# Inspection Report

***We are the regulator:*** *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

## Cedar Grange

Main Street, Cherry Burton, Beverley, HU17 7RF

Tel: 01964551580

Date of Inspection: 04 January 2013

Date of Publication: January 2013

We inspected the following standards to check that action had been taken to meet them. This is what we found:

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|---|---|
| **Respecting and involving people who use services** | ✓ Met this standard |
| **Staffing** | ✓ Met this standard |
| **Records** | ✓ Met this standard |

## Details about this location

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|---|---|
| Registered Provider | Roseberry Care Centres UK Limited |
| Registered Manager | Mrs. Paula Storey |
| Overview of the service | Cedar Grange is a large detached property that is situated in the village of Cherry Burton, close to the town of Beverley, in the East Riding of Yorkshire. The service is registered to provide accommodation and personal care for up to 31 older people, including those with dementia related conditions. The registration incorporates a detached bungalow described as The Lodge. The Lodge provides accommodation for eight people. |
| Type of service | Care home service without nursing |
| Regulated activity | Accommodation for persons who require nursing or personal care |

# Contents

*When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.*

## Summary of this inspection

### Why we carried out this inspection

We carried out this inspection to check whether Cedar Grange had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Staffing
- Records

This was an unannounced inspection.

### How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 4 January 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

### What people told us and what we found

At the previous inspection of the home in September 2012 we issued three compliance actions. The providers submitted an action plan to tell us how they had become compliant with these outcomes.

At this inspection we reviewed the information held at the home and spoke to the registered manager, the quality manager, two members of staff, two people who lived at the home and a relative. This was to help us reach a decision about the improvements made by the home. We found that they were now compliant with the outcomes assessed.

We observed that staff treated people who lived at the home with respect. The interactions that we saw during the serving of lunch promoted privacy and dignity and people were encouraged and assisted to eat their meals.

The people we spoke with told us that they were satisfied with the care they received. They told us that staff were polite and that they were confident they would help with any concerns or queries they had. The relative we spoke with told us that they were kept informed of any matters pertaining to their relatives care and that they were always made welcome at the home.

We observed that there were sufficient numbers of staff on duty to meet the needs of people who lived at the home.

We checked a variety of records and found that these were complete and had been kept up to date. This meant that staff had up to date information available to ensure that they provided appropriate care.

You can see our judgements on the front page of this report.

## More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

## Our judgements for each standard inspected

**Respecting and involving people who use services** ✓ Met this standard

**People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run**

### Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

### Reasons for our judgement

At the previous inspection of the home in September 2012 we made a compliance action in respect of this outcome. We found that people living at the home did not always have their dignity respected when being assisted to eat their meals and we were concerned about a person who was in receipt of palliative care occupying a shared room.

At this inspection we saw that dignity champions had been appointed at the home and we observed two notice boards dedicated to this topic. They included information that reminded staff about how a person's dignity should be respected. The manager and a senior care worker had attended training on the topic of dignity and were in the process of checking the information pack they had received so that they could share relevant information with staff. The manager said that they intended to send more staff on dignity awareness training courses.

We observed the interaction between people who lived at the home and staff on the day of the inspection, including during the serving of lunch. We found that staff spoke to people in a sensitive and respectful manner. People were told about the meal that had been served to them. We saw that sometimes people were observed to ensure that they were eating effectively and other times assistance was offered. When people were offered assistance, this was done on a one to one basis.

The menu board displayed the choices on offer both in writing and in pictorial format. We saw that the food choices displayed were the same as the choices available on the day, and that there was a choice of meal at each meal time. In addition to this, we saw that snack boxes were available for people who lived at the home. These contained small packs of biscuits, crisps, chocolate and fruit. This enabled people to help themselves to a snack at any time of the day or night.

The manager told us that the person in receipt of palliative care mentioned in the last inspection report had been in a shared room for a few days. They had taken the person as an emergency admission and had accommodated them in a shared room until someone having respite care had vacated a single room.

We visited The Lodge, a bungalow in the grounds of the home that was part of the same registration. People accommodated in The Lodge were more independent. They spent most of the day in their own rooms (which had en-suite facilities) and some of them went into the dining room for meals. Each room had an external door that enabled people to use outdoor space when they chose to do so. One person told us about the gardening they had undertaken and about the exercise equipment that had been installed for them outside their external door.

We spoke with one person who lived at the home and their wife, who was visiting on the day of the inspection. They told us that they were very satisfied with the service provided by the home. The relative told us that she had been invited to have Christmas lunch with her husband and that she had always been made to feel welcome at the home.

The manager told us about social events that had happened in the village and how people who lived at the home had been involved. One example of this was that the procession arranged for the Queen's Jubilee celebrations had started from the grounds of the home. People told us that they went out for a walk, either on their own or accompanied by staff, and we observed this on the day of our inspection. The mobile library visited the home. People were supported in promoting their independence and community involvement.

One of the activities coordinators had spent time checking and updating 'This is me' forms so that there was a record of a person's likes and dislikes regarding interests and socialisation. The manager told us that they had plans in place to introduce one to one sessions for people who did not like to take part in group activities or declined (or were too ill) to leave their rooms.

Care plans included information about a person's capacity to make decisions and whether they had an advocate or power of attorney appointed to manage their financial or health care affairs. One person's care plan recorded, "I can make simple choices for myself but if my health needs change I am aware my daughter and health care professionals will work together with Cedar Grange to meet my care needs and ensure my liberties have not been denied".

