London And Manchester Healthcare (Romiley) Ltd

Cherry Tree House

Inspection report

167 Compstall Road
Romiley
Stockport
Cheshire
SK6 4JA

Tel: 01614496220
Website: www.lmhealthcare.co.uk

Date of inspection visit:
11 May 2016
12 May 2016
16 May 2016

Date of publication:
08 October 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 11, 12 and 16 May 2016. Our visit on the 11 May was unannounced.

Our inspection was brought forward because we had received concerns relating to staffing levels and the high number of safeguarding alerts raised with the local authority by health and social care professionals.

When we previously inspected this location in December 2015, we identified seven breaches of the Health and Social Care Act Regulated activities 2008 (Regulated Activities) Regulations 2014. We found systems to monitor the quality of care were lacking; consent was not always sought; care plans were not reviewed regularly and did not identify how risks would be managed; there were insufficient staff who had not been recruited safely or provided with adequate supervision, and medicines were not properly managed. During this inspection we found that there had been improvement in some areas but we found further issues of concern and further improvements were still needed.

When we visited the service there was no registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service had recruited a new manager, who was present throughout the inspection, and informed us that she had begun the process of registration.

Cherry Tree House is a purpose built three-storey care home owned by London and Manchester Healthcare (Romiley) Ltd. It provides nursing care for up to 81 people. Accommodation is provided across three units. Bramhall Unit, situated on the ground floor, and Romiley Unit, on the third floor, catered for people who needed nursing care. Marple unit, which predominantly supported people living with dementia, was situated on the first floor. All bedrooms are single occupancy with ensuite toilet and shower facilities. The home has a secure garden and off road parking is provided. There were 56 people living in Cherry Tree House at the time of our visit.

We identified multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, of which some were continued breaches of regulations following our inspection in December 2015. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

There had been a high number of safeguarding concerns investigated by the local authority, and we found that staff did not always report issues of concern, leaving people at risk.

There were insufficient numbers of suitably qualified staff to meet the needs of the people who used the service. People told us that at weekends the service was often short staffed, and we saw that during the weekend prior to our inspection only two care staff had been on duty on one of the units.

There had been no staff meetings since our last inspection and staff had not been supervised. One Unit manager told us "Supervision has taken a back seat".

Medicines were not managed effectively. We found numerous recording errors, some medicines out of date, a confusing ordering and storing system, and evidence of missed medicines. Medicines had been lost and consequently not provided. We saw that the home was conducting a review of the medicines procedures and would introduce a new cycle or ordering and dispensing stock.

People told us they enjoyed the food on offer. We saw meals were fresh and looked and smelled appetising.

Fluid and diet charts were not always completed in enough detail to accurately monitor what people were eating and drinking, and advice from nutritionists was not always recorded.

At out last inspection we noticed that people on the Marple unit had not been consulted following a decision to provide only decaffeinated coffee. When we returned this time, they were still denied the choice.

We saw care plans contained numerous errors; notes were inconsistent and did always refer to people's likes and preferences. Information was missing or out of date in some care plans. However we were reassured to see that the service had recognised that the systems in place to record and store information was not fit for purpose and were in the process of implementing a new system.

There were no effective systems in place to identify the risks to people's health, welfare and safety. Where issues had been identified, the steps required to deal with these issues had not been taken.

The service employed activity co-ordinators on each unit who actively engaged with people individually or in groups. There were activities on offer throughout the day to suit peoples tastes, including visiting performers. However, on the second day of our inspection the activity co-ordinator on one unit was absent, and no activity had been arranged.

The premises were kept secure, with keypad entry to each unit. The communal areas and the bedrooms we looked at were clean. Policies and procedures to minimise the risk of infection were followed.

Where people who used the service lacked capacity to consent to care and treatment the appropriate steps were taken to protect their rights.

We saw some good interaction and communication between staff and people who used the service, but not all staff were familiar with the people who used the service and did not spend much time with them. Care was taken to ensure that individual's privacy and dignity was respected.

We saw that the service had a written complaints policy and a procedure which was visible at the entrance to all units. One visiting relative told us that their complaint had been looked into by the service. However, a record of complaints and any actions taken had not been maintained.

The staff we spoke to were confident that the manager was helping to improve the service. We saw that they had begun to implement systems for improving the quality of care.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to

propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

People who used the service were being put at risk because medication was not given safely.

Advice from specialist health care staff was not always recorded or followed.

Staffing levels did not reflect the levels of dependency of people who use the service and there were often staff shortages at weekends.

Safeguarding concerns were not always identified or investigated in a timely manner.

Is the service effective?

Requires Improvement

The service was not always effective.

A large proportion of the staff team were unfamiliar with the people who used the service.

Staff did not have up-to-date training and ongoing planned supervision, but people who used the service felt the staff were skilled.

