CareQuality Commission

Outreach 3-Way
Cherrymead

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 took place on 16 February 2016 and was unannounced.

Cherrymead provides care and accommodation for up to seven people. There were seven people aged 51 to 73 years living at the home when we inspected. The service specialises in the care of adults with a learning disability.

All bedrooms were single and each had an en-suite bathroom with either a shower or bath. There was a communal lounge, dining room and a conservatory which people were observed using.

The service had a registered manager who also had another management role for the organisation so worked part time at Cherrymead for between two and four days a week. 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 service did not use a dependency tool to assess the level of staffing needed to meet people's needs. On the day of the inspection we observed there were insufficient staff to meet people's needs.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse. People and their relatives said the staff provided safe care.

Care records showed any risks to people were assessed and there was guidance of how those risks should be managed to prevent any risk of harm.

People received their medicines safely.

Staff were well trained and supervised and had access to a range of relevant training courses, including nationally recognised qualifications.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity to consent to their care and treatment assessments were carried out in line with the MCA and its associated Code of Practice. DoLS applications had been made where people's liberty was restricted for reasons of safety.

There was a choice of food and people were involved in planning the menus. People's nutritional needs were assessed so the right action could be taken if people were at risk of malnutrition.

People's health care needs were assessed, monitored and recorded. Referrals for assessment and treatment were made when needed and people received regular health checks.

Staff were caring and interacted well with people. A relative told us, "The staff care is absolutely fabulous." People were observed to be comfortable approaching staff who responded to them with understanding and kindness.

Care was provided to people based on their individual needs which we call person centred care. People's preferences and individual needs were acknowledged in the assessment of their needs and in how care was provided. Staff had a good knowledge of people's changing needs.

People were supported to attend a range of meaningful activities including community facilities.

The service had an effective complaints procedure. Complaints were looked into and responded to.

People and their relatives were able to give their views on the service.

The service did not have a system for delegating a staff member to be operationally responsible for the service in the absence of the registered manager; staff and a relative were unclear about who was in charge during these periods. This was addressed following the inspection so there was a 'lead' staff member in charge when the registered manager was not present.

There were a number of systems for checking the safety and effectiveness of the service such as regular audits.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

At the time of the inspection the service did not have enough staff to safely meet people's needs.

The service had policies and procedures on safeguarding people from possible abuse. Staff knew what to do if they suspected any abuse had occurred.

Risks to people were assessed and guidance recorded so staff knew how to reduce risks to people.

People received their medicines safely.

The service was generally hygienic but we observed one staff member did not follow procedures for preventing the spread of infection.

Is the service effective?

Good

The service was effective.

Staff were trained in a number of relevant areas and had access to nationally recognised qualifications in care. Staff were supported by regular supervision.

People's capacity to consent to care and treatment was assessed and staff were aware of the principles and procedures as set out in the Mental Capacity Act 2005 Code of Practice and Deprivation of Liberty Safeguards (DoLS).

People were supported to have a balanced and nutritious diet and there was a choice of food. People were supported when they were at risk of malnutrition.

People's health care needs were monitored. Staff liaised with health care services so people's health was assessed and treatment arranged where needed.

Is the service caring?

Good

The service was caring.

People were treated with kindness and dignity by staff who were patient and understanding.

Care was provided based on each person's preferences.

People's privacy was promoted in the way they were treated by staff.

Is the service responsive?

Good

The service was responsive.

People's needs were comprehensively assessed and reviewed. Care plans were individualised and reflected people's preferences.

People were supported to attend a range of activities including the use of community facilities.

The service had a complaints procedure and people knew what to do if they wished to raise a concern.

Is the service well-led?

Good

The service was well-led.

People and relatives had opportunities to give their views on the service. People were involved in making decisions in the service.

There were a number of systems for checking and auditing the safety and quality of the service.

Care Quality Commission

Cherrymead

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced and took place on 16 February 2016 and was carried out by one inspector.

During the inspection we spoke with two people who lived at the service. We also spoke to three relatives of people who lived at the service, three care staff and the registered manager.

We were not able to speak to everyone who lived at the service due to their communication needs, so we spent time observing the care and support people received in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care plans and associated records for three people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints. Records for four staff were reviewed, which included checks on newly appointed staff and staff supervision records.

We spoke with a social worker who was involved in the placement of people at the service. This person gave their permission for their comments to be included in this report.

