Salveo Care Ltd

# Cherry Tree House Residential Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| Is the service safe? | Good |
| 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

We undertook an unannounced inspection of Cherry Tree House Residential Home on 10 August 2017.

Cherry Tree House Residential Home is registered to provide care and accommodation for up to 20 older people. At the time of our inspection there were 18 people living at the service.

There was a registered manager in post. 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.

People and their families told us they felt safe at Cherry Tree House Residential Home and had no concerns about their safety at the home. One person said "Oh yes, I do feel very safe".

Staff understood their responsibilities in relation to safeguarding people. Staff received regular training to make sure they stayed up to date with recognising and reporting safety concerns. The service had systems in place to notify the authorities where concerns were identified. People received their medicine as prescribed.

People benefitted from caring relationships with the staff. One person said "Staff are so nice. They could not be better" and a relative said "The care is very, very good". People and their relatives were involved in their care and people's independence was actively promoted. Relatives and staff told us people's dignity was promoted.

Where risks to people had been identified, risk assessments were in place and action had been taken to manage these risks. Staff sought people's consent and involved them in their care where possible.

People, relatives and staff told us overall there were sufficient staff to meet people's needs. This was confirmed on the day of our inspection as we observed staff numbers were adequate to meet people's needs. The service had safe recruitment procedures and conducted background checks to ensure staff were suitable to undertake their care role. Staff told us they were given scenarios when being interviewed to test their knowledge and care ethic.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The service was operating within the principles of the Mental Capacity Act 2005(MCA).

People and their families told us people had enough to eat and drink. People were given a choice of meals and their preferences were respected. Where people had specific nutritional needs, staff, including the chef, were aware of these and ensured they were met.

Relatives and people told us they were confident they would be listened to and action would be taken if they raised a concern. The service had systems to assess the quality of the service provided. Improvements and learning needs were identified and action was taken to make improvements which promoted people's safety and quality of life. Systems were in place that ensured people were protected against the risks of unsafe or inappropriate care.

Staff spoke positively about the support they received from the registered manager and all of the team at the home. Staff supervisions and other meetings were scheduled as were annual appraisals. People, their relatives and staff told us all of the management team were approachable and there was a good level of communication within the service.

Relatives and people told us the team at Cherry Trees House Residential Home was very friendly, responsive and very well-managed. Comments received included, "We came to the home as a family, we had lunch and mum liked it so much she stayed" and "The management is very good, good leadership, definitely". The service sought people's views and opinions and acted on them.

The management teams' ethos was echoed by staff and embedded within the culture of the service.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

People and their relatives told us people were safe. Staff knew how to identify potential abuse and raise concerns.

There were sufficient staff deployed to meet people's needs and keep them safe.

Risks to people were identified and risk assessments were in place to manage the risks. Staff followed guidance relating to the management of risks.

People had their medicine as prescribed.

### Is the service effective?

Good

The service was effective.

People were supported by staff who had the training and knowledge to support them effectively.

Staff received support and supervision and had access to further training and development.

People had access to healthcare services and people's nutrition was well maintained.

### Is the service caring?

Good

The service was caring.

Staff were kind, compassionate and respectful and treated people with dignity and respect which promoted their wellbeing.

Staff gave people the time to express their wishes and respected the decisions they made. People and their relatives were involved in their care.

The provider and staff promoted people's independence.

### Is the service responsive?

Good

The service was responsive.

People's needs were assessed prior to moving into Cherry Tree House Residential Home to ensure their needs could be met.

Care plans were personalised and gave clear guidance for staff on how to support people. People were supported in their decision about how they wished to spend their day.

Relatives knew how to raise concerns and were confident action would be taken.

## Is the service well-led?

Good

The service was well led.

There was a positive culture and the registered manager and provider shared learning and looked for continuous improvement.

People, their families and staff told us there was good management and leadership in the home.

The service had systems in place to monitor the quality of service.

# Cherry Tree House Residential 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 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 took place on 10 August 2017 and was unannounced. The inspection was carried out by one inspector.

We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law. We sought feedback from the commissioners of the service and other stakeholders. We did not ask the provider to complete a PIR prior to this inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information during our inspection.

During the inspection we spoke with three people who used the service and two relatives of people who lived at Cherry Trees House Residential Home.

We looked at three people's care records, medicine administration records and we observed people receiving their medicine. We looked at three staff records and records relating to the general management of the service. We spoke with the registered manager, the provider, two care staff, one senior care staff member and the chef. We also spoke with one professional visiting on the day.

