Blueberry Transitional Care Ltd

Cherry Blossom

Inspection report

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17 July 2020
20 July 2020
21 July 2020

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Ratings

Overall rating for this service	Inspected but not rated

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

Summary of findings

Overall summary

About the service
Cherry Blossom is a residential care home providing personal care and accommodation to six people with a learning disability. At the time of the inspection three people lived at the home.

The service has been designed taking into account best practice guidance and the principles and values underpinning Registering the Right Support (RRS) in respect of the environment. The building design fitted into the residential area as it was domestic in style in keeping with other homes in the street. There were deliberately no identifying signs, intercom, cameras, industrial bins or anything else outside to indicate it was a care home. Staff were also discouraged from wearing anything that suggested they were care staff when coming and going with people.

People's experience of using this service and what we found
People were not always safeguarded by the systems in place relating to the use of physical intervention and lessons were not always learned about how to better support people during periods where they have behaviours that challenge.

Staff were not always recruited safely as not all required checks had been undertaken prior to commencing work at the home.

At the time of inspection known fire risks were not always managed to mitigate the risk of harm to service users and staff. Following the inspection action was taken to address these known risks.

People received their medicines when needed and staff where trained to administer people's medicines safely.

Peoples support plans where not always updated to ensure they reflected people's individual needs and had not considered the impact of COVID19 restrictions on people using the service.

A lack of oversight meant potential risks to people's safety had not been responded to appropriately. Systems to monitor the quality and safety of the service were not effective and had not identified the areas for improvement found at this inspection.

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
This service was registered with us on 09 April 2019 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding, use of restraint, and in

relation to the care being provided. Additional concerns were shared with us by the Clinical Commissioning team. A decision was made for us to inspect and examine those risks.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them.
You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to person centred care, safeguarding, recruitment practices and governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The service rating in two domains 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 6 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 Blossom

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 Care Act 2014.

Inspection team
The inspection was carried out by three inspectors. Two inspectors visited the home on the 20 July 2020, whilst the third inspector undertook telephone calls to staff and relatives.

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

The service did not have a manager registered with the Care Quality Commission.

Notice of inspection
We gave a short notice period of the inspection because of the risks associated with COVID19. This meant that we could discuss how to ensure everyone remained safe during the inspection.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. We looked to see if statutory notifications had been sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We used all of this information to plan our inspection.

During the inspection
We saw all of the people that lived in the service however they were not able to effectively communicate with us. We spoke with one relative about their experience of the care provided to their family member. We

spoke with four members of staff, maintenance person, regional manager and provider. We also spoke with one healthcare professional.

We reviewed a range of records. This included three people's care records and medication records. We looked at two staff files in relation to recruitment. We also looked at records that related to the management and quality assurance of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Systems and processes were not established or operated effectively to prevent potential abuse of people living at the home.
- Staff supported some people that displayed behaviours that may challenge others. We found where restraint was used, the records did not always detail the actual duration of the restraint, the de-escalation techniques used prior to the restraint being imposed, and the position of the staff members implementing the restraint. This meant it was not clear and transparent if the restraint used was the least restrictive and for the shortest possible time.
- Staff we spoke with and the records we reviewed, confirmed a manager / provider did not always review the physical incident records to check the details provided. This meant checks were not undertaken to ensure the restraint implemented was proportionate to the distressed behaviours displayed by people.
- The provider confirmed analysis of the incidents of restraint and distressed behaviours displayed had not been regularly reviewed. Therefore, the records staff completed and staff knowledge was not utilised to identify any patterns and trends in people's behaviours or any potential triggers.

This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A relative told us they had concerns about the management of risks associated with providing support to their family member. A relative told us about incidents which posed a risk of harm to their family member and told us staff were not always able to keep them safe. We found the provider was currently aware of these incidents and was addressing them.
- Risk assessments were in place and detailed the risks staff needed to be aware of. However, these did not always contain the most up to date information for staff to refer to. This put staff and people at risk of harm without access to the most up to date details of risks.
- Staff were aware of their responsibilities to report and act on any safeguarding concerns. A staff member told us, "It is anything that could harm someone." Another said, "It is how we look upon the residents and keep them safe from abuse. If I saw anything I would report it to my manager or to the LA and CQC."

Assessing risk, safety monitoring and management;

- Timely action had not been taken to safeguard people from potential risk of harm.
- A fire risk assessment had been undertaken in December 2019 by an external consultant. Recommendations were made in the report and these included to fit closures to several doors in the home. We observed, and the provider confirmed, this action had not been taken. This placed people at potential risk of harm in the event of a fire.

This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A week after our inspection visit the provider told us action had been taken and self-closures had been fitted to all required doors.

Staffing and recruitment

● We reviewed the recruitment files for two recently employed staff. One file did not contain evidence that a disclosure and barring check (DBS) had been undertaken for the staff member who had commenced employment in the home. A risk assessment had also not been completed to demonstrate what measures had been put in place to safeguard people whilst the provider waited for the DBS check to be returned. In addition, references for this person had not been obtained by the provider.

● We found gaps in the employment history for both staff members which had not been explored.

● The reference for the second member of staff had not been validated to ensure it had been checked as accurate. This meant recruitment processes were not effective in ensuring staff were suitable for the roles prior to employment.