The service was last inspected on 3 December 2013 when no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

People's relatives gave us mixed views about whether there were enough staff on duty to meet people's needs. For example, one relative stated two care staff on duty were not sufficient especially during meal times when staff were cooking. This relative also said people's needs had increased due to their age which was not reflected in any increase in staffing levels. A further comment was made that one staff member on duty at night was insufficient as it did not take account of circumstances such as emergencies when staff may have to deal with emergency services. A second relative felt staffing levels could be improved as people's behaviour sometimes required staff to take immediate action which took them away from supporting others. This relative also said staff would be able to engage with people more if there were more staff on duty. A third relative considered there were enough staff to meet people's needs.

Staff told us they considered the service generally had enough staff to meet people's needs, but one staff member said people's needs had increased and that additional staffing would be desirable. This staff member said delivering the combined duties of personal care, cleaning and cooking could place strains on meeting people's needs. Another staff member said there were always enough staff on duty to meet people's needs. The registered manager said she regularly asked staff if the staffing levels were enough. A social worker considered the service to have sufficient staffing levels to look after people.

The service had two care staff on duty from 8am to 9.30pm each day with a third staff member on duty from 8am to 1pm on Wednesday, Thursday and Friday. Care staff also carried out all the cooking and cleaning duties. It was unclear how these staffing hours were assessed as being sufficient to meet people's needs. The previous report referred to the lack of a risk assessment or needs analysis of the staffing levels to meet care needs. At this inspection we saw a risk assessment had been completed regarding staffing levels but a dependency assessment tool was not used to assess the staffing levels. The review of staffing levels resulted in the third staff member being deployed from 8am to 1pm on Wednesday, Thursday and Friday. The registered manager said the decision to deploy additional staff at these times was made after discussion with the staff team. At night time there was one staff on a 'waking' duty.

We observed the early evening meal when there were two staff on duty plus the registered manager. One staff member was cooking and another staff member was supporting someone with their incontinence. The registered manager was also assisting with the mealtime. One person needed significant staff intervention to go to the dining table and to eat, two people needed their food cut up and another was observed being supported to eat by staff. This was a busy time when only two staff would normally be on duty as the registered manager stated her work did not involve working as part of the care team. The registered manager worked at the service two to four days a week. Although the service only accommodated seven people it was clear at the time of the inspection the demands on the staff were considerable. If the registered manager had not been present there would have been one staff member cooking and one person supporting someone with incontinence issues, which meant there would have been no staff member on hand to immediately support the needs of other people. A relative also commented that they considered the changing and unpredictable behaviour of people meant the staff team were stretched and that staff were sometimes too busy to engage with people in activities. The registered manager stated the meal time was

particularly busy due to staff having to support one person who was unwell. A relative questioned whether there were sufficient staff at night to deal with emergencies and whilst each person had a personal emergency evacuation plan the night time staffing level should have been more formally assessed to ensure people could leave the building safely in an emergency. In view of the lack of a dependency staffing tool, the observations on the day of the inspection, and, the comments from relatives, we judged sufficient staffing levels were not provided at the service. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives said safe care was provided by the service and felt people living at the service were safe. For example, when we asked a relative if people were safely cared for the response was, "Absolutely." Another relative said one of the positive outcomes for their relative was that staff had made them feel safe at the home, which had increased their confidence and well-being.

There were established systems to ensure staff were trained in the safeguarding of adults and any concerns were acted on. The service had policies and procedures regarding the safeguarding of people, which included details about the definitions of what constituted abuse, how to recognise abuse and how to raise a safeguarding alert. The service had systems in place for recording any suspected abuse and for reporting this to the local authority safeguarding team as well as a form to record the outcome of any safeguarding referral. There was also a copy of the local authority safeguarding procedures, which was available to staff. Staff were trained in safeguarding procedures and understood their responsibilities to report any concerns of this nature. Easy read leaflets were available in the hall at the service and were held with people's records in order to make it easier for people to report any concerns they had. A social worker told us they considered the service was a safe place for people to live and that people received safe care.

The service supported people to manage their finances and personal allowance. This included looking after money on behalf of people in a secure place. Records were kept of any money held on behalf of people as well as any transactions, such as where people withdrew money to go out shopping. The records of money held on behalf of people matched the amounts held. This support helped to minimise the risk to people of financial exploitation.