Care plans did not accurately reflect people's individual health and social care needs. As a result, people did not always receive care that met their personal needs.

People told us they enjoyed the food on offer. We saw meals were fresh and looked and smelled appetising.

Is the service caring?

Requires Improvement

The service was not always caring.

We found that staff's approach to people did not always take their individual needs and preferences into account.

We saw some positive interaction between people and staff, but

staff who were unfamiliar with the people who used the service were unsure how to deliver care in a person centred way.

Staff were polite and courteous.

Is the service responsive?

Requires Improvement 

The service was not always responsive.

We saw that care records did not always reflect up-to-date information for staff to be able to meet people's needs. Information about people's preferences, choices and risks to their care were not recorded.

The service had commissioned a staff survey, but had not sought the views of people who use the service or their relatives.

The service had a written complaints policy, which was on display outside all the units. However, a log of complaints and actions taken in response had not been maintained.

The service employed activity co-ordinators who arranged activities for the people who lived at Cherry tree House

Is the service well-led?

Inadequate 

The service was not well led.

People were put at risk because systems for monitoring quality were not effective.

The culture of the service was not centred on the person.

Morale amongst staff was low.

Cherry Tree House

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.

The inspection took place on 11, 12 and 16 May 2016 and involved one adult social care inspectors and two Specialist Advisors.

Before our inspection we were told that there had been a high number of safeguarding concerns had been brought to our attention. The local authority and health services were sufficiently concerned that they had taken the decision to create a team of health and social care professionals to work with the management and staff of Cherry Tree to try to identify and improve poor practice. For these reasons we brought our inspection forward.

We reviewed the information we held about the service including notifications the provider had sent to us about safeguarding and other significant events. We contacted the local authority safeguarding and commissioning teams. We also noted concerns relating to staffing levels and poor care raised directly to the CQC through our 'share your experience feedback.' This is a web-based form which allows members of the public to inform us of any concerns or compliments they might have about a specific service.

As we had brought forward our inspection we had not requested the service to complete a provider information return (PIR); this is a document that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

During the inspection we observed how staff interacted with people using the service and how care and support was being provided in communal areas. We spoke with seven people who used the service and four visitors. We also spoke to the new manager, all the unit managers and two other members of the management team, three registered nurses and six health care assistants.

We looked at a range of records relating to how the service was managed; these included care records and

records of medicines administered. We also reviewed training records, and examined the rotas for the three weeks prior to our visit.

Inadequate

Is the service safe?

Our findings

There was evidence that people had access to multiple external care agencies, including, District Nurse, Speech and Language Therapists, (SALT), Physiotherapist, Consultant Psychiatrist, General Practitioners (GP). However, the advice provided by these external agencies was not reflected in risk assessments. In one file we saw that following a referral and visit, a physiotherapist provided advice and instruction regarding safe moving and handling. However, the information had not been used to update the care plan, which provided out of date advice on the most appropriate way to support the person. Notes in a third care file recorded 15 falls. The care plan had identified the person as being at risk of falls, but there were no recommended actions to minimise this risk, nor was there any evaluation of the person or situation.

We saw that steps were being taken to monitor risk, for example, when we observed the newly introduced daily seniors meeting it was noted that a person had had a number of falls, and action was taken to seek advice from the GP. However, care plans and risk assessments were not updated to reflect advice and the level of support now required.

The above examples demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider was not taking practical steps to mitigate risks.

We brought our inspection forward partly because we were concerned about the high number of safeguarding alerts raised by the local authority about people who lived at Cherry Tree House. There had been a number of safeguarding alerts raised since December, some of which were subject to police and coroner investigations. Visiting general practitioners had also raised concerns about poor care and treatment at the home. When we spoke to the local authority they informed us that they had investigated and concluded 76 safeguarding referrals between September 2013 and April 2016, of which 46 were substantiated, one partially substantiated, twelve not determined and 17 were not substantiated. A further fourteen allegations of abuse were still under investigation at the time of our inspection.

We saw that the service had a whistle blowing policy but some of the staff we spoke to did not have a clear understanding of whistle blowing, and some told us that they would be hesitant to report any issues of poor practice to their line manager. At the time of our inspection, the home had employed a large number of staff from a sister home who had been asked to work at Cherry Tree House on a temporary basis to allow regular staff time to attend essential training. They disclosed to us that they had witnessed a number of concerns about poor practice. Examples included poor monitoring of diet, people being left sitting in poor postural positions, unsafe and faulty equipment being used and urine bottles being left on tables. One person told us that they had witnessed a person who used the service struggling to walk up a corridor. The person asked a member of staff for help, only to be told 'Oh, you don't want to walk up there, it'll only tire you out', before the care worker walked on without providing assistance, and another incident where a member of staff had been seen pushing pieces of banana into people's mouths. We asked if they had reported these to the manager, and were told that they were reluctant, as they believed that they might also be incriminated or that the concerns could not be substantiated, as it was one word against another, and felt that they would not be believed. On reflection, however they agreed to speak with the manager. If staff are reluctant to

report poor practice there is a danger that unsafe or unprofessional conduct will be condoned.

