Cherry Trees I.W. Limited

Cherry Tree Care Home

Inspection report

149 Park Road
Cowes
Isle of Wight
PO31 7NQ

Tel: 01983299731

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This comprehensive inspection took place on 9 March 2017 and was unannounced. Cherry Tree Care Home provides accommodation with personal care for up to 25 people, including for people living with a cognitive impairment. At the time of the inspection 24 people were living at the service with one person expected to move in later that day.

The home was based over two floors, connected by a passenger lift and stairwells. Not all bedrooms had en-suite facilities but there were toilets available on each floor. There was one communal space available for people to socialise.

There was a registered manager in place at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

Not all risks to people were minimised through the use of effective risk assessments which identified potential risks and provided information for staff to help them avoid or reduce the risks of harm.

Not all risks posed by the environment had been assessed or mitigated. For example, doors to corridors and people's rooms were wedged or hooked open and some bedroom doors did not fully close. This would put people at risk in the event of a fire.

People were supported to receive their medicines safely. However, medicine was not always stored at a safe temperature.

People were protected from the risk of abuse and staff knew how to identify, prevent and report abuse. Individual risks to people were managed appropriately and staff understood how to keep people safe in an emergency.

Appropriate pre-employment checks were completed before new staff commenced working in the home and there were enough staff to meet people's needs.

A training programme was in place although not all staff had completed all essential training in a timely manner.

Although people were satisfied with the way they were treated we found there was a task driven approach to care and staff did not always respect people's right to choose when they got up in the morning.

Staff followed legislation designed to protect people's rights.

People were encouraged to remain independent and their privacy and dignity was respected. People received a varied diet and were supported appropriately to eat. People received mental and physical stimulation in the form of organised activities.

There was a complaints policy in place and people knew how to raise concerns. Where issues had been raised the provider had acted to the satisfaction of the person raising the concern.

We identified breaches 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.

Environmental and individual risks to people were not always managed and mitigated effectively.

People received their medicines at the right time and in the right way to meet their needs. However, action had not been taken to ensure medicines were always stored at a safe temperature.

People felt safe at the home and staff knew how to identify, prevent and report abuse.

There were enough staff to meet people's needs and recruiting practices helped ensure that all appropriate checks had been completed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training had not always been received or updated as required by the provider's training plan.

Staff were not supported in their role by regular sessions of supervision.

Staff sought verbal consent from people before providing care and followed legislation designed to protect people's rights.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's privacy.

People were encouraged to maintain friendships and important relationships.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive personal care in line with their personal preferences.

Peoples care plans did not always support staff in a consistent or individualised way. People or their families if required had not been involved in care plan reviews.

People received appropriate mental and physical stimulation and had access to activities that were important to them.

The registered manager sought feedback from people using the service and had a process in place to deal with any complaints or concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

Some management tasks had not been completed and not all audits and checks in relation to the safety of the environment were robust in highlighting issues or concerns.

The provider's values were clear and understood by staff. The registered manager adopted an open and inclusive style of leadership.

People, their families and staff had the opportunity to become involved in developing the service.

Cherry Tree Care Home

Detailed findings

Background to this inspection

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

The inspection was unannounced and was completed in response to concerns raised about the safety and quality of the service. It was carried out on 09 March 2017 by two inspectors 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.

Before the inspection we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with eight people using the service, six visitors and two health professionals. We also spoke with a representative of the provider, the registered manager, 12 members of the care staff and the cook. We observed care and support being delivered in the communal area of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at care plans and associated records for six people using the service, staff duty records, three staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in August 2015 when no issues were identified. This resulted in Cherry Tree Care Home being rated as 'Good' at the last inspection.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Cherry Tree Care Home. One person said, "I feel very secure here". Family members told us they did not have any concerns regarding their relative's safety. One family member said, "Safe, absolutely" and another told us, "We [family] don't have to worry about [our loved ones] safety at all".