There were comprehensive records regarding the assessment and management of risks to people. For each person there were assessments called 'Risk management analysis,' for a variety of needs and situations. Following this, a risk assessment was carried out and recorded for each need or situation where a risk was identified. Alongside this were care plans of how to mitigate these risks, such as the risks of choking, travelling in the service's vehicle, finances, mobility and personal care. For example, there were clear procedures for supporting people to safely have a bath with staff support. We observed staff safely supported people who had mobility needs. A relative told us they had observed on one occasion that staff failed to use the brakes on a wheelchair when supporting someone to get into the wheelchair which could have caused an accident. The relative said this was raised with the staff. We discussed this with the registered manager who was unaware of this, but agreed to follow this up with staff.

We looked at the staff recruitment procedures. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. Records showed there was a thorough assessment of the applicant's suitability to care work which included an interview and assessment of their literacy and numeracy. This ensured the provider could make safe recruitment decisions.

The service had policies and procedures regarding the safe ordering, storage and handling of medicines. People said they were supported to take their medicines when they needed them. Staff were trained in the

safe handling of medicines, which involved observation of their competency to do this. The service used a monitored dosage system to store and administer medicines. This system makes it easier for staff to handle and administer medicines as they were in a blister pack which was organised to reflect the times people needed to take their medicines. Staff recorded a signature on a medicine administration record (MAR) each time they supported someone to take their medicine. The MAR and blister packs of medicine showed people had received their medicines as prescribed.

Where people had medicines on an 'as required' basis care plans included guidance for staff to follow to recognise the symptoms when this medicine was needed. We checked a stock of 'as required' medicine which tallied with the amount recorded. This showed medicines were safely administered to people, were securely stored and well managed.

The service had policies and procedures regarding the prevention and control of infections and for dealing with any body fluids. There was a named staff member with responsibility for coordinating infection control in the service. The infection control procedures included reference to the use of protective clothing for staff, such as aprons and gloves. We observed a staff member used gloves when cleaning areas affected by incontinence but did not wear a protective apron and held a soiled cushion on their clothing whilst cleaning. The staff member then served food to people. Following the inspection the registered manager confirmed this was an oversight by the staff member and that staff were aware that they should use aprons and gloves when cleaning.

Infection control audits were carried out and there were infection control risk assessments. Staff received training in infection control. The registered manager explained how colour coded mops and buckets were used to prevent infections spreading by specific cleaning mops for different spillages. The service was found to be clean with the exceptions of a rust mark in one en suite shower floor area and a rusty hand rail support around a toilet which would be difficult to keep clean.

Checks were made by suitably qualified persons of equipment such as the passenger lift, gas heating, electrical wiring, hoists, fire safety equipment and alarms, Legionella and electrical appliances. Each person had a personal evacuation plan so staff knew what to do to support people to evacuate the premises. First floor windows had restrictors on them to prevent people from falling out. Temperature controls were in place to prevent any possible scalding from hot water. Covers were installed on radiators to prevent possible burns. At the time of the inspection supplementary heating was being used in the conservatory area which was used by people as the radiator was not working correctly. The risks of burns from these heaters had not been assessed. Immediately following the inspection the registered manager confirmed the radiator was repaired and the conservatory was now warm and checks were being carried out on the air temperature. The registered manager also confirmed risk assessments were completed regarding the use of the supplementary heaters.

Good

Is the service effective?

Our findings

People and their relatives said staff generally had the right skills and knowledge to meet people's needs. For example, one relative said, "The staff care is absolutely terrific. The staff are fabulous." This relative said the staff had "turned (person) around" by dealing with the person's physical health needs. This relative also said that staff support had resulted in the person feeling more confident which led to the person leading a more fulfilled and active life. Another relative said staff were sufficiently trained but also felt they did not have sufficient knowledge about the needs of people who were living with dementia, although we noted staff had completed training in dementia awareness.

Newly appointed staff received an induction training programme to prepare for work at the service. The induction involved enrolling on the Care Certificate which is a nationally recognised induction process set out by Skills for Care. There was also an interactive on-line IT induction training package which staff used. 'Classroom' based training was also provided in moving and handling, cardio- pulmonary resuscitation and working with people with a learning disability. A checklist was completed so the registered manager could monitor that newly appointed staff had completed the required induction training to prepare them for their role. A staff member said the induction was good and that they were supported by staff during this time adding, "The staff were brilliant." This staff member said the induction included a period of 'shadowing' experienced staff and that the registered manager checked with them that they felt adequately trained.

