ADL Plc

Cherry Tree House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Cherry Tree House is a residential care home providing personal care for up to 34 older people who may be living with a physical disability or dementia. On the first day of our inspection 21 people were using the service; by the last day of our inspection 15 people were using the service.

People's experience of using this service and what we found
People were at risk of harm because the provider had failed to adequately assess and manage risks. Concerns identified at our last inspection had not been addressed, putting people at continued risk of receiving ineffective or unsafe care.

The provider had not ensured people's medicines were managed and administered safely. Infection prevention and control risks were not effectively identified and managed. Concerns relating to the environment and fire safety risks had not been properly assessed. People's care plans and risk assessments did not always provide enough information about their needs, risks to their safety or provide guidance to staff on how to safely support them. Robust systems were not in place to monitor and make sure people's needs were met.

Sufficient numbers of suitably qualified and competent staff were not deployed to safely meet people's needs. We observed numerous practice issues in relation to staff's use of personal protective equipment, moving and handling practices and the support provided with people's medicines. The provider did not have a robust system in place to ensure staff were suitably trained and to identify and address practice issues. Good practice guidance was not always followed.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The provider had not acted to prevent people being unlawfully deprived of their liberty.

Whilst the new manager began addressing our concerns and made some improvements during the course of our inspection, this was reactive rather than proactive management. Overall, the service was not well-led. The provider did not have a robust system of audits to oversee and ensure the service was safe. They had not taken sufficient and timely action to address known issues and risks. They had not met the requirements of CQC's warning notices and put people in their care at ongoing risk of harm by their failure to act.

For more details, please see the full report which is on the Care Quality Commission's (CQC) website at www.cqc.org.uk.

Rating at last inspection and update

The last rating for this service was inadequate (published 23 December 2021) and there were multiple breaches of regulation.

At this inspection we found the provider remained in breach of regulations and rated inadequate overall. This service has been rated inadequate or requires improvement for the last three consecutive inspections.

Why we inspected
We carried out an unannounced focussed inspection of this service on 18 and 19 August 2021. Breaches of legal requirements were found, and we issued two Warning Notices in relation to Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This focussed inspection was carried out to follow up on action we told the provider to take and to check whether the provider had met the requirements of these Warning Notices.

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

This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained the same. This is based on the findings at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to 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 identified breaches in relation to providing safe care, safeguarding people from abuse and improper treatment, staffing and the provider's governance and oversight of the service.

Since the last inspection we recognised the provider had also failed to adequately display their rating on their public website in line with relevant legislation. This was a breach of regulation.

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will

return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service remains 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Cherry Tree House

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.

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

Inspection team
The inspection was completed by three 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.

Service and service type
Cherry Tree House 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 CQC. A registered manager along with the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The service had been without a registered manager since 26 October 2021. A new manager started at the service on 29 November 2021, but they had not applied to become the registered manager.

Notice of inspection
Our inspection site visits were unannounced.

What we did before the inspection
We reviewed information we received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used information the provider sent us in

the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and two relatives about their experience of the care provided. We spoke with three professionals who regularly visit the service. We spoke with 10 members of staff including the manager, deputy manager, seniors, carers, and the cook. We also spoke to a director working for the provider and the provider's nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of other records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found and seek assurances about risks.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection risks were not always effectively managed. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People were at risk of harm, because risks were not always quickly identified or appropriately managed.
- Action had not been taken to assess and manage risks relating to the environment. For example, risks relating to window safety had not been effectively monitored and managed.
- Fire safety risks had not been effectively assessed and managed. We sought urgent assurances from the provider and shared our concerns with Humberside Fire and Rescue Service.
- Care plans and risk assessments did not always contain enough information or provide guidance for staff on how to safely support people.
- Robust systems were not in place to monitor and make sure people's needs were met. For example, monitoring charts were not always used effectively to help make sure people were supported to regularly change their position to reduce the risk of developing skin damage.
- Staff recorded accidents and incidents that occurred, but robust systems were not in place to ensure these records were reviewed and action taken in a timely way to help prevent a similar thing happening again.

The failure to assess and manage risks was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Whilst the new manager began acting to address these concerns, sustained improvements were needed before we could be assured people would receive consistently safe and effective care.
- At our last inspection site visit, the provider had taken some action to address our concerns about fire safety. Staff had received training and simulated evacuations had been completed to check and make sure staff could safely evacuate people in an emergency.

Using medicines safely

At our last inspection medicines were not managed and administered safely. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

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

● People were at increased risk of harm as safe systems were not in place to monitor and make sure they received their medicines as prescribed.
● Records did not always provide a clear and complete account of the support provided with people's medicines.
● There was a risk people would be exposed to potentially harmful allergens as clear information was not always recorded about people's medicine allergies.
● Where people were prescribed 'as required' medicines, clear guidance was not always provided to help make sure staff administered the right dose of people's medicines at the right time.
● Robust systems were not in place to monitor medicines in stock and those administered; this meant we could not be certain people had not been overdosed or missed doses of prescribed medicines.

The failure to ensure the safe management and administration of people's medicines was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection infection prevention and control risks were not effectively managed. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People were at increased risk of catching and spreading COVID-19, because the provider did not always follow good practice government guidance to minimise risks.
● Staff did not always use personal protective equipment appropriately to keep them and the people they supported safe.
● A robust system was not in place to make sure staff completed regular COVID-19 tests in line with government guidance.
● Effective systems were not in place to monitor and make sure all areas of the service were regularly and thoroughly cleaned.