Care plans also included information about a person's preferences regarding personal care, such as "I have no preference for a male or female carer" and "I don't mind a bath or a shower. I like my morning wash before breakfast". Care plans recorded specific information about a person's wishes regarding their clothing and makeup choices and about nail care. We saw that care plan agreement forms had been signed by the person concerned when they were able to do so. Relatives had been asked to sign these forms when the person did not have the capacity to understand the content of their plan.

We saw that one person's care plan recorded specific information about their wishes for end of life care, including clear instructions regarding the involvement of the church.

**Staffing** ✓ Met this standard

**There should be enough members of staff to keep people safe and meet their health and welfare needs**

## Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

## Reasons for our judgement

At the previous inspection of the home in September 2012 we made a compliance action in respect of this outcome. Some people told us that there were insufficient numbers of staff to meet the individual needs of people who lived at the home.

At this inspection we spoke with two members of staff who told us that, although staffing levels had not increased, the deployment of staff had been more organised in the last few months. An allocation sheet had been introduced to assist with the allocation of tasks. There were enough qualified, skilled and experienced staff to meet people's needs.

The manager told us that they had recruited two bank staff. She said that they had hoped to recruit more but she believed that the village location and lack of public transport to the home had reduced the number of applicants.

The vacancy for an activities coordinator had been filled – one person worked 20 hours per week and another worked eight hours per week. This had given care staff more time to concentrate on care tasks and had provided people who lived at the home with regular opportunities to socialise and take part in activities; there was a movement to music session on the morning of the inspection and eight people had taken part.

We checked the staff rota and this recorded that there were five care staff on duty each morning, four care staff on duty each afternoon/evening and three care staff on duty overnight. One of these would always be on duty in The Lodge. The manager told us that these were the standard staffing levels. We were told by staff that these levels had been maintained when staff had been on holiday or off sick.

Ancillary staff were employed in addition to care staff. On the day of the inspection we saw that there was a cook and a domestic assistant on duty, plus the activities coordinator. There was a kitchen assistant on duty for one day per week and we discussed the likelihood of this role being extended with the manager.

We observed the serving of lunch and found that there were sufficient staff on duty to meet people's individual needs. The atmosphere in the dining room was calm and people were offered appropriate assistance. The lunch was taken to The Lodge in a heated trolley and the trolley could be 'plugged in' to ensure that the meal remained hot. No concerns were expressed about meals not being hot when they were served.

A person who lived at the home told us that staff responded to the call bell as quickly as they could, including during the night, and that this made them feel safe living at the home.

**Records** ✓ Met this standard

**People's personal records, including medical records, should be accurate and kept safe and confidential**

## Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

## Reasons for our judgement

At the previous inspection of the home in September 2012 we made a compliance action in respect of this outcome. We found that some records, including care plans, contained insufficient information and others had not been kept up to date.

The quality manager was present on the day of our inspection and they told us that they had checked the content of care plans for every person who lived at the home since our previous inspection. We checked the care plans for three people who lived at the home. We found care plan records to be complete and up to date, although the provider may wish to note that one person's care plan had not been laid out in a way that allowed staff easy access to information. This could have resulted in people not receiving the care they needed.

The manager showed us an example of the 72 hour assessment that was used for people who were newly admitted to the home. This document contained brief information on all of the care plan topic areas and would be used by staff until more in-depth information could be gathered.

Care plans recorded information about a person's choices in relation to personal care, their daily routines, whether they preferred a male or female carer, clothing and makeup, social interests and food and drink likes and dislikes. The care plans that we saw had been reviewed each month to ensure that the information remained up to date. We observed that care planning documentation had been stored securely. People's personal records including medical records were accurate and fit for purpose.

We saw that nutritional tools had been used to assess a person's level of risk regarding food and fluid intake. When a risk had been identified, monitoring charts had been completed to record the actual food and drink consumed and to record a person's weight.

Monitoring charts also recorded the checks made by staff on people who remained in their rooms all day and on people who were 'turned' to reduce the risk of pressure sores developing.

## About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

## How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

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| ✓ **Met this standard** | This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made. |
| ✖ **Action needed** | This means that the standard was not being met in that the provider was non-compliant with the regulation.<br>We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard.<br>We monitor the implementation of action plans in these reports and, if necessary, take further action.<br>We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete. |
| ✖ **Enforcement action taken** | If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people. |

## How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

**Minor impact** – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact –** people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact** – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

## Glossary of terms we use in this report

### Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

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| Respecting and involving people who use services - Outcome 1 (Regulation 17) |
| Consent to care and treatment - Outcome 2 (Regulation 18) |
| Care and welfare of people who use services - Outcome 4 (Regulation 9) |
| Meeting Nutritional Needs - Outcome 5 (Regulation 14) |
| Cooperating with other providers - Outcome 6 (Regulation 24) |
| Safeguarding people who use services from abuse - Outcome 7 (Regulation 11) |
| Cleanliness and infection control - Outcome 8 (Regulation 12) |
| Management of medicines - Outcome 9 (Regulation 13) |
| Safety and suitability of premises - Outcome 10 (Regulation 15) |
| Safety, availability and suitability of equipment - Outcome 11 (Regulation 16) |
| Requirements relating to workers - Outcome 12 (Regulation 21) |
| Staffing - Outcome 13 (Regulation 22) |
| Supporting Staff - Outcome 14 (Regulation 23) |
| Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10) |
| Complaints - Outcome 17 (Regulation 19) |
| Records - Outcome 21 (Regulation 20) |

### Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

## Glossary of terms we use in this report (continued)

**(Registered) Provider**

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

**Regulations**

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

**Responsive inspection**

This is carried out at any time in relation to identified concerns.

**Routine inspection**

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

**Themed inspection**

This is targeted to look at specific standards, sectors or types of care.

## Contact us

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