Training records for staff were maintained in an IT system so the registered manager could check staff had completed training considered mandatory to their role. These included fire safety, food safety, health and safety, nutrition, infection control and the use of hoists amongst others.

The provider supported staff to attain the National Vocational Qualification (NVQ) in care or the Diploma in Health and Social Care. The provider confirmed four of the 12 staff were trained to NVQ level 3 and one to NVQ level 2. One staff member was also studying NVQ level 3 at the time of the inspection. The registered manager was qualified at NVQ level 4. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

Staff told us the training they received was of a good standard and that they had access to relevant training courses. Staff also said they were able to discuss their training needs at the supervision they had with their line manager and at their appraisals. Therefore staff were supported to achieve further qualifications to enhance their skills and knowledge.

Staff received regular supervision with their line manager. The registered manager also received supervision with her line manager. Records were maintained of staff supervision and each staff member also had a record to show there was an appraisal of their work. Records of staff meetings showed these gave staff more up to date information in areas such as the Mental Capacity Act 2005 (MCA), health and safety, menus and any policy updates

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

Staff were trained in the MCA and had a good understanding of the legislation. There were policies and procedures regarding the MCA and information on the principles of the legislation were displayed in the office. Care plans included well recorded details about how staff communicated with people to find out what they preferred to do and there was a form called, 'Decision making agreement' which detailed what support people had agreed to. We observed staff spoke with people by asking them how they wanted to be supported and sought their agreement before proceeding. Relatives who made decisions on behalf of people subject to Power of Attorney said they were kept informed of any changes in their relative's health so arrangements could be made for any checks or treatment

A recognised 'toolkit' was used to assess the capacity of those who were unable to consent to their care and treatment. Applications were made to the local authority for a DoLS authorisation where people did not have capacity and their liberty was restricted for reasons of safety. Copies of the MCA assessments and DoLS applications were available for us to see. The registered manager told us the service linked with health and social care professionals where 'best interest' decisions needed to be made on behalf of people who did not have capacity such as for medical treatment.

People's nutritional needs were assessed and referrals were made to the relevant health services where people had lost weight or were at risk of malnutrition. For example, care records included the advice of speech and language therapists where someone had difficulties swallowing. The service did not use a malnutrition universal screening tool (MUST) which assesses a person's risk of malnutrition, which is recognised by dieticians. This was discussed with the provider and was a tool they may wish to consider using. A record of people's weight was maintained so action could be taken if people gained or lost weight. The registered manager and staff were aware of those people who needed additional support with eating and drinking. Staff told us the calorific value of foods was increased where people were at risk of losing weight. Records were also maintained of what each person ate so this could be monitored.

We observed staff supporting and encouraging people to eat during the early evening meal. The meal was nutritious and plentiful. One person told us enthusiastically how much they liked the food, saying, "I've had three dinners today." Staff were calm and patient when supporting people with their food. Where people were reluctant to eat staff spent time trying different approaches to encourage them to eat and drink. Staff also checked what one person had eaten earlier in the day to monitor whether the person had sufficient food. The meal was meatballs, mashed potato, swede and cauliflower. Fresh vegetables were used. Dessert was apple crumble made from fresh apples and a crumble mix served with custard. There was an alternative dessert of rice pudding. Staff told us how fresh produce was used and showed us the food stocks which were plentiful and included fresh fruit, fresh vegetables, salads and fresh fruit juice. Staff were observed to check on people asking them if they wanted any drinks in the afternoon to ensure they had enough fluids.

The registered manager explained how the food provision was reviewed and improved following comments from a health care professional. There was a two week menu plan which showed varied and nutritious meals. People told us they liked the food. Records of residents' meetings showed people were able to discuss the menu plans so they incorporated their preferences. Relatives said the food was, "OK at present,"

and "very good." A relative said people's preferences for food was taken account of and that since moving into the home their relative had eaten more. Another relative said the food quality had improved and commented that some staff were more skilled than others in cooking meals.