When we spoke to the manager about this she assured us that she would look into all the concerns and investigate any specific issues raised. We saw evidence that on one occasion an issue of poor practice had been brought to the attention of the management team and was fully investigated, with proportionate disciplinary action being taken.

When we spoke to care staff they demonstrated a general understanding of issues relating to safeguarding and were able to describe different forms of abuse including physical, psychological and financial abuse. They understood that they were required to report to senior staff or managers any clear episodes of abuse they may be aware of or witness. Two care workers told us that they had raised concerns about poor practice to their line manager and that they have now been dealt with. When we checked we saw that this incident had not been reported to the relevant authorities for over two months. The staff who reported the incident said that they had made the manager aware at the time of the incident, but no action was taken. Without appropriate and prompt action, vulnerable people could be placed at risk of harm.

Moreover, safeguarding concerns had not always been identified by care staff. For example, one relative we spoke to told us that they had made a complaint when they discovered that their relative had been left in a chair until 11:00pm, when the care plan stated they go to bed at 8:00pm. They were assured it would not happen again, but shortly after the person was left once more. The person attempted to walk to their room and fell. It was unclear how long this person had been left on the floor. Neither incident was raised by the service as a safeguarding alert, but the relative informed the local authority who commissioned the care. The local authority completed a safeguarding investigation and substantiated the allegation.

The above examples demonstrate a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Service users must be protected from abuse and improper treatment.

We were made aware that one person who used the service, whilst not requiring one to one observation had safety observation checks on a half hourly basis. A chart provided a tick check of when the observations were made. We saw that people who stayed in their rooms for the majority of the day, for example, if they were on bed rest, were checked on a regular basis.

We observed that those people who were physical able, were free to move around the home unimpeded and we did not see any restraint techniques being used. We asked staff about any training they may have received around the use of restraint. One described having been taught moving or restraining techniques that were safe and minimised risk of harm if required – citing they had received 'Citrus'' (Creative Intervention Training in Response to Untoward Situations) training. A second care worker seemed unclear about safer restraining techniques and stated they (staff) were not allowed to restrain people.

One person told us they had reported to a previous manager that for safety reasons they felt that there should be oxygen and a defibrillator on the unit. She reported that her manager replied, "If they need oxygen, they need an ambulance." The nurse stated, "It strikes me as basic safety." When asked they told us that managers did not take the issue further. We raised this with the current manager who agreed to look into the need to have this equipment.

When we spoke with staff who were relatively new to the service they reported further concerns. For example, one member of staff told us they had wanted to help a person get out of a chair, and asked to use the standing aid. They were told by regular staff that the unit did not have one, but they later found the

equipment in a store cupboard. This person also told us that that they had observed staff using a toilet sling to hoist a person who used the service from a chair, and when they asked why a toilet sling was being used the staff they spoke with reported that they did not know where the appropriate slings were kept. This member of staff had then located them.

When we examined the rota we saw that a range of staff were deployed across all three units. Unit managers were trained nurses who worked in supervisory and managerial roles. Prior to our inspection unit managers had worked office hours, but the manager informed us that this meant that there was no senior cover at other times. New rotas reflected a change in working patterns for unit managers who had started to work during the evenings and at weekends on a rolling basis. This ensured that there was management cover throughout all waking hours.

A registered nurse was rostered to work each shift, and there would be four care assistants deployed on each unit. Additionally each unit employed an activity co-ordinator (one full time and two worked 24 hours each week); and on Bramhall unit 'hostesses' were employed from early morning to after lunch to assist with meals. Reception, domestic, laundry, maintenance and kitchen staff were employed across the service.

One Nurse told us that the managers always try to cover staff shortages and that there were "more or less trained agency staff every night."

The rotas confirmed a heavy reliance on agency workers; for example, when we looked at the previous weeks' rota for Marple Unit, three of the six nurses on duty during the day were agency, and only one night nurse had a permanent contract. This meant four different agency staff were being used to cover the remaining night time shifts. There was a greater level of consistency with care assistants but a full week rota still required the addition of agency staff for day and night shifts. The rotas for both Romiley and Marple units demonstrated a similar use of agency staff. Agency staff are not employed by the service but work through an agency and subsequently did not always know the service or the people who lived in the home, for example one nurse on the first day of our inspection informed us that this was the first day she had worked at the service, and did not know the people who lived there. The manager recognised use of agency staff can lead to a lack of consistency, and was trying to counter this by block booking individual agency staff, and we saw that two agency staff had been offered regular hours on a two to three month basis.