Although people told us they felt safe we were concerned about risks to them in the environment as not all environmental risks had been assessed or mitigated. For example, doors to corridors and rooms were wedged or hooked open and some of the bedroom doors did not fully close. One door had a notice on which stated, 'Door should not be propped open unless staff are assisting people to the lift'. Throughout the inspection we noted that this door was held open with a hook and eye device even when it was not in use. This meant that in the event of a fire people would be at high risk as the fire door would not act to slow the spread of fire and smoke.

Not all risks to people were minimised through the use of effective risk assessments which identified potential risks and provided information for staff to help them avoid or reduce the risks of harm. For example, there was not a risk assessment in place for the use and safe storage of fluid thickener and staff were unaware of the risks fluid thickener posed to people if eaten dry and not mixed with a drink. We saw a tin of fluid thickener left in a person's bedroom which other people could access if they entered the room.

Risk assessments were in place in relation to some people's doors being left open at night but these were very generic and not person centred. These risk assessments all stated, 'Left open at night due to health condition'. We asked the registered manager what people's individual specific health conditions were and they told us that one of these risk assessments was in place because, "[The person] does not use their call bell and is at risk of falls". This person's bedroom was in a location that was not overlooked by staff through the night. Therefore the door being open at night would not have mitigated the risk to the person falling but placed the person at high risk should there be a fire. The registered manager added that, "People had chosen to have their doors open at night". There was no information available to show when people had requested to have their doors open at night or that the risks of this, in the event of a fire, had been explained and understood by the person. The risk assessments were therefore not addressing the risk to the person and the solutions were placing people at higher risk.

The failure to ensure risks relating to the safety and welfare of people using the service are assessed and managed is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Other individual risk assessments were in place. Moving and handling assessments set out the way staff should support each person to move and correlated to other information in the person's care plan. Staff had been trained to support people to move safely, although not all staff had completed updates to their training as required by the provider's training programme. This could therefore result in out of date moving techniques being used, resulting in harm and injury to both people and staff. We observed staff used moving

and handling equipment, including a stand aid and walking frames. Staff used these carefully, gained people's consent, did not rush people and gave explanations and reassurance to people when using equipment.

Where there were specific individual risks, people were provided with appropriate equipment and action was taken to keep people safe. For example, where people had fallen, their risk assessments were reviewed and staff had considered additional measures they could take to protect the person. This included using special equipment to monitor people's movements and referring them to health professionals. People who were at risk of skin damage used special cushions and pressure relief mattresses to reduce the risk of damage to their skin. However, pressure relief mattresses were not all set correctly according to the person's weight. These were adjusted during the inspection and the registered manager stated they would introduce a system to check these on a regular basis. People at higher risk of pressure injuries were assisted to change position to reduce the risk of pressure injury. Where people were at risk of choking on their food, they had been referred to specialists for advice and were provided with suitable food and drinks to reduce the risk. Where people required equipment to assist them to reposition or move they each had their own designated equipment. This helped to ensure the correct size of equipment, such as hoist slings, were being used and this reduced the risks of the possible spread of infection and falls or harm to people if inappropriate equipment was used.

Incidents and accidents that had occurred where recorded which enabled the registered manager to identify any actions necessary to help reduce the risk of further incidents. For example, one person had experienced a number of falls in the weeks prior to the inspection and we saw action had been taken to mitigate the person's risk of falls.

Not all staff had received up to date safeguarding training. However, the registered manager and staff knew how to respond appropriately to concerns about safeguarding and knew what they would do if concerns were raised or observed. One staff member told us, "I would speak to [the registered manager]". Another staff member said, "If I had concerns I would contact the manager or home owner who would make sure everything is done correctly". All staff were confident the registered manager would take the necessary action if they raised any concerns and knew how to contact the local safeguarding team if required. Records confirmed the service had reported concerns to the appropriate authorities when needed.

People were supported to receive their medicines safely. One person said, "I always get the medicines I need". A family member told us, "I don't have any concerns about my [loved one] getting their medicine".