This was a breach of regulation 19 (Fit and Proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff and relatives told us sufficient staff were on duty to meet people's needs. Our observations confirmed staffing levels were as required in accordance with the assessed needs of people and as agreed by the funding authority.

Preventing and controlling infection

● Staff were following government guidelines and wearing personal protective equipment such as face masks.

● Staff were able to show us evidence of cleaning schedules that had been completed and tell us what additional measures had been put in place in response to COVID19. This included wiping down regularly touched surfaces such as door handles.

● We observed the home to be clean and well maintained.

Using medicines safely

● A review of the records confirmed people received their medicines as prescribed.

● The provider had appointed a medicines champion in the home who had identified some improvements required, including work with the GP to coordinate all service users medicine cycles starting at the same time.

● Staff confirmed they had received medicines training and had their practice observed to ensure they were competent in this area.

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.

This is the first inspection for this newly registered service. This key question has been rated Inadequate.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; The lack of governance systems and oversight meant people were at risk of receiving poor quality care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Systems and processes were not effective in reviewing and maintaining oversight of the service being provided.
- The provider confirmed they did not have any systems in place to monitor the quality of the service provided until the appointment of an operations area manager in November 2019. We were informed there were no records to support what systems were in place by the previous manager of how they monitored and maintained the service provided. Although an audit and service improvement plan had now been completed, timely action had not been taken to review and monitor this and the improvements that should have been made by the timescales recorded.
- The lack of audit systems and processes meant incident reports of restraint used within the home were not reviewed to ensure they were completed in full. In addition, the lack of systems meant these reports had not been analysed to support the ongoing review and management of peoples distressed behaviours. A staff member told us after incidents of restraint, "We speak about it as a staff team, but we don't record this."
- The lack of oversight meant records such as physical incident records had not been checked to ensure the language used was respectful to the person the staff were recording the information about. We found some wording in the records where staff had used derogatory language such as "[Person] had played up or [person] had kicked off."
- The lack of effective audits meant people's care plans and risk assessments were not always reviewed and updated, to ensure staff had access to consistent and accurate information about people's support needs. This included an individual intervention plan for one person.
- People's support plans, and routines had not been updated to take into consideration the impact COVID19 had on people due to the restrictions in place. Audits had failed to identify this, therefore not ensuring risks were effectively assessed, monitored and mitigated.
- Some people were prescribed 'as required' (PRN) medicines. We found the PRN protocol for these medicines were lacking in detail stating, "Behaviours that are not socially acceptable." It was not clear from the protocol when staff should administer PRN medicines, staff were consistent in their practice.
- The lack of oversight meant timely action was not undertaken to act on a known risk following the fire risk assessment which identified that fire doors did not have self-closing mechanisms. This placed people at potential risk of harm in the event of a fire.
- Audit systems and processes had not identified the errors we found in recruitment processes.
- The lack of effective systems and processes resulted in the training information provided to us being inaccurate. The information did not confirm the training staff had undertaken. When asked the provider was

unable to provide certificates to demonstrate staff had completed training in physical intervention. The provider had to contact the agency that provided this training and request copies of the certificates to confirm staff had received the required training to enable them to safely restrain people when they were at risk of harm to themselves or others.

● The service has not had a registered manager since December 2019. The provider told us a new manager had been recruited and was due to start employment in August 2020.
● The provider acknowledged the shortfalls we found in the service and advised they were working towards addressing the shortfalls we found. They were also addressing the action plan the local authority have given them following their visit to the home and their own internal improvement plan.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People's support plans had not been updated to account for the impact of COVID19 on their needs and daily routines. Staff told us people enjoyed accessing various activities in the community such as college. People were unable to engage in these activities when they were closed due to the restrictions imposed due to COVID19. Support plans and people's daily routines had not been updated taking into consideration the impact these restrictions would have on people and the alternative activities that people could participate in. This meant people hadn't been fully involved in making decisions or involved in discussions about the changes to their daily routines. This demonstrated a lack of a person-centred approach to peoples care.
● We saw an activities board in the communal dining room which staff told us the service users were supported to choose the activities they wanted to engage in during the coming week. One service user had chosen to visit three different theme parks in the coming week. When asked staff informed us no-one had checked to confirm the theme parks were open or what restrictions, hygiene procedures were in place during the COVID19 pandemic.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● A relative we spoke with told us as they were unable to go into the home during lockdown. They were able to visit twice per week by arranging the time of the visit with the home then stepping back from the doorway. This enabled them to to see each other from a distance as their family member was unable to use the phone.

● The provider understood their responsibilities in relation to the duty of candour regulation.
● The provider was receptive to our feedback and advised us of their commitment to making the required improvements.

Working in partnership with others;
● The manager and provider had engaged on a regular basis with the local authority during the COVID19 pandemic. This evidenced partnership working between the home and external professionals to enable positive outcomes for people.

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 failed to ensure fire doors had self-closing mechanisms fitted

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to completed pre-employment checks to ensure fit and proper persons employed

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure the use of restraint was the least restrictive for the shortest time and analysis was completed.

The enforcement action we took:

We imposed a positive condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure they had oversight of the service provided

The enforcement action we took:

We imposed a positive condition on the providers registration.