Relatives said people's health care needs were raised with them so arrangements could be made for appropriate appointments. Records showed people's blood pressure and pulse were monitored for any changes. Each person had a health care plan setting out how people were supported with their health care needs. These showed people had regular checks with their GP, dentist, optician and chiropody services. People also had a document called a 'health passport' with a summary of their health and medicine details which could accompany them to the hospital so ambulance and hospital staff had this information.

Each person had their own room with its own en suite bathroom. People's rooms were personalised with their own belongings and we saw people enjoyed spending time in their rooms watching television or listening to music.

We noted the carpets in the lounge were worn and the registered manager confirmed these were to be replaced. A relative also said some of the furniture was worn and that the garden could be kept tidier.

Good

Is the service caring?

Our findings

People were supported by staff who were kind, caring and committed to ensuring people were able to exercise choice in their daily lives. People said the staff were kind and friendly. Relatives said the staff were "caring" and understood the needs of people who had a learning disability. A social worker described the staff as valuing of people who they treated with dignity and respect.

Staff were observed working with people during the early evening meal time and were patient and calm in their interactions with people. Staff had established positive working relationships with people. Staff told us they knew people's needs well which was evident in how they spoke with people. In turn, people were seen to be comfortable in speaking to and approaching staff. People were supported on an individual basis. For example, one person was observed to be given space, time and gentle encouragement from staff to sit at the dining table. Staff spoke to people in a friendly manner asking them how they were, if they enjoyed the food and if they wanted any more. Where people needed support to eat this was done tactfully and staff spoke to people about what they were doing maintaining eye contact. Staff gave people space and time so the meal was unhurried. For example, one person needed support with personal care which was accommodated by staff so the person did not feel they were interrupting the mealtime.

Staff told us they treated people in a manner which promoted people to have choices in their daily lives such as the activities they did and how they spent their time. We observed people were free to spend time in their rooms or in the communal areas.

Staff stressed the importance of getting to know people well by spending time with them and for enabling people to access community facilities. For example, a staff member said, "We are here for what they (people) want to do. We know them well and can recognise what they want. We help them by taking them out." Another staff member said they treated people with respect and in the same way as they would like one of their relatives, or themselves treated. A relative commented how the approach of staff had resulted in their relative's mood improving which led to them going out and about which they would not have done before.

Care records showed people's preferences were reflected in the way care and support was provided in a person-centred way. These included details of any religious observances and staff told us how people were supported to attend church services and social events at a local church. Care plans were structured so preferences were considered under headings such as, 'My relationships,' and, 'What's important to me.' Care plans also included details of how people were supported with emotional needs. Care records were agreed with people and there were guidelines recorded so staff knew how to communicate with people.

People's privacy and dignity was promoted in the way staff supported people with personal care. Where people needed immediate assistance this was always carried out in private and the person supported tactfully by staff. Each person had their own room so they were able to spend time in private.

Good

Is the service responsive?

Our findings

People's relatives said the staff were responsive to people's needs. Relatives said how they were kept informed of any changes in people's care or health needs and that there were good communication channels with staff and the registered manager. The relatives said they had an ongoing dialogue with staff about care needs and that staff acted on suggestions. One relative said the staff "have done extremely well" in responding to people's care needs with obvious benefits for their relative whose mood and activity level had greatly improved since moving into the home. Relatives also said they felt able to raise any issues they had which were acted on and responded to. People said their care needs were met. One person, for example, said, "I only have to ask the staff and they get me what I need."

Each person's needs were comprehensively assessed in a way which took account of people's wishes. These included details about people's mental health, mobility, medicines and personal care. The service also had copies of social services' assessments and care plans so staff had background information on people's needs and preferences. The care plans were detailed and gave staff clear guidance about how to support people. For example, we saw a care plan regarding the routines for helping someone get dressed, which was individualised and reflected the person's choices. The registered manager said people were fully involved in their care plans adding that one person had effectively written their own care plan. The care plans also focussed on how people could lead a lifestyle which was important to them under headings such as 'What's Important To Me,' 'What's Working and What's Not Working,' and, 'My Perfect Week.' Each person's records detailed a weekly plan of what they liked to do and showed people were involved with a range of activities. Social needs were assessed including the risks of not having enough social contact so the person could be supported to have company.

People's communication needs were assessed and there was detailed guidance of how staff could find out what people wanted by the use of non- verbal communication. This included details about gestures and signs which staff used to communicate with people.