Cherry Tree Care Home was storing some medicines that required to be kept at cooler temperatures in a fridge. Records showed that the medicine refrigerator temperatures were monitored daily. However, staff had been regularly recording temperatures which were below zero degrees and therefore too cold for the safe storage of these medicines. Staff and the registered manager were unaware of the correct temperature which these medicines should be stored at. This meant that the effectiveness of any medicines stored in the refrigerator could not be assured. During the inspection the registered manager contacted their pharmacist who confirmed the need for a replacement refrigerator. We were informed this would be delivered the day following our inspection.

Where people were prescribe 'as required' medicines there was information for care staff as to what each medicine was for and some information as to when it should be given. However, there was insufficient information available to ensure people received 'as required' medicines consistently. For example, one person was prescribed a medicine to be administered if they were agitated when staff were providing personal care. Staff described techniques they used to encourage the person to accept care; however, these

were not detailed in the person's care plan or in the guidance for the administration of the medicine. Where people were receiving 'as required' medicines there were recording systems on the Medication Administration Record sheets (MARs) to record the exact time these were given. This helped ensure there was adequate time between administrations.

All medicines were stored securely and appropriate arrangements were in place for obtaining, recording, administering and disposing of prescribed medicines. The MAR charts documented that people had received their medicines as prescribed. Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them. Safe systems were in place for people who had been prescribed topical creams. Charts were used to help staff know where these should be applied and a record was kept of when tubes or containers of topical creams were opened. This meant staff were aware of when the topical cream would no longer be safe to use.

People and their families told us there was sufficient staff to meet people's needs. There was a calm and relaxed atmosphere at the home and staff appeared unhurried in their duties. Comments from people and their families included, "There is enough staff, they are on the ball", "They [staff] respond quickly to call bells" and "There is always staff around".

The registered manager told us that staffing levels were based on the needs of the people using the service. They said, "I talk to the staff and people about individual needs". They added "I will consider people's changing needs and the skill mix of the staff". There was a duty roster system in place, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime or cover from staff employed by the provider at another home nearby. The registered manager and heads of care were also available to provide extra support when required.

The provider had a safe and effective recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. A DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. A staff member confirmed that they were unable to start work until their DBS and references had been received and they had successfully completed the induction procedures. shadowing and observations.

Equipment, such as hoists and lifts were serviced and checked regularly. The temperature of hot water at water outlets was monitored regularly by staff. This helped protect people from the risk of scalding. There were plans in place to deal with foreseeable emergencies. Staff were aware of the action to take in the event of a fire and fire safety equipment was checked regularly. Personal evacuation and escape plans had been completed for each person, detailing action needed to support people to evacuate the building in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

Staff were not up to date with all training. The provider had identified training staff required and had a system to record the training that staff had completed and when training needed to be repeated. On reviewing training records, we saw that staff training had not always been received or up dated as stated as required in the provider's training log. This included essential training, such as medicines training, moving and positioning, safeguarding adults, fire safety and first aid. On reviewing staff duty rotas we established that on some shifts there were no staff on duty who were up to date with moving and handling training.

We discussed this with the registered manager and the provider's representative who agreed to review the staff rotas and change staff shifts to ensure all shifts had some staff who were appropriately trained. During the inspection the registered manager also arranged urgent essential training for staff to take place the following week.

Staff did not receive regular supervisions. Supervisions should provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. The registered manager told us, "Supervision is not done as regularly as it should be. I probably do formal supervisions once or twice a year". The registered manager added, "Some staff do get supervision more than others". One staff member told us, "I get supervision" and another staff member said, "I can go to the manager at any time". Staff said they felt supported by the management team and senior staff and that they could raise any concerns straight away.

We discussed the lack of formal supervision for staff with the registered manager who informed us that plans are in place to increase the frequency of supervision. The registered manager also highlighted that she has an open door policy and staff had the opportunity to discuss any issues of concerns they had at anytime. Staff members confirmed this.

