The Fremantle Trust

Cherry Garth

Inspection report

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24 January 2022

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Cherry Garth is a residential care home providing accommodation and personal care for up to 60 people. The service provides support to older people, people living with mental health conditions, people with dementia, physical disabilities and sensory impairments. At the time of our inspection there were 39 people using the service.

Accommodation is provided over three floors, divided into five areas which are each called 'houses'. Each person has their own bedroom, and there are communal toilets, bathrooms, lounge and dining areas. There is a hairdresser and a coffee shop. At the rear of the building, there is a garden and entertainment areas. Various offices for staff are located throughout the building.

People's experience of using this service and what we found
People were not protected against avoidable harm. Medicines management was inadequate, and there were multiple medicines incidents. Incidents and accidents were not investigated in a robust way, and learning from events was not used to prevent recurrence of the same issue. Most people's risk assessments were out of date and contained inaccurate or conflicting information. Not enough staff were deployed on some shifts. Relatives and staff commented on the impact this had on people's care. Infection prevention and control was unsatisfactory. This placed people, visitors and staff at risk of infections. Actions to detect, investigate and report allegations of abuse or neglect were insufficient. Adults at risk were not effectively safeguarded.

Systems to assess, mitigate and review risks remained unsatisfactory. Although there was an action plan in place for improvements, the progress of addressing risk-based issues was too slow. The service had not properly ensured they were open and honest with people and relatives when safety incidents occurred. The service had failed to send legally required notifications to the Care Quality Commission (CQC) without delay. The workplace culture was viewed as unsatisfactory by care staff. Feedback from people, staff and relatives was collected and recorded by the service. However, analysis of the feedback was not completed in a timely way and improvements were not made based on survey results. Lessons were not learnt from the high number of falls and medicines incidents. The management and provider were working closely with the local authority and other partners to address failings.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 22 February 2020) and there were breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We also received concerns in relation to safeguarding people from abuse and neglect, falls, medicines incidents and governance of the service. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

You can read our last comprehensive inspection report, by selecting the 'all reports' link for Cherry Garth on our website at www.cqc.org.uk.

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

At this inspection, we have identified breaches in relation to safe care and treatment, safeguarding, governance, staffing, duty of candour and reporting incidents.

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

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

The overall rating for this service is inadequate and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in 'special measures' will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in 'special measures'.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Cherry Garth

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by two inspectors, a medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Cherry Garth is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

At the time of the inspection, the service did not have a manager registered with CQC. The home manager had applied to register with the CQC.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we already held and had received about the service since the time of the last inspection. We sought feedback from the local authority, safeguarding team and other professionals who

work with the service. We checked information held by the fire and rescue service, Companies House, the Food Standards Agency and the Information Commissioner's Office. We checked for any online reviews and relevant social media, and we looked at the content of the provider's website. We used the information the provider sent us in the provider information return. This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
The site visit was completed by inspectors on 19 January 2022 and 20 January 2022. We made telephone calls to relatives on 24 January 2022. We observed people's care and staff interaction with them. Some people were not able to participate in a conversation with us. We spoke with four people who lived at Cherry Garth. We spoke with 16 relatives about their experience of the care and support provided by the service. We spoke with the nominated individual about their oversight of the service. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with the director of operations, two operations managers, the clinical quality business partner, and a quality manager. We also spoke with the home manager, deputy manager, and 10 care staff. We reviewed a range of records. This included six people's care records, three staff personnel files and 11 medicines administration records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested and received further care documentation, quality assurance documents, call bell records and staff training data. We received an action plan from the service.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

In our prior inspection reports published 19 October 2018 and 22 February 2020, we included evidence in this key question regarding breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In this inspection report, follow up information about this regulatory breach is detailed in key question Well-led instead.