Charts were used to monitor care needs such as weight and behaviour. Records showed care needs were reviewed and care plans updated when changes occurred.

The service had its own vehicle so people could access community events and have trips out. People attended day centres and the registered manager said people liked to attend events at a local church. There were photo displays of people attending art classes and birthday parties. People were observed spending time in their rooms or in communal areas using games or items related to their hobbies such as DVDs. One person showed us their collection of DVDs and said they were going with staff to the cinema to see a new version of a 1970s comedy they liked.

Relatives were aware of the complaints procedure and said that when they raised any concerns they were dealt with and responded to. The complaints procedure was displayed in the hall and there was an easy read format for people to access and understand. A record was kept of any complaint along with details of the service's investigation and the outcome of this. A written response had been made to complainants of

the findings of any investigation and subsequent action.

Good

Is the service well-led?

Our findings

People told us they liked the registered manager who they said was approachable and kind. Relatives gave us mixed views about whether the service was well-led or not. For example, one relative described the registered manager as "fabulous," approachable and was always willing to listen to their views. Another relative also spoke positively about the registered manager but felt there was a lack of "permanency" in the way the service was managed. This relative said how the registered manager was often not present in the service due to commitments in managing another service and that during these times they were unaware of who was in charge of the service. This relative said this made it difficult to know who to approach if they had a query or wished to share information. We spoke to staff about the management arrangements in the absence of the registered manager and they said no specific arrangements were in place. One staff member said in these circumstances the most experienced staff member assumed the role of being in charge but this was not formally agreed on. Another staff member said responsibilities were shared between the team without any staff member in charge. The registered manager confirmed there was no system of identifying a member of staff as operationally responsible for the service in the absence of the registered manager. The registered manager confirmed she worked three days a week at the service in the three weeks preceding the inspection. In the absence of the registered manager there was no clear way of identifying if any staff member took responsibility for any operational responsibility or decision making. This was discussed with the registered manager following the inspection who confirmed a system of delegated responsibility for being in charge of the service in her absence was introduced.
Relatives said they had an ongoing dialogue with the registered manager and staff which they found useful in raising any issues or for general feedback about the service. Survey questionnaires were used to ask people and relatives what they thought of the service. The registered manager said the results of these were compiled regionally which meant specific feedback for Cherrymead was not available. Relatives were asked to give feedback on individual staff performance as part of the staff appraisal system. Relatives' forums or meetings were not held to aid communication and feedback between the service and relatives although the provider had a family liaison person for dealing with families across the region.

Individual care to people was person centred and focussed on and reflected people's needs and preferences. Surveys were not used to obtain people's views of the service but there were regular residents' meetings where people were able to contribute to decision making regarding menus and activities. People's rooms were personalised and the registered manager told us how people were consulted about any redecoration and were able to choose colour schemes for their rooms. The registered manager told us how people were involved in the process of selecting staff as they met all applicants and were asked to give their views on each applicant which was then considered.

Staff said they were able to contribute to decision making at the service, which ranged from issues about people's individual care and to the policies and procedures. Staff said this was done by direct discussion with the registered manager or at the staff meetings. For example, a staff member gave us an example of how a suggestion for helping people have a photograph display in their rooms was adopted, which had positive benefits for people. Staff described the provider's management as approachable and said any concerns would be looked into.

The registered manager said how she kept her training updated by attending conferences and courses. A staff member thought the registered manager was skilled in checking staff were fully informed about any developments in care procedures or reports into care incidents to ensure staff were keeping people safe and working to a good standard.

The provider used a number of audit tools to monitor the safety and effectiveness of the service. This included a four monthly check called, 'Compliance Audit Template,' which assessed whether the service was meeting standards regarding the facilities and equipment, people's health and care needs, staff training, staff supervision, medicines and observations of staff working with people. The service also commissioned an assessment and report of the service quality by someone with a background in the care of people with a learning disability. The registered manager and staff also completed monthly health and safety checks which were recorded as well as checks on equipment such as hoists and wheelchairs. The provider carried out audits regarding fire safety, the premises and finances. The results of the checks and audits were used to implement any changes or improvements.

A social worker described the service as well-led and that staff had good working relationships with other agencies which aided joint working in meeting people's needs.

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 did not take formal enforcement action at this stage. 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 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient numbers of staff in order to meet the needs of service users. Regulation 18 (1).