People were supported by staff who had received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. Each member of staff had undertaken an induction programme, including a period of shadowing a more experienced member of staff who assessed their suitability to work on their own. One staff member who had not done care work before confirmed that their induction included the completion of the 'Care Certificate'. The Care Certificate sets fundamental standards for the induction of adult social care workers.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. We saw staff followed these by consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests. For

example, for one person, a best interest decision had been made in respect of the use of restrictive equipment such as bed rails and pressure mats. For another person there was a documented best interest assessment completed for the person's medicines to be crushed. This form considered the benefits and disadvantages from a medical, welfare, emotional and ethical perspective.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements. The registered manager had applied for DoLS authorisations where necessary and was waiting for these to be assessed and approved by the local authority. Information on the DoLS applications was clear as to why the application had been made. Staff understood their responsibilities and knew how to keep people safe in the least restrictive way.

People and their families told us that staff asked for their consent when they were supporting them and that they received the personal care they required in a way that met their preferences. A person told us, "They [staff] let me choose when I want to do things". Staff told us how they offered choices and sought consent before providing care and were clear about the need to seek verbal consent. We heard care and other staff seeking verbal consent from people throughout the inspection. Staff respected people's rights to make choices. For example, one person slept in a recliner chair as they were uncomfortable sleeping in bed. Care plans included information about people's ability to make decisions and support they may need to do this. For example, one care plan reminded staff that a person could make choices about day to day things, such as food selections.

Care plans included guidance for staff as to the actions they should take if people refused care or medicines. This guided staff to explain to the person why the medicine was required, to record any refusals and if this continued to inform the person's doctor. Staff were aware of people's rights to refuse care and were able to explain the action they would take if care was refused. One care staff member said, "We ask them. If they said no, we explain why it would be a good idea and then try later or someone [another care staff member] would try, that usually works."

People's nutrition and hydration needs were met effectively. People received the appropriate amount of support and encouragement to eat and drink. Some people were being fully supported to eat and this was done in a kind, unhurried way. The staff members providing the support were talking with the people, encouraging them and asking them if they were ready for more. Staff were attentive to people and noted when people required support. When necessary, staff recorded the amount of drinks people had received. People were supported to eat independently and where necessary specialist cups, crockery and cutlery were provided. People told us they enjoyed their meals and their comments included, "The food is very good", "I get a good choice" and "I am very happy with the food". Three people commented that they found they got their evening meal slightly early, but all confirmed that they could get a snack or sandwich in the evening if they wished.

Staff told us they could provide people with food at any time this was requested or required. Records showed people were provided with food when they wanted it; for example, records showed people had been given snacks and sandwiches at night if they were awake and hungry. Staff were aware of people's dietary needs and preferences which were recorded in their care plans. We saw one person, who had a medical condition which meant they must avoid certain foods, was provided with a specialist breakfast cereal which was safe for them to eat. People received varied meals including a choice of fresh food and drinks.

People were encouraged to walk to the tables for meals and were not rushed in doing so. This provided an opportunity to change position and exercise. One person chose to have their meals in their bedroom and this was respected. Mealtimes were a social occasion and people were able to choose where they sat and with whom.

People's general health was monitored and they were referred to doctors and other healthcare professionals when required. A health professional told us they were consulted appropriately and felt Cherry Tree met people's mental and physical health needs well. People were seen regularly by doctors, opticians and chiropodists as required. The registered manager was aware of how to arrange home visits for dentists if required. Where people had specific known medical needs, such as diabetes, systems were in place to monitor these and ensure people received the correct support, such as diet, they required.

Good

Is the service caring?

Our findings

People and their families were positive about the caring attitude of the staff, who they described as, "very friendly", "kind" and "caring". A family member told us, "The care is exceptional, the staff really do care". Comments made by people and relatives in the provider's quality assurance survey, completed in May 2016, included, 'All staff are extremely caring and considerate' and 'Cherry Trees reputation is beyond reproach'. A comment from feedback sent to a care review website read, 'The home is very well managed, comfortable and nothing is too much trouble for the staff".

People were cared for with dignity and respect. We saw staff kneeling down to people's eye level to communicate with them and heard good-natured banter between people and staff. People felt able to approach staff with any concerns they had. For example, we heard one person tell a staff member that they had been cold the previous night, but had not informed the night staff. The person was reassured by the staff member who discussed providing them with an extra blanket and checked the heating was working.

