff had completed safeguarding training and they demonstrated a good knowledge of the different types of abuse that can occur and how they should report them. The registered provider had a whistleblowing policy in place which staff were familiar with. Whistleblowing is where staff can raise concerns either inside or outside the organisation without fear of reprisals. This helped ensure that people were protected from the risk of abuse.

Recruitment processes were robust and helped ensure that staff were of good character and suitable to work with vulnerable people. We looked at the recruitment records for three members of staff. Staff were subject to a check by the Disclosure and Barring Service (DBS) to ensure that they were not barred from working with vulnerable groups of people. New staff had been required to provide two references, one of which was from a previous employer. The registered manager had verified the authenticity of references received.

There were sufficient numbers of staff in place to meet people's needs and keep them safe. Staff responded promptly to people's needs and rotas showed that there were consistent numbers of staff in place. People and their family members told us that they felt that there were enough staff in place.

People were supported to take their medication as prescribed which helped to ensure their health and well-being was being maintained. We observed a medication round taking place which was completed safely. During the medication round the member of staff waited with each person to ensure they had taken their medication. Medication administration records (MARs) were being signed appropriately by staff. This was done to demonstrate that medication had been administered as required. There were clear instructions in place on when to administer PRN ('as required') medications, for example pain relief. Where medication needed to be taken before meal times, this was clearly outlined on the MAR.

Risk assessments were in place to help maintain people's safety. These included risk assessments around people's day-to-day needs, for example where people were at risk of falls. In one example a person had a diabetic risk assessment in place which clearly outlined the symptoms associated with their blood sugars being too high or too low. This outlined what action staff should take in response to this. Personal emergency evacuation plans were in place which provided clear detail to staff on what support people required in the event of an emergency.

Environmental risk assessments were in place and action had been taken to keep the environment safe. For instance, a check of the water supply had been completed to ensure this was free from harmful bacteria. Checks on electrical equipment such as hoists had been completed to ensure they were safe for use. The lift

had also been serviced to ensure it was in working order.

Staff had received training in infection control and we saw examples where they used personal protective equipment such as disposable gloves and aprons prior to attending to people's personal care needs. This helped to protect people from the risk of infection.

Good

Is the service effective?

Our findings

One person's family member commented that staff were skilled and good at their jobs. Their comments included, "The quality of the care is literally utterly excellent". Family members also told us that people were supported to access healthcare professionals when needed. One family member commented, "Someone regularly comes in to give people nail care to stop people's nails becoming too long". We also spoke with a visiting health professional who commented positively on the support provided to people.

The service specialises in providing care and support to people living with dementia, however we identified some areas of improvement. Therapy dolls were being used as a means of promoting people's sense of wellbeing. However risk assessments and care plans were not in place around their use. Whilst the use of therapy dolls can be beneficial, careful planning is required to ensure that they are appropriate, and will not cause distress to the people using them or others. People were interacting with these positively, however, when not in use these were not being stored appropriately. In two examples we observed these were being kept in plastic bags in the lounge and main office, in full view of people. This had potential to cause people distress, where they may confuse them with real children. We raised this with the registered manager so they could address this.

During our inspection we found that the environment was not always dementia friendly. The environment contained minimal decoration and signage to help people remain oriented to their environment. For example well placed pictorial representations can help people to understand and recognise what specific rooms are used for and can support both reminiscence and wayfinding. Placing photographs of people on their bedroom doors can also help them recognise which rooms are theirs. The use of contrasting colour schemes can be used to support people living with a visual impairment who may experience episodes of confusion. This can act to promote people's wellbeing and increase their quality of life.

We recommend that the registered provider seek advice and guidance from a reputable source around practical ways of supporting people living with dementia.

A majority of staff had completed training in the areas needed for them to carry out their role effectively. Where staff training was not up-to-date the registered manager was able to provide evidence to show that this training had been scheduled for completion. Staff had completed training in areas such as moving and handling, fire safety and infection control. Training had been delivered to staff via a mixture of both e-learning and classroom based training. This helped ensure that staff skills were up-to-date and in line with best practice.

There was an induction process in place for new staff which included a period of shadowing experienced members of staff. New staff were also required to complete training in areas such as safeguarding vulnerable adults, moving and handling and infection control. The induction process being provided met some of the standards required by the Care Certificate, but not all of them. The Care Certificate is a national set of standards which care staff are required to meet. We raised this with the registered manager for them to address.

Staff received supervision with the registered manager every three months. Supervisions were thorough, and the registered manager used these as an opportunity to test staff knowledge in certain areas. For example a discussion had taken place with one member of staff around the Mental Capacity Act 2005, what process to follow in the event of a death within the service, and how to respond to verbal and physical abuse. New staff received regular supervisions to assess their performance and ensure they were suitable for the role. Annual appraisals were also carried out, during which staff set objectives and the registered manager reviewed performance for the whole year.