Good

# Is the service safe?

## Our findings

People and their relatives told us they were safe. Comments included; "I feel safe and I am well looked after"; "My mother is absolutely safe and they identify when she is not well" and "I know my mother is safe. She had a fall and they identified the reason for this very quickly". One professional said "Safe, absolutely, no problems". One staff member told us, "People are very safe here".

People had equipment to enable them to move around the home safely and staff were aware of when this equipment should be used, for example walking frames. We saw staff were very attentive to people in the home and checked with people to ensure they were safe when mobilising around the home. Staff knew how to keep people safe. They told us how one person had a tracker device on their walking stick and how the staff monitored their whereabouts when they were away from the home. This ensured the person's safety was maintained without restricting them from leaving the home alone. They were also aware of the need to check bath temperatures to ensure they were at a safe level so people were not at risk of scalding. The visiting professional told us they had no concerns about people's safety. They said staff moved people safely, including when hoisting people. We saw when people were in their bedrooms, they had their call bell close to them. This enabled people to call for assistance when needed.

We saw the provider had environmental and equipment checks in place to ensure people's safety. For example, Legionella water testing was completed and there was no presence of bacteria detected. This ensured people were safe from potential infections. Other safety checks included regular fire checks and drills, slings used to move people were checked and checks on utilities in the home, for example, gas appliances.

The chef acted on potential risks to people as they ensured the food was of the correct temperature before serving and fridge and freezer temperatures were monitored daily to ensure food was kept at a safe temperature.

We saw the registered manager had a crisis plan in place which detailed actions staff should take and who to contact in case of an emergency or for example, utility failure. The plan also included details of temporary accommodation arrangements.

Staff had completed safeguarding vulnerable adults training. Staff we spoke with were able to tell us about the different types of abuse and the signs that might indicate abuse. Staff had a clear understanding of their responsibilities to report any concerns and were aware of which outside agencies they could report to as well as their own management team. Staff said, "It's about making sure everyone is safe. I would report any concerns and record them. I would not hesitate in calling the police if I felt it was necessary"; "If I felt someone was not safe or staff were not doing their job properly, I would report it"; "I would report any concerns straight to the senior care worker or the registered manager and also the local safeguarding team if action was not taken" and "It's about safeguarding people from abuse or harm. I have a flow chart to follow when reporting concerns, it is very clear. I would also tell the registered manager immediately and also the provider".

We saw details of who to contact if people had safeguarding concerns were displayed in the corridors. Staff also knew about whistle blowing and said they would not hesitate to report anything if they felt the registered manager or provider was not doing anything about concerns raised. They said they would report their concerns to the local authority and also the Care Quality Commission (CQC). Whistleblowing is where someone can anonymously raise concerns about standards of care. We saw systems were in place to record any safeguarding incidents and the registered manager had reported these to the local safeguarding team and CQC.

People's care plans contained risk assessments which included risks associated with falls; nutrition; pain; and medicines. People's risks were scored to enable the registered manager to identify what support or equipment the person needed. Where risks were identified care plans were in place to ensure risks were managed. For example, where people were in bed and at risk of developing a pressure sore or at risk of not having enough fluids, charts were in place and completed by staff to monitor the person's health. We also saw body maps were completed when people had any marks or wounds. Appropriate equipment was in place to mitigate the risk of pressure sores developing, for example pressure relieving mattresses. This showed the provider recognised how to keep people safe and ensure risks to their health were managed. Risk assessments were regularly reviewed to ensure the measures in place were managing the risk effectively.

Accidents and incidents were recorded and actions to be taken were followed by staff. For example, we saw one person had numerous falls. A referral had been made to the GP and the falls team. As a result a walking frame was provided to the person. Details were recorded of how the injury was sustained, the involvement of health care professionals and the treatment provided. We saw the registered manager reviewed all incidents on a monthly basis to look for themes and took the necessary action to mitigate the incident, for example the provision of specialist equipment.

Arrangements for emergencies were in place. We saw people had individual personal emergency evacuation plans (PEEPs). Details recorded included the mobility needs of individual people at the home and their individual care needs, for example, communication. People who lived at Cherry Tree House Residential Home were involved in these plans. These were easily accessible in case of an emergency and a copy was also held in people's bedrooms. The registered manager told us they were in the process of putting together a 'grab bag' to use in case of emergency, for example with torches and emergency blankets. A map of the home was also available to assist the emergency services when dealing with an emergency. This ensured details were available to emergency staff when needed.