On the days of our inspection there were sufficient numbers of care staff on duty to safely meet people's needs. We were informed that twenty-seven care staff had been seconded from a sister home nearby, which was currently closed, and had been brought in to support the regular staff whilst the regular staff underwent essential training. We were told by the manager that staff from the sister home had started at Cherry Tree House the previous week and they had spent their first week as 'observers,' where they were given the chance to get to know the service and the people who lived there. The staff we spoke with disputed this and said that they had been expected to work with people who used the service immediately. One told us, "We were brought in to make up the numbers."

This led to an unstable staffing mix. For example, on the first day of our inspection the staff team on Marple unit consisted of one longer serving Cherry Tree staff member; recently seconded staff from the sister care home, including the temporary unit manager; a qualified agency nurse, who told us they had never worked at Cherry Tree previously and another other agency care staff. Across all units we saw an 'us and them' demarcation between staff; regular staff resented being told what to do by the staff who had been brought in to provide support, and seconded staff were critical of the quality of care provided. One care worker said to us: "I was annoyed with the [seconded] staff this morning because they just stood about and I told them they should be sitting and talking to some of the residents", whilst seconded workers told us they had not

been given any specific duties, or access to any care plans. They said that they had been told, "There's no point in looking at care plans they won't tell you anything." This led to a disjointed and reactive delivery of care rather than a proactive approach to meeting needs. There was a lack of collective working, some frustration amongst staff and no clear lines of individual accountability or responsibility.

One person who used the service told us: "I love it here; I just wish they had more staff". When we spoke to the current manager, she recognised that staffing was an issue, and that historically the service had been unable to recruit and retain staff. We saw that attempts were being made to seek new staff, and interviews were taking place on the days of our inspection for both nurses and care assistants. A unit manager identified staffing as the biggest problem on their unit, stating that the workload was heavy, and people would not stay. She explained that this had led to a dropping of morale, people leave and so morale drops further, staff call in sick and this leaves gaps in the off duty rota.

This view was echoed by the staff we spoke to. We asked if they felt there were enough staff, and one nurse told us: "To meet basic needs, yes. To give more detailed care, no". A care worker replied, "If I'm honest, no. Especially not at weekends. Last weekend was horrible." The staff member went on to explain about how the unit they worked on was left with only two staff. They informed us "I told the Nurse on duty I was going to go [walk out] but I didn't because of the residents. Who's going to be there for them? I felt it was hard and felt the residents were being neglected. I could only give basic care." This person informed us that they were handing in their notice, stating, "I've had stressful jobs before but this is the worst".

We checked the duty rota which confirmed that there had only been two members of care staff on duty on that unit. When we spoke to a visiting relative about this, we were told that their relative had said that on the previous Saturday there had only been two staff on duty and that they had been in bed all day. This person believed that it was easier for staff to have their relative in bed all day.

The staff we spoke to told us about recent shortages at weekends and said that there had been a lot of staff sickness, which meant that they were only able to meet the basic needs of people who used the service. They said that outstanding shifts were not always covered; although attempts to find cover were made these did not always materialise. Staff were unsure of staff to resident ratios required on each shift, but one unit manager we spoke to informed us that they had completed a dependency level assessment. However, this had not been used to calculate the number of staff needed. This person informed us that the majority of people on that unit required assistance of two people with all activities of daily living and personal care, and were unable to move about independently. They believed a minimum of six carers would allow for safe moving and handling and providing a presence on the floor at all times. They also felt that the current level of two people at night did not provide enough cover: due to the number of people who required assistance of two people, this meant they could not respond to a second person if they were already called to assist someone who required help

The above examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Sufficient numbers of suitably qualified competent skilled and experienced persons must be deployed.

We saw that trained nurses were responsible for dispensing medicines. This took up a large proportion of their time, which meant that whilst they were administering medicines they were unable to provide direct nursing care.

Medicines were kept in a locked clinic on each unit when not in use. Although secure, we saw that the clinic room on Romiley unit was disorganised and dirty on the first day of our visit, with working surfaces littered

with files and documents. This meant there was nowhere to put medicines when organising the medicines round, so they were placed in the sink. We asked the unit manager to tidy the room, and when we returned this had been done.

Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These are called 'controlled drugs'. We saw that controlled drugs were stored securely in a locked cupboard bolted to a wall. All controlled drugs were counted, and we checked that the number of tablets tallied with the number recorded in the records.

The medicines trolley was locked when not in use but there was no facility to attach it securely to the wall. This would have strengthened the security of all medicines stored on the trolley. Similarly, we found the medicines fridge was not locked. We saw that the fridge and room temperatures were checked and logged but these had missing dates and signatures. There were guidelines on display showing the ideal temperatures. If medicines are stored at the wrong temperature they can lose their potency and become ineffective. However, when asked, one of the nurses was unable to say the correct temperature at which medicines should be stored.
In the clinic on Romiley Unit there was a hand wash soap dispenser, but when we checked this was empty, and there was no alternative provided. This meant that staff using the clinic would be unable to properly wash their hands whilst dealing with medicines.