Using medicines safely
At the inspection on 14 and 15 August 2018, there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because systems for the safe management and storage of medicines did not contribute to people receiving safe care and treatment. At the inspection on 17, 18 and 21 October 2019, there was a continued breach of Regulation 12. Medicines were not managed effectively, good practice guidelines were not followed in relation to administration of medicines.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

- There was a medicine policy in place for medicines management. However, staff members did not always follow it.
- Staff monitored temperatures for medicine storage rooms and the medicines refrigerator. However, the records showed that the temperatures in the room and refrigerator had been higher or lower than the recommended range for three months. No action had been taken regarding this. If medicines are not stored at a temperature recommended by the manufacturer, they may not have the desired effect.
- The ordering process of medicines was not robust. There was overstock for some people's prescribed liquid medicines and creams. For two people, the stock of medicines prescribed for pain did not match the records of current stock recorded on the medicine administration records (MAR).
- Some people were prescribed medicines to be given on an 'as required' basis. However, for one person there was no information in the care plan or a protocol in place to ensure the prevention of constipation. For another person there was no information in the care plan about medicines prescribed to be given at specific times and before food to ensure the desired effect.
- Three people at the home were prescribed insulin for their diabetes, which they were self-administering. However, no assessment had been carried out to check their ability to safely manage their own insulin. We raised concerns about this with the management team. The clinical quality business partner completed an assessment of people's abilities to administer their insulin. The staff member determined that two people could not self-administer their insulin. They supported the two people with their insulin administration that evening. They called the district nurses and requested an assessment. The district nurses attended the next day, completed assessments and took over the administration of insulin for the two people.

● One person's allergies to medicines were not recorded on their MAR. This had been raised as a concern during the previous inspection also but had not been addressed. For two additional people prescribed skin creams had not been applied.
● Staff had discarded packaging of medicines with pharmacy dispensing labels attached to them in the general waste bin. This meant there was a risk of unauthorised access to confidential information about medicines prescribed to people, which could be misused. We alerted the management team to our concern. The service took immediate action, and removed and disposed of all labels in a confidential waste bag that was sent for shredding.
● The provider e-mailed their services important alerts regarding medicines to note, and take necessary actions. For the prior two months, the service had failed to print the government alerts, and had not taken relevant actions related to them. We pointed this out to the management team; they obtained the alerts and took remedial actions during our site visit.
● Multiple relatives commented about medicines incidents. Incidents related to medicines had not been shared with relatives. Feedback from relatives included, "Events around medicines in the last few weeks; one event concerned tablets that…have gone missing, or [the person] may have been overdosed", "They no longer keep me informed as to what medications are being given, or the creams that I buy for [the person] are not given [applied]", "Several times [I have been] contacted; [the person] didn't get morning medicines…their paracetamol [and] codeine" and "Even the monthly medications catch up [with the service], we used to have occasionally, has stopped now."

Systems were not effective to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a continued breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed staff give medicines to people. The staff were polite, gained consent and signed for each medicine after giving it on the medicine administration record.

Assessing risk, safety monitoring and management
At the inspection on 17, 18 and 21 October 2019, there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to robustly assess the risks relating to the health, safety and welfare of people.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

● People's risk assessments remained unsatisfactory. Most people's risk documentation was out of date with some contradicting other documents in use for the same person.
● Since the last inspection, a small number of risk assessments had been reviewed and re-written. These pertained to the highest risks, such as nutrition and mobility. However other historical risk assessments remained in place without changes. Staff carrying out monthly evaluations of the risk assessments had not identified or amended them where they were out of date or inaccurate..
● Care staff told us they felt unprepared for writing risk assessments, hadn't received training and those that had received training stated there was insufficient time on their shift to revise risk assessments.
● A 'clinical risk matrix' was in place, which listed the severity of each person's risks such as choking, falls and pressure ulcer development. The document was held by managers, but not updated regularly enough. Care staff did not have the overall picture of people's risks because they did not have easy access to the matrix.
● The provider failed to examine whether the high rate of falls and medicines incidents people experienced

was related to other overall factors, for example effective staff deployment.
● Relatives expressed concerns about the service managing people's risks. One said, "It took quite a lot of concern and pushing for them to do a better job of protecting [the person], for example, to get a sensor mat sorted out because they were saying they didn't have any." Another said, "One incident [was] reported to us, but we don't feel everything is reported. [For example], [the person] said that they had been hit by another [person] at the home." A further relative said that deterioration in their family member's condition was not promptly addressed by staff. They stated, "[I] have been able to see things, like [the person's] legs being swollen and a suspicious rash that the staff seemed not to have picked up on."