During meal times staff sat with those people who needed support with eating and drinking, and offered to cut other people's food up to make sure they could eat it more easily. Where people required a special diet, for example thickened fluids, or softer food options due to swallowing difficulties, this was provided. In a majority of cases staff were attentive, and provided the support people needed. In one example however staff did not act to offer assistance when they noticed that a person was not eating their meal. As a result of this, this person did not eat much of their food before their plate was taken away. We checked to see whether this person was at risk of malnutrition and found that they were not.

People told us that they liked the food that was available. Their comments included, "Yes the food OK" and "It's not bad". However during meal time there was a mixed response to the food. One person commented, "I dread to think what's in this", whilst another person commented, "Hot cross bun? That's not dessert". Other people appeared to like the food and cleared their plates. Alternative food options were not offered to people where they appeared not to like what they had been given, and only three people were offered an alternative dessert. It is important that alternatives are made available to promote good dietary intake. We raised this with staff on duty and the registered manager so that they could make the required improvements.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had applied for DoLS as required for those people who needed them.

Not all staff had completed training in the MCA. However they were able to give appropriate examples around letting people make decisions. Whilst we identified issues around choice being offered at meal times, in a majority of examples staff were guided by people's own preferences on how they wanted to be supported. For instance, in one example staff asked people what they would like to watch on television. In another example a member of staff let a person choose where they would like to sit. The registered manager confirmed that training in the MCA was being organised for staff.

People's care records contained a good level of information around their cognitive abilities, and how staff should act to communicate effectively, for example using short, simple sentences where people had difficulty processing information. One person's care record outlined that any planned medical interventions would require a mental capacity assessment to be completed, and a decisions to be made in their best interests. The registered manager was aware of those family members who had Power of Attorney and were able to make decisions on behalf of their relatives where they did not have mental capacity. This helped ensure that there was support in place for people where they may need decisions to be made in their best interests.

People were supported to access the health and social care professionals, for example their GP or social worker. People's care records contained information about visits from professionals, or information relating to health appointments. This helped ensure that people's health and wellbeing was maintained.

Good

Is the service caring?

Our findings

Staff were kind and caring in their approach to people. We observed staff and people spending time chatting to each other in a familiar and friendly manner. In one example we observed a member of staff laughing at something on the television with two people. In another example one person gave a member of staff a hug, whilst another told us that the registered manager was a "lovely person".

Staff were patient with people, acting to provide reassurance where needed. Some people spent their time walking around the service and we observed examples where staff regularly asked if they were ok, or if they needed anything. In one example a member of staff brought one person a blanket after hearing them say they were cold, and helped settle them into a chair. Where people required a hoist for transfers, staff gave clear instruction and focussed on the person to ensure they did not become distressed.

People's family members were made to feel welcome when they visited. We saw examples where staff offered them refreshments whilst spending time with their relatives. One person's family member commented, "Oh yes, they most certainly do make me feel welcome". This was important so that people could continue to maintain positive relationships with their loved ones.

People's privacy and dignity was maintained by staff. Staff knocked on doors prior to entering people's rooms, and ensured that doors were shut when they were attending to people's personal care needs. Where staff prompted people to use the toilet, they did so discreetly so as not to embarrass the person. People and their family members described staff as "respectful".

People's confidentiality was maintained. Records containing personal information was kept securely in a locked office, and where information was stored electronically this was password protected. Where staff had to take people's personal information outside the office they kept this with them at all times and did not leave it unattended.

Not all people were able to contribute to making decisions relating to their care and treatment. The registered manager confirmed that they maintained a list of those family members who were legally able to make decisions on people's behalf so that they could be consulted. We spoke with three family members who confirmed that they had been involved in care planning for their relatives. Care records contained details relating to people's preferences which showed that their needs and wishes had been considered.

Advocacy support was made available for those people who required this, and the registered manager was aware of those circumstances where an advocate would be needed. An advocate acts as an independent source of support for people where important decisions are being made about their care needs. This helps to ensure that people's wishes and feelings were considered.

At the time of the inspection visit there was no one who required end of life support. However people's care records contained information around how they would like to be supported during the end stages of their life. For example one person's care record stated that they would like to be cremated at their local church.

Do not attempt resuscitation orders were kept at the front of people's care records where they had decided that they would not like to be resuscitated in the event of them becoming unwell. This helped ensure people's end of life wishes could be respected.

Good

Is the service responsive?

Our findings

People commented that staff provided the support they needed. One person told us, "Oh yes they are very helpful". People's family members also commented positively on the support that staff provided to their relatives. Their comments included, "[My relative's] clothes are always clean and carers always get down on the same level as them when they are talking to them. You can see [my relative's] face light up whenever they speak with her. It's lovely". Another family member told us that staff had "bent over backwards" for their relative, and also commented that "Staff seem to look after people well".

Prior to people being supported by the service, the registered manager or another member of the management team completed an initial assessment of their needs. This considered aspects such as people's social and religious needs, their previous medical history, and any current physical and mental health needs they may have. This information was used to determine whether the service could safely accommodate the person's needs.