We saw that there was a 'Destroyed & Returned medication book' in place. This is used to record any medicines which are no longer viable and can be returned to the pharmacist for appropriate and safe disposal.

Medicines Management Guidelines and procedures to administer PRN medicines (medicines required on an ad hoc basis or 'as needed') were clearly displayed on the wall of the clinic, and there was a BNF (British National Formulary) available, but this was not the most current version. The BNF lists all medicines and includes their effects and any side effects and warnings. We also saw that there was a blood pressure machine, blood glucose monitoring equipment, and other clinical equipment such as thermometers, but there was no evidence of regular testing or calibration.

We saw that liquid medicines had been labelled with date they were opened. However not all medicines were stored within the appropriate shelf life, as we found a bottle of eye drops and a batch of pain relieving medicine patches which were out of date. This meant that they may no longer be effective.

We were shown a medication administration record (MAR) for one person which showed that ear drops provided by a relative were administered on a nightly basis but these had not been prescribed by a trained medical practitioner. MAR charts are a formal record of medicines prescribed by a registered health clinician and record when they are given. They provide all information about the person's current prescription, including dose, formulation (i.e. whether in tablet or liquid form) and time of administration. In this instance, the general practitioner (GP) had not prescribed the eardrops and the staff were unable to say if they were appropriate or necessary for the person. We were informed that the nurse administered the drops at the request of the person's family, but there had been no assessment of need, or to determine if the drops were safe for the person. The member of the management team who showed us this record agreed that they would investigate this issue.

We spoke with nurses about administration of medicines, and observed part of the morning medication rounds on Romiley Unit. We saw that the nurse followed safe administration procedures with regard to dispensing and administering medicines to people who used the service. The nurse had been seconded

from the sister home just three days before and was unfamiliar with the needs of the people who used the service. She informed us that she believed the medicines round was very time consuming, and we saw that it took over an hour to complete the morning medicines on this one unit.

Medicines were dispensed from a lockable trolley, but this was not at all well organised. Half of all tablets were in monitored dose cartridges supplied by the pharmacist, whilst the rest were stored individually in named boxes stored in the doors of the trolley. Up to 20 boxes of varying medicines were stored on each shelf. There was no labelling system. We saw the nurse spent a lot of time searching for the right medicines and on one occasion could not find what she was looking for so she had to interrupt her round to go and ask another nurse. The nurse ensured the trolley was locked, to prevent any unauthorised access.

We looked at the medicine administration records (MAR) for six people who received medicines. MAR sheets we looked at showed medicines received from the pharmacy were booked in and logged onto the MAR sheet. They included a current photograph of the person for identification, records of any allergies and protocols for people who needed medicines 'as required', all of which provide positive supports to safe medicines management records. We also saw charts for blood glucose levels for a person receiving diabetic medicines, and where a person on Romiley Unit was receiving warfarin we saw faxed blood results were in place within the MAR sheet, alongside the prescribed dose. However, the administering system was not clear as there were no specific dates attached to the daily dose required. The nurse reported that there was no specific individualised care plans in place regarding warfarin, nor were we able to find any.

On three of the MAR sheets we looked at some signatures were missing. This could mean either that the medicines were overlooked or the person administering the medicine had neglected to sign to say they had been given. We saw that that each sheet included a code, with 'R' as code for refused. This code had an instruction on the MARs to list the reason for refusal on the back of the sheet, but this had not been done. We saw on one MAR sheet that a person had consistently refused a specific medicine. The nurse told us that they had made the GP aware but we were unable to find any evidence of this or that staff had considered monitoring any effects of consistently refusing to take the medicine.

Topical creams were signed with an (O) meaning 'Other'. When we enquired about this, the nurse explained that creams were kept in the person's rooms and applied by healthcare assistants. They stated that this was verified verbally with carers on a daily basis. When we asked if the creams were applied every day, the Nurse replied, "Should be". It was not clear if these creams had been applied, or if they had been applied in the correct manner.

We asked the provider for copies of any medicines audits for the previous six months. These showed that audits had been completed in December 2015, January 2016 and February 2016 and all showed numerous and consistent errors, some of which matched our findings. For example, random checks of medicines administered did not tally with the quantity of tablets remaining. This meant that it could not be determined if the person had taken the medicines or not. Administration records had not been signed, so it was unclear who had given the medicines. People were offered medicines such as paracetamol on an 'as required basis' with no medical instruction. Bottles of liquid medicines opened but with no date to say when they were opened, it is important to record when a bottle is opened as once opened the medicine can lose its potency and become ineffective. When we checked liquid medicines we saw that they had been labelled with the date they had been opened. However, not all medicines were stored within the appropriate shelf life. We found a bottle of eye drops and a batch of pain relieving patches, which were out of date.