The provider did not always assess and do all that was reasonably practicable to mitigate the risks to people who received care. This placed people at risk of harm. This was a continued breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care staff knew people and their needs well.
● The small number of revised risk assessments were written to a good standard, and stated appropriate methods to mitigate people's risks.
● Professional referrals had been made by the staff for six people experiencing high rates of falls. They were reviewed by a physiotherapist and advice was provided to the service.
Learning lessons when things go wrong
● The management of incident and accidents remained unsatisfactory.
● Some incidents were not reported in writing until days after the event happened. No notes were recorded about the delayed reporting by care staff.
● Incident reports passed to the management team had basic notes recorded on them, but most had not been thoroughly investigated. For example, they were not accompanied by staff statements or recollections of events, and no reviews of care documentation or action plans.
● Overall themes and trends from accidents and incidents were known, but not effectively analysed and acted on to prevent recurrence. There were frequent falls and medicines incidents in 2021, where people sustained harm or were placed at risk. A pictorial chart of all falls was started in December 2021. Themes were not analysed to identify common causes and no action plan was created to reduce the frequency of falls.
● There were missed opportunities to protect people from harm. One person had a coughing episode and medical advice was sought. No change to their care or treatment had been made as a result. Two days later they had a repeat episode, and medical advice was again sought. The person's condition required 999 to be called, but this was not done in a timely way. The person was eventually transferred to hospital due to the severity of their illness. The incident report after the hospital admission stated the person had the coughing incident two days prior, but there was no incident report for that date and no record of actions taken to ensure the person's safety.
● Another person had multiple falls in 2021, sometimes sustaining avoidable harm. Interventions such as sensor mats, physiotherapy review and GP consultations were undertaken. However, the service failed to consider whether a different setting should have been explored, to ensure the person's safety from repeat harm. This option was only explored in 2022.
● Delays by staff reporting incidents and accidents to management had reduced in 2022 with reports being submitted to the managers, for review. However, thorough investigation of more serious incidents still was not taking place.
The provider did not always assess and do all that was reasonably practicable to mitigate the risks to people who received care. This placed people at risk of harm. This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● The safeguarding system was inadequate and people were at risk from abuse, neglect and omissions of care.

● Important information pertaining to safeguarding allegations was not collected in a timely way. Days had often elapsed before managers had examined the allegations and taken action.

● Staff were required to undertake safeguarding electronic learning. Nine staff working with people had not done the training. No effective measures were in place to ensure those staff knew how to recognise, prevent and report incidents and/or allegations of abuse.

● The managers met with senior care staff. They explained safeguarding, handed them the provider's policy and asked them to sign their attendance. There were no effective systems in place to ensure care staff understood their responsibilities in protecting people from the risk of abuse.

● Almost all safeguarding reports to the manager had insufficient investigations with the service relying on the local authority social workers to complete the fact finding for investigations.

● The provider held a weekly safeguarding panel, attended by senior managers who reviewed safeguarding allegations, incidents, accidents and complaints across all of their services. Notes from the panel held on 12 January 2022 showed just one event for Cherry Garth recorded in the provider's electronic system for the prior seven days. The nominated individual e-mailed the service on 12 January 2022 stating, "…there were extremely low numbers of incidents, accidents, complaints and safeguarding alerts recorded on [the incident reporting system].

● The deputy manager replied to the e-mail, confirming there were 16 incidents and accidents in January 2022, none of which were entered in the provider's electronic system.

● The single safeguarding allegation listed in the provider's panel minutes did not correspond with the number of safeguarding allegations reported to the local authority or the CQC.

People were not protected from abuse and improper treatment. Systems and processes were not operated to effectively investigate, immediately upon becoming aware of, any allegation or evidence of abuse. This was a breach of Regulation 13 (1) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At the inspection on 17, 18 and 21 October 2019 we recommended the provider use a nationally recognised dependency tool to ensure people's dependency levels were assessed and recorded in line with their support needs.

● The service implemented the use of a dependency tool after our recommendation.

● The provider's dependency tool calculated the minimum number of staff required to support people on each shift. The dependency tool did not consider other factors such as time for staff training and supervision, the physical layout of the building and other factors affecting staff's ability to respond to people's care requests.

● Staff allocation records and rotas showed the minimum number of staff that should be deployed according to the dependency tool. However, allocation sheets showed on some occasions staffing fell below this level. The rotas also showed multiple unfilled shifts.

● Although there were bank (casual) care workers, there were insufficient deployed to fill the vacant shifts.

● Staff consistently said there were insufficient care workers deployed on some shifts. They described themselves as rushed, pressurised and not always able to provide the care people needed. They stated staff deployment was not safe and they often did not have breaks or took shortened rest breaks, as they felt obligated to stay on the houses.