People, relatives and staff told us they felt there were usually enough staff to look after people safely at Cherry Tree House Residential Home. Some people and relatives felt staff were at times rushed. Comments included "Staff are nice, but don't have much time to converse as they have a lot to do"; "Staff come when needed, I don't have to wait" and "There have been a lot of staff changes, but I am happy with the staff at the home. Sometimes they appear to be 'stretched' and busy, but they do make time to talk to mum".

The registered manager told us how they worked with staff when concerns were raised regarding the level of staff. They said they would work with the staff on shift to assist them to look at practices, but if it was identified further staff was required the provider agreed further staff could be called in. They told us they were looking at employing another senior care worker and did bring additional staff in to enable people to be accompanied to go into the local village. We saw a dependency tool was used to assess people's needs to ensure enough staff were available to support people. This dependency tool was reviewed on a monthly basis, but could be reviewed at any time if a staff member had recognised a person's needs had changed.

Records relating to recruitment of staff contained relevant checks that had been completed before staff worked unsupervised in the home to ensure they were of good character. These included employment references and criminal history checks via the Disclosure and Barring Service (DBS). DBS checks enable employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. The staff files we viewed showed that no one had started to work with people until their DBS had been received.

Records showed staff had completed a job application form and we saw there were no gaps in a person's employment record. Interviews had been completed, competency questions were used to assess staff suitability to their role, photographic identification was obtained and health checks were present in staff files.

Safe systems were in place to manage people's medicines. We observed the medication round with the senior care staff member at Cherry Tree House Residential Home. We saw the staff member wore a 'do not disturb' bib to enable them to concentrate on administering people's medicine and to inform people they should not be disturbed. The staff member was diligent and approached people in a calm manner. For example, they encouraged people to take their medicines and were patient, supportive and did not rush people. We saw people's medication administration records (MARs), topical medicine and 'medicine as required' records were completed appropriately. A reducing balance method was used to monitor the quantity of people's medicine was correct once administered. This enabled the staff to identify any discrepancies in quantities and to identify if a medicine had been missed. The medication trolley was stored in a locked room and was secured to a wall. The medicine room had a temperature check and a secure controlled drugs (CD) cupboard. We saw records for people who were prescribed a CD were recorded in detail. We saw daily temperature checks were undertaken of the room and the fridge to ensure people's medication were stored at the right temperature to keep these effective. We saw any returns medicine (when people had not taken their medicines) was managed safely. However, on the day of our inspection we found two envelopes of returned medicine although were sealed and had been signed by the staff, they had not been completed with the name of the person and the date the medicine was not given. The senior care staff member took immediate action and we saw them complete these details. A record of these returned medicines was maintained and signed by the pharmacy when collected. This meant the provider had systems in place to manage people's medicine.

People received their medicine when required in a way which suited their needs. We saw one person who received their medicine covertly. The administration of covert medicine is where the medicine is added to a person's food or drink. We saw the GP had assessed the person's needs and had agreed the person should have their medicine crushed in their food. One staff member told us, "If a person refuses their medicine, I will notify the GP within 48 hours or sooner, depending on the type of medicine". People and relatives comments included, "I have to have my medicine at a specific time and I get it when needed"; "I do my own eye drops but other medicine is given to me by the staff" and "There is no issue with medicine. My mother has it when needed". The professional we spoke with told us they had no concerns about the administration of people's medicine.

The service ensured that people had access to the information they need in a way they can understand it and were complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We saw the provider used a recognised national tool to assess people's pain levels. This was a pictorial card with faces ranging from happy to very sad. We saw staff used this with people which enabled them to evaluate how people were feeling and also how effective the pain relief given had been.

We saw systems were in place to minimise cross infection, for example in the laundry people's clothes were separated into different colour coded bags to ensure soiled clothing was separated from clean clothing. This meant the registered manager and the provider had robust systems in place to keep people safe.

Good

# Is the service effective?

## Our findings

Staff had the skills and knowledge to meet people's needs. Staff had completed training which included moving and handling, safeguarding vulnerable adults, medicine administration, infection control, health and safety, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, equality and diversity and food safety. Staff told us they completed the nationally-recognised Care Certificate course. This was a four day course and included dementia training and specific training, for example in Parkinson's disease. The provider also offered staff training in addition to their core training. The professional we spoke with told us they had recently provided wound training for staff. They said the training was well attended and staff were very responsive to the training. They commented, "Staff are competent, they know what they are doing". The provider told us they had also provided training to staff on the nationally recognised 'Smile for Life programme'. This enabled staff to promote healthy snacking and food choices when assisting people with oral care.