People were supported to be as independent as possible and staff understood people's abilities. Care plans gave information about what people were able to do for themselves and when support was required. Comments in care plans included, 'If handed the flannel and towel I am able to wash my hands and face', 'I am able to choose what I wear' and 'I can eat independently but have a small appetite'. People confirmed that the staff only helped when they need it. One person said, "I get myself up in the morning but will ask the staff if I need help". Staff encouraged people to mobilise independently and we heard staff explain to people how to stand from sitting and remind people how to use their walking frames safely. At lunch time plate guards and adapted cutlery were provided for some people to enable them to eat independently. One person told us, "Staff always cut up my meat for me". This allowed them to eat independently.

Staff know the people they cared for well including their needs and likes and dislikes and we saw many instances when staff demonstrated this knowledge. These included during breakfast when staff gave one person their drink in a lidded beaker and another person was provided with a jar of sweetener powder which was left on their table for them to add themselves. Staff added fluid thickener to a person's drink as highlighted in their care plan to the correct consistency recommended by healthcare professionals. Staff were aware that it was important for one person to have their handbag with them; they carried it to the breakfast table for the person and made sure they were happy where it was placed. Later when the person was returning to the lounge, staff made sure the bag went along with the person. A staff member said to us, "Their bag is very important to them".

With the exception of the time people preferred to get up, staff understood the importance of respecting people's choice. They spoke with us about how they cared for people and we observed that people were offered choices in what they wanted to wear, what they preferred to eat and whether they took part in activities. Choices were offered in line with people's care plans and preferred communication style. Where people declined to take part in an activity this was respected. One family member said, "They [staff] respect [loved ones] wishes and will always give them a choice of what they want to do. I would have no qualms at all about recommending the home to others".

People's privacy was respected when they were supported with personal care. Staff were able to describe the practical steps they took to preserve people's dignity and privacy when providing personal care. This included ensuring doors and curtains were closed and making sure people were covered. We observed staff knocking on doors, and asking people's permission before entering their bedrooms.

Family members confirmed that the registered manager and staff supported their relatives to maintain their relationships and told us that they were always made to feel welcome and could visit at any time. Care plans detailed people's spiritual beliefs or needs and any support they required in relation to this. People were supported to maintain their religious and spiritual needs and people has access to monthly Holy Communion service. Volunteers from the local church also support people to attend church services on Sundays if they wished. The registered manager was aware of how to access other religious leaders if required. People's bedrooms were individualised and reflected people's interests and preferences. The bedrooms were personalised with photographs, pictures and other possessions of the person's choosing.

Information regarding confidentiality formed a key part of staff's induction training for all care staff. Confidential information, such as care records, was kept within the office and only accessed by staff authorised to view it. Any information, which was kept on the computer, was also secure and password protected.

Requires Improvement

Is the service responsive?

Our findings

People and their families told us they felt the staff were responsive to their needs. A family member said, "The difference in [my love one] since they have been here is amazing. They are happy and relaxed and it is good to see them smiling and laughing again". Another family member told us, "[My loved one] gets all the attention they need; I can now take my foot off the pedal and relax". A third family member explained about a time their loved one was unwell and a staff member had sat with them all night. They finished by saying, "It was the care and attention from the staff that pulled [their loved one] through".

Although people were satisfied with the way they were treated we found there was a task driven approach to care, especially around personal care routines. We found staff did not always respect people's right to choose when they got up in the morning. For example, we arrived at the home at 06.30 to find that some people were up, washed and dressed. When we asked people about this, one person said, "I am usually up now; I like to get up later than this, but am told I have to get up now as there are too many people to get up". We checked this person's care plan which stated, '[Person] prefers to get up between 7am-8am'.

We said to a second person who was also up, "You're up early today". They responded with, "Am I, what time is it?" When we told them, they put their head in their hands and said, "That's early, I didn't know it was so early". 20 minutes later this person was fast asleep in the chair. Other people told us they were happy with the time they were got up. Comments included, "I am well looked after, I am woken up about 7 (am) when I am helped to wash and dress", "They [staff] do get me up early but I like it" and "I am happy with the early morning start".