● The local authority confirmed they were present in the service during December 2021 to ensure people's safety. They stated that during their observations, there were often not enough staff deployed, placing

people at risk.
● Relatives also felt not enough staff were deployed. They said, "They [the service] are continually a bit tight on staff levels. They [staff] seem very rushed and it can be hard to find a member of staff", "They [staff] are very busy. When [the person] has been upset in the last two months, they [staff] haven't had time to help [the person] phone me, to talk about it", "They [the service] are so short of staff on weekends I don't even try to call, because there is nobody to answer" and "…when I am able to visit it can be hard to find a member of staff…or get them to answer the phone when I call."

Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed. This placed people at risk of harm. This was a breach of Regulation 18 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment files contained all the required information. We checked three personnel files which contained all records required. This included full employment history, proof of identity, proof of right to work, proof of conduct in prior care roles and criminal record checks.

Preventing and controlling infection
● We were not assured that the provider was preventing visitors from catching and spreading infections.
● Government guidance to permit entry to visiting professionals was not followed. Screening checks for visiting professionals and staff were not fully completed. Two visiting professionals were not screened for acute respiratory infection before entering the service and their temperatures were not taken.
● In addition, a member of management staff was permitted to enter the building by a member of staff without completing any screening such as temperature checking, proof of vaccination status or negative lateral flow test result.
● Handwashing guidance in the toilet used by visitors was not evidence-based and was out of date. An instructional poster advised staff and visitors to "wash hands when visibly soiled, otherwise use hand rub." This information was not correct.
● We were somewhat assured that the provider was meeting shielding and social distancing rules.
● We were somewhat assured that the provider was admitting people safely to the service.
● We were not assured that the provider was using personal protective equipment (PPE) effectively and safely.
● We observed a staff member bringing a clinical waste bin through the front door of the home. They were not wearing gloves and they did not disinfect or wash their hands before touching the keypad and door handles.
● We observed two staff members were not wearing gloves or aprons whilst pushing trolleys containing soiled laundry. In addition, we saw a member of staff in an office who was wearing a mask incorrectly, under their chin.
● Clinical waste bins had been placed in the corridors outside the rooms of people who were self-isolating due to them having COVID-19. Apron strings were trailing out of these clinical waste bins onto the floor. In addition, clean, single use aprons were hung on handrails. They were trailing onto clinical waste and domestic waste bins, potentially becoming contaminated.
● Donning and doffing stations for staff to put on or remove PPE were soiled and had inappropriate objects on them such as coat hangers.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were somewhat assured that the provider was making sure infection outbreaks were effectively prevented or managed.

● We were somewhat assured that the provider's infection prevention and control policy was up to date.
● We have also signposted the provider to resources to develop their approach.

Effective systems were not in place to prevent and control the spread of infections. This placed people at risk of harm. This was a continued breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. We found the service had effective measures in place to make sure this requirement was being met.
● Relatives stated they were informed of any changes to visiting. They said, "Changes to visiting arrangements are generally emailed to us explaining what we needed to do to visit safely", "They let us know when they closed down [lockdown], which happened quickly and safely" and, "I was informed by email. They have been very good really."

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

In our prior inspection reports published 19 October 2018 and 22 February 2020, we included evidence in the key question Safe regarding breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In this inspection report, follow up information about this regulatory breach is detailed in this key question instead.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At the inspection on 14 and 15 August 2018, there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the service did not maintain accurate records relating to people's health and welfare. Quality systems and processes did not monitor and improve the quality of the service effectively. At the inspection on 17, 18 and 21 October 2019, there was a continued breach of Regulation 17 and we issued a warning notice against the provider. Records were not accurate, complete and contemporaneous in relation to care delivery. Auditing systems were ineffective.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17

- People remained at risk of, and continued to sustain harm, because steps taken to ensure good governance of the service were fragmented and progress to improve was too protracted. Documentation of people's care remained inadequate.
- The service had a continuous action plan in place, containing 50 items requiring actions to improve. The action plan detailed areas for improvement previously identified by the local authority, clinical commissioning group, healthcare professionals and a small number by the provider. However, new issues requiring improvement were not always added to the action plan.
- The home manager was listed as the responsible person for nearly all improvements set out in the action plan. Target dates for completion of improvements had not been met, and the target dates were not revised or updated accordingly. This left people at continued risk of harm from known issues.
- The results of an audit of people's nutrition risk assessments were listed in the January 2022 clinical review meeting. The minutes demonstrated continued and repeated failings in the risk assessments which "…has put them [people living at the service] at risk." Whilst the meeting listed the improvements required, no target date or responsible staff members were listed and the action plan referenced a target date for improvement of December 2021 which was not met. Training for staff to complete the risk assessment training was only scheduled for February 2022 despite the issue being known for several months.