Staff told us they had opportunity to progress within the home. One staff member said, "I am being supported to study at university and I am doing dementia training. I am really pleased as I will be the in-house trainer which is a great development opportunity for me" and "I am going to be studying induction for staff, leadership and management and advanced care planning". This demonstrated staff were supported to develop in their care role at Cherry Trees House Residential Home.

Staff were complimentary about the training provided and were able to request any additional training they felt would improve their skills and knowledge. One staff member commented, "The training is brilliant. Definitely enough training".

New staff completed an induction and were supported by more experienced staff until they felt confident to work alone. Comments from staff included, "The induction is really good. Staff show you and really get you involved and the training is well structured. I shadowed for one week so I could get to know the residents. I read their care plans each day and I would ask people about their care and chat with them so I could get to know them better"; "The induction is very, very good" and "I shadowed a senior care worker to learn and understand my role. My competency was checked, for example to make sure I used the hoist safely". We saw workbooks were completed by staff to assess their competence and to identify where further training was needed.

The provider had systems in place to monitor staff training. The registered manager used a training matrix which showed the type of training, date completed and the renewal date for all staff including management, ancillary and care staff. The registered manager told us how they used feedback from staff to plan further training. For example, they had identified further training was required in management of people's nutrition and falls. Workshops had been arranged and additional hours had been allocated to enable staff to attend. They also told us specific training was being arranged for Parkinson's disease and angina (a heart condition).

We saw communication processes were in place to keep staff up-to-date. Handover meetings took place

between shifts. Details of how each person's health on the day was discussed and what specific support people required. For example, staff discussed individual personal care delivery to people and what activities they had taken part in. Details were recorded in a handover book so that if any staff were unable to be present or wanted to check details, this was available throughout the shift.

Staff felt well supported by the management at Cherry Tree House Residential Home. Staff had regular supervisions every six weeks. We saw a supervision matrix was completed with actual and planned dates. They told us it was an opportunity to discuss any concerns and development needs. Comments from staff included, "Supervision is a two way conversation. We can raise concerns and any issues are dealt with quickly"; "We also have observational supervisions to check our competence" and "Yes we have regular supervisions and annual appraisal".

The Mental Capacity Act 2005 (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). 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 saw people's capacity had been assessed in their care plan. People were supported to make decisions of their day to day care. People's consent was appropriately obtained and recorded. Care plans outlined whether people had capacity to make decisions on care and treatment, and where appropriate, a lasting power of attorney was in place which had been authorised in accordance with the MCA. We looked at people's care files and found records of these were present which meant the provider ensured relatives were acting in accordance with the legal framework of the MCA.

We spoke with staff about their understanding of the MCA. They told us, "Everyone has a right to make their own decisions. We need proof though that they cannot make a decision. But people can make unwise decisions, it's their choice. If I see a person struggling I will tell the senior care staff member. I know a meeting would be arranged with the family and professionals to discuss the case"; "It's about choice, they can have their bath when they want, or choice of food, for example a poached egg, it's their choice"; "You don't restrict people, it's about choice"; "Just because people have dementia it does not mean they cannot make choices, don't assume. It is about the whole person, you need to give them choice, even if they don't have full capacity" and "Keep the person as safe as you can without depriving them. You cannot assume they cannot make a decision. You need to do an assessment to see what decisions they can make".

The management team demonstrated a clear understanding of their responsibilities in relation to MCA and DoLS. DoLS applications had been made to the supervisory body where an assessment had identified the person lacked capacity to consent to the decision. There was a mental capacity assessment which identified the person lacked capacity to understand risks. At the time of the inspection the registered manager was waiting for a decision from the local authority regarding the three referrals they made.

Staff new the importance of equality and diversity for people. One commented, "Everyone is entitled to be themselves. Just because they are different does not mean they don't have the right to be different".

We saw people's care plans included an end of life plan of care and funeral plans. It made reference to completed "do not attempt resuscitation" (DNAR) forms which were in place for individuals. These were located at the front of the person's care file so that details were immediately accessible. We saw these were signed and where people did not have the capacity to make these decisions we saw professionals and staff were involved and had authorised these decisions.

People's opinions of food and drink at the service were mainly positive. Comments received included, "The food is wholesome and it varies at times"; "The food is alright, nicely cooked and I can have a glass of wine at lunchtime if I wish" and "The food is good, we have roast dinners, which is what I like". Relatives commented, "My mother has her food pureed. They keep the items separate and try to make it look nice" and "Food is good. The chef is very good with my mother and regularly comes to see what she would like". We saw the food looked appetising and was well-presented. The professional we spoke with told us "The food is very nice here".