Information from the initial assessment was used to develop people's care records. These contained information for staff regarding what they needed to do to support people. For example where people required support with their mobility, care records outlined how many staff they needed to support them and if they required the use of any equipment such as a hoist or wheelchair. Where people were known to be at risk of developing pressure ulcers, care records outlined those parts of the body that people were more prone to developing pressure ulcers on, and what staff should do to help prevent these. This ensured that staff had access to relevant information around how they should support people.

Care records were personalised throughout and contained details around people's preferences. For example one person's care record stated that they preferred a shower rather than a bath and liked to wash their hair twice a week. Another person's care record stated that they preferred to wear "pants not skirts", whilst another stated one person, "prefers to go to bed between 7:30 and 8:00PM". Care records also contained details about people's life histories, and included details on those people or family members who were important to them. This helped staff get to know people, and supported with the development of positive relationships.

Care records were reviewed on a monthly basis by staff to ensure that information was up-to-date and accurate. The registered manager also reviewed care records on a three monthly basis during supervision with staff, so that any issues could be addressed directly with the member of staff responsible for people's care. Where developments occurred with regards to people's needs, care records had been updated to reflect this. This helped to ensure that accurate information was available for staff.

Daily notes were maintained by staff which included details on the support that had been given to people throughout the day and night. Where any issues had arisen, these had been clearly documented and showed that appropriate action had been taken, for example supporting people to access support from health professionals. Where people required pressure relief to prevent pressure ulcers from developing, or monitoring of their diet and fluid intake, charts were being completed by staff to show that this was being

done. This helped maintain a running record of people's needs, and could be used to plan changes to the delivery of people's care.

There was a complaints process in place which people and family members had made use of. One person commented, "I have no complaints, but I would if I needed to". A family member also commented, "Absolutely I would make a complaint if I needed to". The registered manager kept a record of complaints and quality concerns that had been raised directly with the service or via the local authority. However we noted that two concerns that had been raised with the local authority were not included within this record. It is important that an accurate record of complaints is maintained so that the registered provider can identify common trends and themes, and act to prevent these concerns from occurring again in the future. We raised this with the registered manager who told us that a record of future concerns would be maintained in the future.

People and their family members confirmed that there were activities available to people. Their comments included, "They did crafts last week, and a choir recently came to sing. The church visits on Sunday to do communion". During the inspection visit we observed people playing a game of bingo, or spending time speaking with staff. Other people had chosen to spend their time reading or watching television. This helped to protect people from the risk of social isolation.

Good

Is the service well-led?

Our findings

The service had a registered manager in post who had been registered with the CQC since March 2015. People knew who the registered manager was and told us that she was approachable. We observed examples where people spent time talking with her, and occasions where she spoke kindly and gave reassurance to people. One family member told us they felt the registered manager and staff "cared deeply" about the service and the people using it, whilst another person told us that the registered manager was a "lovely person".

An accurate record of complaints was not maintained by the registered manager, which did not adhere to the registered provider's own complaints policy. This meant that an analysis of those concerns raised could not be completed to identify trends and patterns, to prevent similar issues from occurring again in the future. We raised this with the registered manager who told us that a more accurate record of concerns would be maintained in the future.

Audits were in place to look at other aspects of the service. For example medication audits were completed on a weekly and monthly basis, which looked at stock levels and ensured that people were receiving their medication as prescribed. Where any issues were identified with the quantities of medicines held this was recorded on an incident sheet, and an investigation was completed into the cause. Where staff were neglecting to sign MARs this was followed up with the member of staff responsible. Falls audits were also completed which had identified where people were having repeated falls. These ensured that action had been taken to refer people to the appropriate professionals. For example one person who had fallen a number of times over a period of three months had been referred to their GP and the local falls team for support.

A quality monitoring audit was completed on an annual basis. This ensured that safety checks had been completed on the environment, for example monitoring of water temperatures and the completion of risk assessments. Where issues were identified by this audit system, action was taken to make the required improvements.

There was a clear management structure in place and staff knew who to report to. During the first day of the inspection the registered manager and deputy manager were not available. In this instance staff reported to a senior member of the care staff, who ensured the smooth running of the service. Both the registered manager and deputy manager were available for support over the phone, and later in the day the deputy manager came in to ensure staff were supported during the inspection process.

An annual survey was carried out by the registered provider. This gave people, family members and external professionals the opportunity to give feedback on the service. Eleven responses had been returned to the registered provider. All of the responses gave positive feedback about the service. In some instances however family members had responded that they were not always offered refreshments when visiting their relatives. During our visit we saw refreshments were offered, which showed that the registered provider had responded to rectify this.

Staff meetings were held on a monthly basis which enabled the registered manager to discuss aspects of the service with staff. For example in a meeting in January 2017 a discussion had taken place around infection control procedures. In another example a member of staff had been congratulated on achieving 100% attendance. Meetings also provided staff with the opportunity to give feedback to the registered manager, and make suggestions regarding the running of the service.

The registered provider is required by law to notify the CQC of significant events that occur within the service. Prior to the inspection we reviewed those notifications that had been sent to us by the service, and found that this was being done appropriately.