● At the time of the inspection, there was no manager registered with the Care Quality Commission for more than six months, with several changes to the home manager during that time. The provider had not complied with the conditions of registration for the service.
● The changes meant that over time, different home managers had worked on improvement actions, and when they left the home manager position, some actions were not followed through. Some unmet improvement issues, identified by prior home managers, had been placed in a folder in the office, and not reviewed by the next home manager.
● The provider moved to an electronic system for completion of audits and checks. This flagged 'tasks' for managers to complete, listed the item to be checked and the frequency. However, for some audits such as infection prevention and control, staffing (dependency) and medication, the audits to check risks were not frequent enough. The provider knew the risks which existed but did not increase the frequency of the audits to assess the risks more often.
● People's food intake, fluid intake and repositioning charts were reviewed. They contained gaps, missing information, incorrect and contradictory information and some documents could not be located for review. The issues with accurate documentation and secure storage were highlighted in staff meetings and the action plan, but this had not led to improvement.
● Relatives expressed mixed feelings about the leadership of the service, especially about the recent changes in home managers. They said, "I had several long calls with the [management], and had to push to get the right arrangements to make sure that repeated trips and falls could be prevented", "I think [the management] are all doing their best", "Now it's great; that wasn't always the case. I haven't actually seen the new manager and I only saw the previous one once when there was an issue" and "Managers can blame the resident rather than understanding they have difficulties." Many relatives said they did not know or had not met the home manager.

The provider did not always effectively assess, monitor and improve the quality and safety of the service. The provider did not always effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of people at risk who received personal care. This placed people at risk of harm. The provider did not always maintain securely an accurate, complete and contemporaneous record in respect of each person, including a record of the care and treatment provided. This was a continued breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had failed to send some required notifications to the Care Quality Commission without delay. This impacted on the ability of the CQC to effectively monitor the safety of people as information was not available at the time of the events.
● The service retrospectively reported the required incidents to the Care Quality Commission. This was completed once the provider became aware of the issue.

The provider did not always notify the Commission without delay of the incidents which occurred whilst services were being provided, or as a consequence of the carrying on of the personal care to people. This was a breach of Regulation 18 (1) of the Care Quality Commission (Registration) Regulations 2009.

● The service's action plan enabled tracking of progress towards improvements. Associated documents were attached to evidence steps recorded in the action plan although some documents did not contain up-to-date information.
● A new home manager commenced in January 2022 and applied to register with the Care Quality Commission. At the time of the inspection, the application was being processed by us.
● The home manager and deputy manager were knowledgeable, skilled and experienced. They were observed to work well together.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● When notifiable safety incidents occurred, the service failed to include all of the information required in their written correspondence to the person or their legal representative.

● Three incidents and accompanying letters were reviewed. They detailed an apology for the injury or harm that occurred to the person at the service. However, the content did not include details of the event, if an investigation was completed or include information about any further planned follow up of the incident.

● Failure to include all of the relevant information meant people and their relatives were not provided with all of the details for the incidents as required or in an open and transparent way.

After notifiable safety incidents occurred, the provider did not provide all required details in a written notification given or sent to the relevant person. This was a breach of Regulation 20 (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

● The service did not act on the feedback gathered from people, relatives and staff. They did not effectively use the feedback they received to improve the quality of the service.

● In November 2021, 38 people contributed to satisfaction questionnaires. Feedback included, "Sometimes staff are not extremely polite…do not come back when I've pressed my buzzer", "I don't know the manager", "Don't know the manager; don't know how to complain" and, "Quality of food is not great…not a lot [of activities] go on…"

● The service did not use the feedback to drive improvement. Analysis of the findings was not completed, the survey was filed away and actions to address the findings were not planned. The outcomes were not shared with people, staff or relatives.