We spoke with the chef at Cherry Tree House Residential Home. They told us how they regularly asked people for comments on the food, this was confirmed when we spoke with staff and people. They told us how they met individual needs. For example, one person liked to have salmon and asparagus instead of fish and chips. We were told and saw there was a four week rolling menu. The menu of the day was displayed around the home. They told us they knew people's specific nutrition needs, likes and dislikes, people's allergies and those who had diabetes or received pureed food. They said, "I get to know people. I have a meeting fortnightly with the deputy manager to look at people's weights and discuss fortifying people's food with double cream, butter or milk powder". They also told us they have a feedback book where people can write comments about the food and care staff will ask people during service. They told us they regularly asked people for feedback and go round after lunch service to ask people what they would like for their supper.

We saw records which showed people's nutrition was monitored. People were regularly weighed to monitor their weight and actions were taken to address any risks.

People were able to have their lunch in a place of their choice, for example, in their own bedroom, a lounge or the dining room. We observed the lunchtime experience for people. There was a good conversation between people and staff. Staff were very caring and knew people's individual needs. The atmosphere was relaxed and quiet. People were mainly independent at lunchtime and did not require assistance. Where people did struggle to eat their food, we saw appropriate equipment was available, for example a plate guard. Staff knew which people required assistance to eat their food. When staff assisted people, they got down to the person's level, were patient, kind and considerate with the person. Staff encouraged people to have their meal. We heard comments included, "Let's have a juice drink" and "You're not hungry? Well let's see what else there is". Staff asked people if they had enjoyed their meal, one said "How is your meal guys?" There was a choice of a hot meal or a salad, a choice of sweets and people could have a choice of drinks, including alcohol.

People had access to health professionals when required. People's care plans showed people had been supported to see health professionals, for example their GP. Relatives told us they were kept informed of any health concerns regarding their family member. The registered manager told us the GP and district nurses attended the home regularly each week to check on people's health and provide continuity of care. A visiting professional told us the GP would regularly do a round with the registered manager or senior care staff member to check on people's health needs.

Good

# Is the service caring?

## Our findings

Relatives told us staff were caring. Comments included, "Carers are absolutely lovely, could not wish for anyone nicer. Everyone is so nice here"; "Care is very good and they are well looked after"; "The staff are all very kind" and "Staff are lovely, all of them". People said, "The staff are nice, I had one staff member to help me with my shower. They were patient with me and nice"; "It's not home, but the staff are good to me overall. They do little things for me, like put some music on and they encourage me to do things"; "The staff member painted my nails for me, they look nice"; "We have a good banter, me and the staff"; "I have nothing to complain about, anything you ask, it gets done" and "The care is very good".

One relative told us when their family member came out of hospital the staff all helped her to settle down again in the home. They said, "It was lovely, one staff member took her for a shower, another staff member got her supper. They looked after her straight away. There were about four care staff helping her in total. They (staff) also visited mum in hospital. It was really nice".

One professional we spoke with said, "It's a good ethos here. They always offer me a cup of tea and it's in a cup and saucer. I know someone whose mother is in here. They (the person) absolutely love it".

Staff knew the people very well and we saw very caring relationships existed between staff and people who live at Cherry Tree House Residential Home. We saw positive interactions between people and staff. Staff were sitting chatting to people. There was a jovial and relaxed atmosphere in the home and people had a banter with the staff. We saw staff were kind, respectful, very attentive and caring toward people.

Care workers told us they felt they were caring towards people. Staff told us, "I always ask the person. I find out what they want"; "I love the people, I like hearing their stories and looking at photographs with them"; "If I can put a smile on someone's face it's all worthwhile"; "Really lovely here, it's homely, everyone seems happy. It's a nice environment for people who live here and work. We (staff) work in their home" and "Its home from home for people and staff are a good team".

One visitor told us "It is very homely here, it is not task orientated, and I would put my name down for here. This is the people's home".

People and their relatives were involved in their care and reviews of their care. We saw care plans were written with the involvement of the person and their relatives. There were care plan agreements in place which people had signed to confirm they had agreed to their care needs. We saw people's consent was obtained before care was provided. Forms were in people's care plans and had been signed by the person or their representative.