The home had not conducted any further audits after February 2016. However due to the number of concerns raised with the local authority and Health Care Clinical Commissioning team (CCG), a Rapid Action

Team was put into place in March 2016 to support the staff and management to resolve ongoing issues and improve the quality of service delivery. This included a full and comprehensive review of all medicines procedures, which was being overseen by the Stockport CCG clinical lead for nursing homes. This person advised us that their review of the medicines process had uncovered a number of the issues we saw. For example, some people who used the service had not been given their medicines and the reason given for this was 'unable to find' or 'out of stock'. One person had not received a specific medicine for 15 consecutive days. The omission was noted on the MAR chart with a comment "not available", and on checking the CCG nurse was able to find a full blister pack of medicines in the returns medication bin. We were further concerned that, once the medicine was noticed to be missing, nobody had taken responsibility for either finding the missing tablets or requesting a repeat prescription.

The CCG have provided an action plan to minimise any further errors. For example, we were told that the system for ordering medicines had been erratic, people would run out of medicines 'mid cycle'. This led to stock being provided in a number of formats rather than the normal controlled dose dispensing system. Stock would go missing and then there would be an excess stock. In order to avoid this risk all units were to begin a new cycle of medicine ordering and delivery. This would mean that each person requiring medicines would be starting any repeat prescriptions on the same day, and stock could be ordered simultaneously, thus reducing the risk of different formats. The manager informed us that this new cycle was to begin the week following our inspection. The manager agreed that there had been too many medicine errors and showed us plans to audit all aspects of medicine management some on a daily basis whilst others would be on a weekly basis. She told us she had arranged a weekly visit with one of the GPs to review all the patients' medical and nursing needs. We spoke to the GP who confirmed that this was the case. The manager was hoping to establish a similar relationship with a second GP.

All nurses were undergoing competency assessments, and where issues of poor practice identified they would be taken off the medicine round until they had proven their competency. We spoke with the supporting manager who was completing these assessments who told us that two nurses so far had been assessed as requiring further training, and consequently they were not administering any medicines.

Although we are aware that the service is taking action to prevent the risk of further medicine errors at the time of our inspection we found the systems in place did not ensure that people received medicines safely.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: The proper and safe management of medicines.

Following the inspection we received information from local commissioners that the management of medicines at the home had improved.

At our last inspection we were concerned that Cherry Tree House was not monitoring skin integrity well, and this was highlighted by a large number of reports of pressure sores developing. At this inspection we found that this had been the focus of much work. The manager informed us that there were currently two people who used the service at risk of developing pressure sores but they were being closely monitored to prevent sores developing. We saw repositioning charts were in place and had been completed, but staff were writing 'skin intact' and were not identifying which specific areas needed checking or had been checked.

When we looked around the building, we saw that a high standard of hygiene and cleanliness was maintained. Communal bathrooms and toilets contained anti-bacterial gel, soap and paper towels. Anti-bacterial gel was available outside rooms in the corridor in dispensers, and we saw these were properly stocked. We observed staff washed their hands appropriately. All staff wore uniforms, and whilst attending

to personal care needs we saw that they had access to disposable gloves and aprons and other protective measures. Wearing such clothing protects staff and people using the service from the risk of cross infection during the delivery of care.

We saw that regular maintenance safety checks were made and recorded on safety equipment, such as the fire alarm, smoke detectors lifts and emergency lighting. We saw that the maintenance manager would deal with any issues reported to them, and they attended a daily meeting with other senior staff where issues of concern could be raised, for example, problems with faulty equipment.

We saw that the fire alarm was tested, that fire extinguishers servicing history was up to date and a personal evacuation escape plan (PEEP) had been written for all the people using the service. These plans explain how a person is to be evacuated from a building in the event of an emergency and take into consideration a person's individual mobility and support needs.

Requires Improvement

Is the service effective?

Our findings

We asked people who used the service if they believed the staff had the skills to meet care needs. One person told us "Oh yes, they know their stuff, and "There's some that know what we like, although there seem to be a lot of new faces."

We asked one of the newer members of the management team if they felt that the staff had the competence to provide care. They told us "Staff are willing but are not skilled enough for nursing care and are not supported by consistent nursing. With consistency and the right support and tuition it could come out on top, but when staff are set in their ways it's hard to break out of the routine".

The service provider, L&M Healthcare Romiley Ltd, have recently recruited a training manager and had identified the need to provide appropriate training to all the staff at Cherry Tree House. At the time of our inspection, a programme of staff training had begun to revisit induction training for long standing staff. In addition, all nursing staff were being given refresher training in medicine management and the service was rolling out a training package to support staff to understand and complete the new record keeping system.