People's daily routines were not always respected or documented. During a walk around the home at 06.50 the main overhead lights were on in some of the bedrooms while people were sleeping. We addressed this with the registered manager and staff on shift and their comments included, "People like their lights on at night", "The person has just received personal care" and "The person is about to get up". Not all care plans stated people's preferred times to get up or if they wanted their main lights on at night and daily records did not indicate when people were assisted out of bed and why. Therefore, staff were unable to confirm that people had been cared for in a way that reflected their individual preferences.

With the exception of getting up, people were provided with personalised care. Care was individual and centred on each person and staff had a good awareness of people's needs. We saw that people's care plans contained information about their life history, preferences, and medical conditions. They also included specific individual information to ensure medical needs were responded to in a timely way. However, people's care plans did not support staff to deliver care in a consistent or individualised way. For example, for 'Oral health' one care plan stated, 'Own teeth'. It did not explain the support the person required to care for their teeth and oral health. Some care plans had hand written additions and crossings out, which made them difficult to follow. This lack of detail in some care plans may result in care not being provided consistently in accordance with people's individual needs.

When people moved to the home they and when appropriate their families were involved in assessing,

planning and agreeing the care and support they received. The registered manager told us that people were assessed before moving to the home. Assessments were completed to ensure that people's needs could be met. A family member said, "[My love one] visited the home and had day care before the decision was made to move in". A second family member told us, "[My loved one] had a short stay at the home before making their decision to stay permanently."

Each person had a daily record of care document in place; however, information in these did not demonstrate that care had been received as required or note any concerns about people's health and wellbeing. For example, some read, 'All care given' and 'Slept well'. Daily records provided little or no information about people's physical or psychological wellbeing, food and fluid intake, continence needs and mobility. This meant that changes in people's needs may not be monitored effectively to allow timely interventions where required.

People's care plans were reviewed monthly by the registered manager or heads of care; however, there was no record to show whether people, or their families if required, had been involved in these reviews. A person said, "I haven't seen my care file". A second person told us, "Review, I don't think I have had one". Family members also confirmed that they had not been involved in reviews of their loved ones' care but commented, "I am always kept updated and informed", "I could look at [my loved ones] care plan if I wanted to, it would always be made available to me" and "I have not seen the care plan since [my loved one] has been here (three years) but I am kept verbally updated regularly". Following the inspection an action plan was received from the registered manager which stated that care plans and risk assessments would be updated with people to reflect their preferences and needs in a more personalised and in-depth manner.

Staff were kept up to date about people's needs through handover meetings which were held at the start of every shift. These meetings provided the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting. Relevant individual information was provided to staff during this meeting which included information about a person who had received pain relief medicines during the night and that a person should be supported to dress early as they had a hospital appointment that morning.

The registered manager told us that they sought feedback through the use of an internet care home review site and quality assurance survey questionnaires that were sent annually to people, their families and staff. We looked at the feedback on the review site and all people had rated the care and environment as 'good' or 'excellent'. Comments included, '[My loved one] was treated as one of 'the family' at the home, treated wonderfully well by all the staff at all times' and 'My [loved one] has never been happier and her confidence and health have improved significantly since returning [to Cherry Tree], due to the care she is receiving'. Comments from the latest survey completed in May 2016 were all positive in respect of the care people received.

Residents meeting were held annually and during the inspection people were being spoken to individually by a member of staff about the service they received and any concerns they may have had. Past meeting minutes were viewed and actions had been taken where required. For example, people had requested alternative food choices and this had been arranged.

The registered manager also sought feedback from people and their families on an informal basis when they met with them at the home or during telephone contact. A family member told us, "When we visit we often see the manager, who will talk to us about the home and care provided to our [loved one]". Another family member said, "We are able to approach the manager at any time and they encourage families to make contact". Families told us they were verbally notified by the staff or the registered manager of any change to

medication, illness or circumstances in the home. One family member said, "I am always kept informed of any changes in [my loved ones] health".