The failure to do all that is reasonably practicable to manage and minimise COVID-19 risks was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Whilst some improvements were observed during our fourth inspection site visit, improvements need to be embedded and sustained over time to evidence the service is consistently safe.

Staffing and recruitment

At our last inspection people were at risk of harm, because the provider had not made sure staffing levels

were safe. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18.

● People raised concerns about staffing levels. Comments included. "Staffing levels can be difficult, and it does affect your comfort levels if you are having to wait" and "They [staff] all work so very hard. I think they could do with more staff, then perhaps they would have more time to chat to us."
● The provider did not have a robust and systematic approach to determining safe staffing levels. Staffing levels were not adequately reviewed as occupancy of the service changed to make sure enough staff were deployed to meet people's needs.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to safely recruit new staff. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 19.

● Recruitment checks had been completed to help make sure suitable staff were employed.

Systems and processes to safeguard people from the risk of abuse
● People were at increased risk of harm, because robust systems were not in place to safeguard people who may be vulnerable.
● Not all staff had completed safeguarding training to support them to identify and report allegations of abuse or neglect.
● Robust and timely action had not always been taken in response to issues and concerns.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At our last inspection we recommended the provider adopt best practice guidance around reviewing the knowledge, skills and competencies of staff responsible for administering medicines. The provider had not adequately addressed this recommendation at this inspection.

- People were at risk of receiving ineffective or unsafe care. The provider had not taken adequate steps to ensure all staff were suitably trained, skilled and competent to meet people's need.
- There were widespread concerns about staff's practice relating to the safe management of people's medicines. Staff who had been trained and competency checked to administer medicines, did not have the necessary skills and knowledge to support people safely.
- Records did not show all new staff received a thorough induction to the service or appropriate monitoring and training before they started work.
- Staff had not completed important training relevant to the needs of the people they supported. For example, one person required support with catheter care, but staff had not received formal training to do this. Other people had diabetes or were receiving end of life care, but staff had not received training in these areas.
- Staff did not always follow good practice guidance putting people at risk of harm.

The failure to make sure sufficient numbers of suitably qualified and competent staff were deployed was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

● Applications had not been submitted in a timely way to prevent people being unlawfully deprived of their liberty.
● The provider had not taken appropriate steps to make sure conditions on people's DoLS authorisations had been met.

The failure to ensure people were lawfully deprived of their liberty 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.

● People's ability to consent to their care and support was not always appropriately recorded. This meant we could not be certain people's human rights were protected.

We recommend the provider review good practice guidance relating to the MCA.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were at increased risk of receiving ineffective or unsafe care. Care plans and risk assessments did not always contain detailed and relevant information about people's needs or to guide staff on how those needs should be met.
● Robust systems were not in place to monitor and make sure people's needs had been met. For example, food and fluid charts were not always used effectively to monitor what people at risk of malnutrition or dehydration ate and drank. Whilst the manager responded to our feedback and began acting to address these concerns, further sustained improvements were needed to ensure effective systems were in place to meet people's needs.
● Professionals gave mixed feedback about the support staff provided for people to access healthcare services.

Supporting people to eat and drink enough to maintain a balanced diet
● People gave generally positive feedback about the quality of the food available, but told us there was not always a choice of what to eat at mealtimes.
● People were not always offered choices at mealtimes, and records did not always show staff offered and encouraged people to have regular drinks and snacks throughout the day.
● Whilst the manager responded to our feedback and began acting to address these concerns, further sustained improvements were needed to ensure effective systems were in place to meet people's needs.
● The provider told us an external company would be providing the meals in future which would ensure people had more choice at mealtimes.

Adapting service, design, decoration to meet people's needs
● The provider had not fully considered people's needs in the way the building was adapted and used. Environmental risks, for example, relating to stairs or unrestricted access to windows, had not been managed.
● Some areas of the service had been decorated. A professional explained, "They have started decorating the place, so it is looking a bit nicer. There are still cosmetic updates that can be done, but it's an old

building and it takes time to spruce things up."

● The service supported a number of people with cognitive impairments or dementia, but there was limited use of 'dementia friendly' design principles.

We recommend the provider reviews good practice guidance in designing, adapting and decorating the service to meet people's needs.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to adequately monitor and improve the quality and safety of the service, and to keep accurate and contemporaneous records. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People were at risk of harm, because the service was not well-led.
- The provider had failed to address significant and widespread concerns identified at our last inspection of the service. This put people in their care at continued risk of harm.
- Known risk relating to the safety of the home environment, infection prevention control risks, fire safety risks and problems with the management of people's medicines had not been adequately addressed by the provider.
- Whilst the new manager acted to make some improvements during our inspection, this was reactive to our feedback rather than proactively driven by the provider.
- The provider had failed to adequately support and supervise the new manager to help ensure necessary improvements were made in a timely way.
- There was a lack of transparency about how risks and issues were managed. Complete, accurate and contemporaneous records were not always available or shared with CQC.
- The provider did not have a robust system of audits to monitor quality and safety issues and drive improvements. This meant we could not be certain issues and risks would be identified and addressed without CQC's interventions.
- This was the third consecutive inspection where the service had been rated inadequate or requires improvement overall and there were multiple continued breaches of regulations. This showed a systematic failure in the provider's organisation and leadership of the service.

The failure to assess, monitor and mitigate risks and take adequate steps to improve the quality and safety of the service was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider did not engage in a proactive way to make improvements to address known risks.
- Good practice guidance, for example in relation to COVID-19, had not always been followed.

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

- The provider understood their duty of candour responsibilities, including to apologise to people if things when wrong.