Staff from the nearby sister home had been brought in to allow the permanent Cherry Tree House staff opportunity to attend 're-induction' training during the week of our inspection.

We were made aware new staff had not completed the Care Certificate, which is a professional qualification to equip new health and social care staff with the knowledge and skills which they need to provide safe and compassionate care. We spoke with the trainer, who demonstrated enthusiasm and a willingness to ensure people understood their role and were competent. They were keen to introduce the Care certificate for staff. This person explained the 'delayed induction' programme, and talked of plans to develop a training package for all staff, based on both e-learning and face to face learning for topics which may require more sensitivity such as safeguarding vulnerable people, dementia care and person centred planning.

The staff we spoke with told us that previous training had been poor. One person told us "I only had a one day induction, and most of that was watching videos. It was no use". Another told us: "I didn't get manual handling training. It kept getting cancelled". However, when we spoke about the new training one care worker said, "I think the company have started to improve. Although the training I had was cut short, it was excellent".

We saw that the initial 're-induction' training had been scheduled for a full week, but this had been cut to three days. This was to allow senior staff to attend training to implement the new recording system. We asked how this affected delivery, and were told, "We can still cover all the topics, but lose the niceties."

We saw that the service had a supervision policy but supervision was inconsistent. Some of the people we spoke with told us that they had not had supervision 'for quite some time'. One Unit manager told us that they had not had a formal supervision session since they started and there had been no clinical oversight of their practice. They informed us that they were responsible for providing supervision to the staff on their unit

but that this "Had taken a back seat, supervision is a work in progress, my priority is care plans, and then I'll get back to doing supervision over a six week period." Supervision provides staff and their manager the opportunity to discuss staff development and performance and any other issues that staff may want to bring to the attention of their manager and vice versa. We spoke with a senior member of staff who had had opportunity to observe staff. They told us "Staff haven't had much attention, either their collar felt or given positive strokes". This was not aided by the successive changes in management at the home.

The above examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people employed by the service must receive appropriate support, training and supervision to enable them to carry out their duties.

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).

Capacity assessments had been carried out on all people who used the service and the decision recorded in care files. Where appropriate, applications for DoLS had been made and a central log of applications was kept, detailing the date of application, when the authorisation was granted and when it was due to expire. The manager was able to demonstrate a good understanding of the legislation to ensure that people's rights were protected, and staff we talked to understood the notions of consent and that capacity can be variable depending on the issues and the person making the decision. For example one member of care staff interviewed informed us about a decision taken to place alarm mats in a person's bedroom as they regularly left their room at night. This person demonstrated a fair understanding of issues that might constitute a deprivation of liberty, and best interest decisions. However, a second care worker informed us they had heard of DoL but was not sure quite what it meant.

We saw evidence that care files provided an opportunity to record and monitor peoples nutritional needs. Records in care files showed use of MUST charts: this is a commonly used screening tool which helps identify adults who are at risk of malnutrition or obesity. People were weighed on a monthly basis, and where any weight loss or gain was identified, weighing occurred every week. We saw that there were fluid and dietary intake/output charts in place for people who needed close monitoring and support with dietary needs. On examining these charts, it was clear that they had not always been completed or had not been completed in enough detail. For example, we could not determine whether people who used the service were just being offered food and drink or had actually consumed it. We saw that people on Marple Unit, for example, would be given a drink, and could wander off, leaving a half-full cup of tea. When we asked managers whether staff were recording drinks and meals offered, or if they recorded the amount taken, they were not sure. Additionally, the fluid intake and output were not being calculated at the end of the day. In one file we looked at, we saw that eating and swallowing had been identified as a potential risk to a person, and that a referral had been made to a Speech and Language Therapist (SALT) for support. Following their assessment, the SALT advised 'Soft options of normal food – prompt to slow down, chew food therefore needs supervision'. This advice did not feature in the care plan regarding nutrition, which meant that staff may not be aware of the advice which if not followed would increase the risk of choking.

These examples demonstrate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: The service was not maintaining accurate, complete and contemporaneous

records.

People told us that they enjoyed the food served at Cherry Tree House. Before lunch, we asked one person what they were having and they told us "I don't know yet, it's a surprise! But it'll be good whatever it is!"

We were told that people were offered a choice of one of two meals the day before it was to be served, so that the kitchen staff knew how many meals of each to prepare. When we observed a daily senior staff meeting however kitchen staff complained that they were not told in advance so they made up half-and-half, which meant that popular meals were sometimes in short supply. We noted that one senior member of staff pointed out that checking what people wanted should not be left to the hostesses, as they may not be familiar with any specific dietary requirements.

We were told that the day's menu was on display outside the dining areas, but when we checked on the Monday of our inspection we saw that the menu displayed was for the previous Friday and was three days out of date.