People received appropriate mental and physical stimulation and had access to activities that were important to them. People's care plans highlighted people's social interests and past hobbies. Staff were knowledgeable about people's right to choose the types of activities they liked to do, and respected their choice. Activities were arranged to cover five afternoons per week. On the day of the inspection people were participating in a quiz. This was well received by people who appeared to enjoy it. Other activities included dominoes, bingo, reminiscence games and live musicians. One person told us, "There are lots of things to do but I prefer to knit or read in my room". Another person said, "I never get bored, there is always entertainment".

The provider had a policy and arrangements in place to deal with complaints. Posters were displayed at the front entrance of the home informing people and visitors how to complain if they wished to. The registered manager explained the action they would take when complaints or concerns had been raised. This included investigating the concern/complaint, providing written feedback to the complainant and notifying CQC and the local safeguarding team if required. All of the family members knew how to complain and were confident that the registered manager would take action when needed. A family member said, "If I was concerned about anything I could approach any of the staff".

Requires Improvement

Is the service well-led?

Our findings

People and their families told us they felt the service was well-led. Family members also said they would recommend the home to their families and friends. One family member told us, "The management are brilliant, you can't fault them". Another family member said, "The manager is really approachable and will talk to me anytime". A third family member told us, "The home is really well run; everyone knows what they are doing". A person said, "I do chat to the manager regularly she is very nice".

Management oversight of the home was not effective. For example, staff had not received regular supervision; risks posed by doors being wedged open had not been identified or addressed; some medicines were not stored correctly and there was insufficient information to guide staff when they should give people some medicines. Not all staff had completed all essential training in a timely manner and not all risk assessments and care plans were person centred or sufficiently detailed. People's personal preferences had not always been considered.

Not all audits and checks were robust in highlighting issues or concerns. For example, although the medicine fridge temperature was checked daily, staff had failed to notice that the temperature was unsafe. There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment. Audits that were carried out included, infection control, cleanliness of the home, medicines management and care plans.

There was a clear management structure, which consisted of a registered manager, two heads of care, senior care staff and care staff. Staff understood the role each person played within this structure. The management team encouraged staff and people to raise issues of concern with them, which they acted upon. One staff member told us, "It's a nice place to work. I can talk to the manager at any time and know if I had any issues or concerns they would act". Other staff members said that they were confident the management team would sort things out and felt able to raise things with them if they needed to.

The provider's representative was engaged in running the service and their vision and values were built around providing a safe, caring and homely atmosphere for people. The registered manager told us, "We want people to feel that this is their home and aim to provide a family friendly atmosphere". Staff members understood the values of the service and many described Cherry Trees as "Their [people's] home" and "A home from home". People and their families echoed this and one said, "They [staff] go about their care in a cheerful manner, such that it feels more like a family home than a care home". All staff said they would recommend the home and be happy for one of their own relatives to be cared for at Cherry Tree Care Home.

Staff meetings were held six monthly. These provided the opportunity for the registered manager to engage with staff and reinforce the provider's values and vision. Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. They confirmed they were able to raise issues and make suggestions about the way the service was run during staff meetings and these were taken seriously and discussed. Staff meeting minutes were reviewed and these highlighted that staff were given the opportunity to discuss the running and culture of

the service and their views were considered. The registered manager also told us that they often, "work alongside" staff and will completed daily spot checks of the home to ensure that they are aware of the culture and standard of care being provided.

Family members told us they were given the opportunity to provide feedback about the culture and development of the home during informal decisions with the manager and through annual quality assurance surveys. All family members we spoke with, and evidence seen on completed quality assurance surveys, showed that relatives and people were happy with the service provided.

The provider had suitable arrangements in place to support the registered manager, for example, regular meetings, which also formed part of their quality assurance process. The registered manager told us that support was available to them at any time from the provider who also visited the home regularly.

The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.

The provider and the registered manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed in the reception area and on the provider's website.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to mitigate risks to the health and safety of people using the service effectively. Regulation 12(2)(a) & (b).