People were offered choice, for example, we saw one person who had chosen to have their lunch in their bedroom and at a specific time. This was respected by staff and the chef. The chef told us when it was a person's birthday; they chose the menu for the day. We saw people had the choice of whether to have their name on their bedroom door, this also included people's preferred names. People's comments included "I

prefer dining in my room"; "I have the choice of what time I go to bed and I can stay in bed if I want to"; "If I am tired I can stay in my room. It's nice and a nice view"; "I can get up when I want to and go to bed when I want to"; "My room is nice. I could choose what I brought in with me, all my own things"; "Staff are very polite. They do not rush me and come when I need them" and "They are very pleasant. They always ask me what I want". We saw some people had mobile phones in their bedrooms. This enabled them to maintain relationships which was very important to them and kept them in touch with their families and friends. One staff member said, "It is about choice for the person. You need to give them time, look at their body language. Communication is the big thing".

People's rooms were personalised, they were able to bring in their own furniture and belongings to ensure their room was homely. People told us they were very happy with their bedroom.

People's dignity and privacy was respected. When staff spoke about people they were respectful and they displayed genuine affection. The language used in care plans was respectful. Staff explained how they promoted people's dignity. They said, "It is about what people want, you don't talk over them"; "I had one lady who was poorly, so I made sure the door was closed and curtains were drawn when I assisted her with care" and "Confidentiality is very important. I know not to share any information when I am away from the home".

At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO). This meant they were working in accordance to The Data Protection Act 1998 which requires every organisation that processes personal information to register with the ICO unless they are exempt. This meant the provider understood the requirement to manage people's personal data responsibly and maintain confidentiality.

Staff told us equality and diversity is important. They said, "That's why I am in the job. What matters is what is important to them". We saw one staff member who recognised when one person was not well. We heard them say, "How are you? You look very tired. Would you like to go into bed for a rest?"

We saw people were dressed appropriately for the weather and looked well. This showed staff recognised the importance of people's appearance and to promote their dignity.

Good

# Is the service responsive?

## Our findings

People were assessed prior to moving to the home and assessments were used to develop personalised care plans. The professional we spoke with told us how care plans reflected people's needs and choice. They said, "People do stay in bed, but it's their choice and in the best interest for the person. Staff do encourage people to get up and sit in the chair". People's comments included, "Yes I am involved in my care and reviews" and "I am involved in decisions about my care most of the time". A relative told us "Yes I am involved in writing my mother's care plan. Reviews, not always, but I regularly speak with the staff and the registered manager when I visit".

Staff told us they regularly used care plans to understand people's needs and that these care plans were regularly updated. We saw staff throughout the day updating people's records. For example, following any personal care given or following lunchtime where they recorded what the person had eaten and what they had to drink. One care staff member told us, "Care plans are completed three times a day. This includes details such as, general observations about people's health and mood, conversations had with the person, personal hygiene needs met and what they had eaten". Another care staff member told us, "We check that care plans have been updated after each shift, including nights. We check details of personal care had been delivered, the person's mood and we are aware that this needs to be factual".

Care plans included detailed information relating to people's life histories, what and who was important to them, their likes and dislikes, daily lifestyle and there was a photograph of the person in the front page of the file. Staff told us there was enough information available to them in people's care plans and they regularly used these to look for any changes in people's needs. People's care plans were very well laid out and information was easily accessible. They were very detailed and personalised. For example, one person did not like their fingernails cut. This was detailed including advice for care staff to follow. This also included the involvement of health care professionals. We saw another person had to avoid certain foods and drink due to the medicine they were taking. We saw people had a 'Global Summary' document in their care file. The information enabled staff to know about people's past and tailor people's care to meet their specific needs.

Care plan reviews were done on a monthly basis or earlier, depending on needs of the person. This included reviews of risks and involved people or their relatives as much as possible, who were encouraged to make comments or amendments to the care plan. Risk reviews included the use of bed rails and people's skin integrity. Where people required further support, this was arranged. For example, one person had recently come back from hospital and their mobility needs had changed as they could no longer stand unaided. The registered manager was in the process of reassessing the person and told us they would involve professionals and look at any aids which could be used to support the person to improve their mobility.

The care plans were very well-organised and information was easy to find. We noted that assessments of when the person first arrived were at the front of the care plan and this would potentially be the first set of information care staff would read. This information, although correct at the time of completion, was now outdated and could mislead the care staff as to what the person's abilities and needs were. For example, one person's record said 'Can walk and is independent to go to the toilet'. However, this person now spends

a lot of time in bed and needs a hoist and two care staff to move them. Although care staff knew this person's needs, new staff may not be aware. We spoke with the registered manager and during our inspection they changed the layout of information in people's care plans to ensure the most up-to-date information was at the front. We were aware of one person whose behaviour had at times, become challenging toward staff. However, their 'Global Summary' did not contain the details of this person's behaviour. We raised this with the registered manager and immediately the person's care records were updated. However, all the staff were aware of this person's behaviour.