● In October 2021, 47 out of approximately 65 staff completed a formal survey. Issues reflected by staff in the survey were some already known to the service, such as staffing levels and organisational structure, not following up concerns and recruitment inclusion and equal opportunity. However, the service had failed to promptly analyse the findings, list the areas for improvement or develop an action plan to address points raised. The results were not shared with staff in a timely way.

● There were numerous written comments from staff such as, "Need better communication", "The concern about being understaffed has been brought up…and not addressed", "Lack of support and appreciation especially during [COVID-19] pandemic from Fremantle Trust" and, "I sometimes feel undervalued after a shift as [I] haven't had the support I should have." These comments were not followed up or discussed in subsequent team meetings.

● There were no recent surveys completed with relatives or health and social care professionals. 'Surgeries' (appointment slots) were available for relatives to speak with managers. There was a limited take up by relatives of the available appointments.

● Relatives commented their involvement in people's support was lacking. They stated, "I have not been involved in risk assessment or care planning in all the years [the person] has been there", "I only found out that [the person] had a 'key carer' because I asked to see the [care] documents and it was recorded there. Nobody had bothered to mention a 'key carer' to [our] family", "They gave me the care plan for me to look through. They were not resistant to me seeing the plan, but it was definitely 'their' plan and it was only shared with me because I asked" and "I did have an initial chat about risks and care planning, but nothing since."

● Seven relatives stated they received a newsletter from the provider, with one relative commenting "…but that's all we get."

● A small number of 'lessons learnt' documents were created after a medicines audit and other incidents.

Staff were not advised of the lessons learnt and the documents were filed without corrective actions being put into place.

The provider did not effectively act on feedback from relevant persons and other persons on the services provided. The provider did not evaluate and improve their practice in respect of processing information. This was a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Support was provided to people in a person-centred way by the care staff. Staff were polite and patient with people.

● However, care staff explained the workplace morale required improvement. They stated they worked well together but continued to feel unsupported by managers and the provider. Some commented they were spoken to unprofessionally, not consulted effectively and given 'directives'.

● Comments included, "[Management] don't ask staff what they want to do, before putting things in place", "Not had good leadership for a while", "Since the [previous] deputy manager left, responsibilities were given to us and [we] were thrown in the deep end", "…if things go wrong they blame you" and "Carers were told they were to update care plans but no training occurred for most. We can't do it on shift if there are not enough staff to manage this."

● General staff meetings occurred, and further meetings were planned. The minutes described changes to process, and issues that required improvement. Some content reflected what staff told us. There were lists of tasks staff were informed to complete and content about negative performance. There was no evidence of asking for staff opinions, what was going well at the service and any support that could be provided to help staff provide good care.

● Relatives were critical of the culture at Cherry Garth. They said, "If I could have moved [the person] I would, because of the management failures, but it's not possible now and so we have to make the best of it", "The total lack of communication initiated by the care home on a one-to-one basis is so frustrating", "If we have a concern, we don't always feel that our concerns will be taken seriously" and "I never hear anything by way of a general catch up on how Cherry Garth is doing, future plans or anything like that."

Working in partnership with others

● The service was working closely with the local authority and clinical commissioning group to develop safe care practices for people. Health and social care professionals were visiting the service and working with staff striving to achieve good health outcomes for people.

● The provider was participating in regular progress meetings with stakeholders to discuss proposed and ongoing areas for improvement.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents How the regulation was not being met: The registered person did not always notify the Commission without delay of the incidents which occurred whilst services were being provided, or as a consequence of the carrying on of the regulated activity service users. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Systems and processes were not operated to effectively investigate, immediately upon becoming aware of, any allegation or evidence of abuse. Regulation 13 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour How the regulation was not being met: After notifiable safety incidents occurred, the registered person did not provide all required details in a written notification given or sent to

the relevant person.

Regulation 20 (4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed. Regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Systems were not effective to ensure the proper and safe management of medicines. The registered person did not always assess and do all that was reasonably practicable to mitigate the risks to service users who received the regulated activity. Systems did not prevent and control the spread of infections.

The enforcement action we took:

We served a warning notice against the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: The registered person did not always effectively assess, monitor and improve the quality and safety of the service. The registered person did not always effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of people at risk who received personal care. The registered person did not always maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided.

The registered person did not effectively act on feedback from relevant persons and other persons on the services provided, for the purposes of continually evaluating and improving the services.

The enforcement action we took:

We served a warning notice against the provider.