The professional we spoke with on the day told us staff were very responsive to people's needs. They commented, "Staff are excellent and they make referrals to us when needed. They will do body charts so it is clear to us, for example, where the wound is. They also know how to grade (assess) wounds. They are very good on pressure area care, there are no problems in this home and no (pressure sores) are acquired here. They always call us when needed".

We were told there had not been an activities coordinator for approximately four or five months. Some people and their relatives told us this had impacted on people's ability to engage in their interests. We were aware that a new activities coordinator had just started at the home and there had been positive improvements. Comments included, "Activities are improving and hopefully they will encourage my mother to be more engaged. Stimulation has been missing for people". One staff member said, "Now we have an activities coordinator, we have a better balance back for us as care staff". The registered manager told us a weekly schedule was designed by people at the home and we saw a copy of this. There were varied options of activities for people. We saw a 'pat dog' was visiting the following day of our inspection. A monthly plan was now in place and the activities coordinator worked with people to choose what they wanted to do.

We were told by staff that the activities coordinator will visit people in their bedrooms, engage with them and have a chat. On the day of our inspection we saw daily newspapers were available for people to read. People were busy getting hats ready for a 'mad hatter's tea party' the following weekend. The chef was also making a multi-coloured cake for the event and the registered manager had props ready, for example large playing cards. We heard the registered manager offering one person the option to go to the cinema to see a first world war film which they knew was of interest to this person. The professional we spoke with on the day told us people went out regularly to the village and visited a number of different coffee shops. They said, "People do have activities. I have seen them doing exercises and bingo".

There was a system in place to manage complaints. The registered manager told us and we saw there had been only one complaint over the last year. We saw this had been dealt with and recorded appropriately, including the outcome of the complaint. Relatives told us they had not made a complaint but told us they would raise any concerns with the registered manager and were confident they would be addressed promptly. Relatives told us, "I have no concerns or complaints" and "I have no concerns. Mum is the type who would tell me if anything was wrong. I have no concerns at all". There were many compliments about the service and the caring nature of care staff.

Staff told us they knew how to handle any concerns or complaints. They said there was a complaints procedure to follow which including different methods of making a complaint, for example by email or the option to speak directly to the registered manager.

Good

# Is the service well-led?

## Our findings

The leadership and management that we saw on the day of the inspection demonstrated an open approach and supportive culture that encouraged good care and team spirit.

The registered manager told us they had introduced 'champion' roles for staff. To date they had a senior care staff member as their dementia lead and the registered manager said other care staff were happy to take on these roles, for example, dignity and respect champion. They said this would improve learning for staff and provide clarity of staff roles at Cherry Tree House Residential Home.

Relatives', visitors' and people's comments on the workplace culture included, "There is an open culture. You can approach anyone at any time"; "A good culture starts at the top and goes down to all staff"; "The registered manager is always about. They talk to people and we can contact her, no problem. I know she (the registered manager) is there"; "The registered manager is really very good"; "The staff are very good. All are really nice here. There is a housekeeper and chef and this makes it so much better for all staff"; "The home is very well-run"; "The Wi-Fi was broken recently, but the registered manager got this sorted quickly. They are doing things right"; "The registered manager has worked really hard for me when I came back from hospital" and "The owners visit three or four times a week and they join in staff meetings". This was confirmed when we spoke with the provider.

The registered manager told us they believed an open culture was essential. They said, "We have an open culture. We say sorry and say it as it is". They told us they have a system in place called 'Like and Admire'. This is where staff completes information about each other. They say why they are in the job and what is important to them in their work. The registered manager said this was going to be shared with people at Cherry Tree House Residential Home so that people can look at the comments. The registered manager said, "The benefits are that staff value each other more, maintains a transparent culture and makes everyone feel valued as an individual. If you create this, it goes toward good staff retention as staff feel valued.

We saw communication was good between families and the home. For example, the provider told us how they would regularly speak with people who lived at the home and staff. They said, "There is an open phone line for people and staff to contact me. I carry out the registered manager's supervision and I have an overview of the audits at the home. I meet fortnightly with the registered manager. These are formal meetings and we discuss how the home is running, staffing for example. These meetings are minuted and a report is produced by the registered manager". They also told us they had informal meetings daily. We saw both the minutes of these meetings and the report. Actions were taken following these meetings to address any concerns or make improvements. The provider added, "We want Cherry Tree House Residential Home to be an outstanding home for local people. We will look at other homes' practices to see what they do and share information to make improvements".

Other forms of communication options were available for people and their visitors to complete. For example, a kitchen feedback book and activities feedback book. These had been received positively and the

people were able to make suggestions and request changes.

Staff told us they were well-supported by the registered manager and the provider. They said, "I have really good support to do my role"; "There is great support here at any time. You can ask the registered manager or any staff member for help"; "It is a good place to work. We are all definitely supported"; "I have regular catch up meetings with the registered manager daily" and "We get support from both the management and all the staff. Everyone is willing to help".

We saw regular residents' meetings took place. People were able to raise any issues or suggestions with the management team. We saw the topics of discussion included meals, forthcoming trips, for example a boat trip in Henley on Thames and laundry provision. Minutes showed people were able to make comments or raise questions or concerns. One person said, "We have residents' meetings so we can bring up any problems". We saw meetings were planned in advance and dates were displayed in the home to enable people to attend.

Regular staff meetings took place at the home. These included senior care staff meetings, care staff meetings and kitchen staff meetings. Minutes showed that staff were able to raise any concerns. We saw that topics included care plan writing, the use of the pain management cards, training workshops available to staff, how staff communication had improved and problems with the piloted laundry system. One staff member commented, "We have a staff meeting monthly, have the opportunity to raise concerns or questions. Our opinions are valued".

Comments about the overall management of the service included, "The management is very good. I am very happy with all the care team, especially the registered manager"; "The registered manager has been like a sister to me. They have supported me very well when things have been difficult"; "The service is well-managed. The registered manager has good leadership and heads the team of care staff well"; "It is a lovely home. The only home I would put my loved one in"; "The home is always clean, including the bathrooms"; "Registered manager is very good, very helpful, always has time for me. There for you and will stop and listen to me" and "They are supportive, call me when necessary and respect my choice to be called".

Staff said "I love it here"; "The registered manager is really great, everyone respects her. We are all happy here"; "It's a pleasure to come to work"; "It is a very friendly place to work, relaxed atmosphere, people are well looked after and they are happy" and "Well managed, yes. Registered manager is more than happy to help on the floor. Open culture, everyone gets on well and work together as a team. I enjoy coming to work".

People, relatives and staff told us they were very happy with the service at the home. They said there was very little needed to make improvements and nothing the service could do better. One relative said, "I am looking forward to my mother getting back to their routine of watching the television and reading a book and staff encouraging this".

Providers are required to comply with the duty of candour regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity.

At the time of the inspection, the service had an appropriate duty of candour policy. The document provided clear steps for the management to follow if the duty of candour requirement was triggered. The registered

manager demonstrated a good understanding of the duty of candour. They commented, "We need to be transparent, don't hide anything and enable people to express concerns. We look at how we handled any concerns, what we have done about it and the way we respond to people. It is a happy home with a happy culture".

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The provider was aware of their responsibilities and had systems in place to report appropriately to CQC about notifiable events.

Systems were in place to monitor the quality of the service. Audits were carried out and included audits of: bruises and blemishes; call bells; medicines; infection control and care plan audits. Where improvements were needed, actions were taken to address these including a 'root cause analysis' of the process failure. These audits were reviewed by the registered manager and the provider. This ensured the quality of care was maintained and improved. We viewed the audits which had taken place of medicines and fire checks and found them to be regularly reviewed.

People and their relatives were encouraged to feedback about the quality of the service. People and relatives told us there were asked for feedback and regularly had access to the registered manager to share this feedback, both formally and informally. We saw the results of both residents' and staff surveys from April 2017. We saw the residents' survey consistently showed people were happy with the service as they scored over 80% for most areas. Where comments were received regarding improvements for the service, these were actioned. For example, there were changes to the activities and menu choices. The staff survey showed a satisfaction rate of between 90 and 100%.

We saw the registered manager worked in partnership with other organisations. We saw the local authority had visited and improvements had been identified. For example, care plans had been reviewed and suggestions regarding changes and improvements had been actioned by the registered manager. We spoke with the local authority representative and they were very positive about the management at the home and how proactive and receptive the registered manager was. We also saw a recent independent pharmacy inspection had taken place. Minor improvements had been identified and actions taken, for example, the medicine storage room cleanliness and room temperature checks.

The service had a positive culture that was open and honest. Throughout our visit management and staff were keen to demonstrate their practices and gave unlimited access to documents and records.