We observed the provision of meals on all units. We saw that there were sufficient staff to ensure all people received their meals in a timely fashion and no radio or TV distraction were allowed to encroach on this time. A number of people were able to feed themselves; however, a number also needed assistance. We saw those people requiring assistance received this in an unhurried manner with staff sitting to one side of them giving quiet assurance. We did not see anyone being neglected at this time. On one unit we noticed one member of care staff responding to a person who used the service calling from one side of the dining room to the other by doing likewise. This increased noise levels and made the mealtime experience less harmonious.

The meals looked and smelled appetising. A choice of steak pie or pork loin was offered with mashed potato and fresh vegetables. Desert was either tapioca or fruit pie with custard. Drinks were readily available and included tea, coffee and juice. We noticed on one unit that staff would leave glasses of fresh water in all bedrooms, but some people required a thickened diet, and this could cause a risk of choking.

When we looked at care files we saw that people had had access to a number of external care professionals, including speech and language therapists, physiotherapist, and occupational therapists. We saw that people who were living with dementia and were prescribed antipsychotics had regular specialist mental health reviews, and we saw that a chiropodist visited on a regular basis. However, as reported we were concerned that the advice provided by these external agencies appears not in all cases to find its way into everyday care planning.

People told us that they were encouraged to have their eyes checked by a visiting optician.

We saw that one GP had agreed to visit the home for three hours each week to review health and medication needs of all their patients. They informed us that they wanted to support the home to manage, monitor and understand the needs of the people who used the service to keep hospital admissions to a minimum.

Many of the people at Cherry Tree House are living with dementia, and we saw that the building was not dementia friendly. Whilst long and wide corridors allowed space to wander safely, many led to dead ends. Furnishings and décor had not been designed in a dementia friendly fashion; we saw wallpaper clocks that give the wrong time; wallpaper books that can't be read, and plastic flowers with no scent. These would cause confusion and potential distress to people who live with dementia. In addition we saw ornaments that may cause anxiety, such as animal horns and large animal ornaments in corridors and busts in

communal bathrooms.

Requires Improvement

Is the service caring?

Our findings

One person who used the service told us, "I'm looked after, I get everything I need". Another said, "Sometimes the staff will come and talk with me, but I know they are really busy, so they don't have the time."

We saw that effort had been made to collate numerous physical orientated details about the people who used the service but information that can assist individual, personalised care appeared sporadic. Life story detail could be found in one of the records we looked at but this did not influence care planning. There were no significant references to individual likes and dislikes or other features pertinent to individual people.

Many of the people employed by the service at the time of our inspection did not know the people who lived there. They had only been there for a few days prior to our inspection and were uncertain if they were likely to stay or not. We saw four staff who had taken the opportunity during a quiet period in the afternoon to go away together to look at care files, leaving the people who used the service without company. Only a small number of staff knew the people who used the service with any depth and new starters or agency staff seemed distanced and reluctant to make anything other than task-orientated contact with people. This led to an atmosphere in which staff were reactive to people's need rather than intuitive and proactive. Longer term more established staff were observed being open and friendly toward the people who used the service and having a greater depth of knowledge of the individuals and demonstrated a genuine fondness and interest.

Care was delivered by caring staff, or by staff who wanted to care but were unsure about how to provide the right interaction with people with whom they were unfamiliar, or lacked the skills and knowledge to provide good quality support. For example, one person who was living with dementia had a nosebleed and was getting angry and frustrated. A carer tried to console this person but was sitting next to them and out of eyesight, so when they attempted to wipe the person's nose they became more agitated.

A visitor said to us "It's like a hotel, all very nice and well laid out, but all so impersonal. There is no sense of belonging". Provision when we inspected was task centred and impersonal, so for example, people were fed as they got up. This meant that some people were having their breakfast as late as 10:30, and then having lunch two hours later with no activity in between, and no opportunity to build up an appetite.

When we last inspected Cherry Tree House we identified that a blanket decision had been made on the Marple Unit, to provide decaffeinated coffee, because they believed that one person's challenging behaviour could be attributed to caffeine. This decision had been made without any consultation with people who used the service on the unit. When we returned we saw that the people who used the service were still given decaffeinated coffee. When we asked why this was, we were told it was "on the advice of a previous nurse."

The above examples demonstrate a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as care and treatment of service users must reflect their needs and preferences.

We saw that the activities co-ordinator on Marple unit was actively engaged with people on a group or one to one basis, for example, reading the newspaper aloud to a person who had difficulty with reading the small typeface, and encouraging the person to look at the paper. On the last day of our inspection, however, the activity co-ordinator on Romiley unit had called in sick, and nobody took the responsibility to organise any activity or stimulation for the people on that unit, and we saw that people were sitting in chairs for long periods with little or no stimulation or interaction with other people. Collage photographs were visible on walls on one unit as a record of group activities and events. However, a carer told us, "There's not enough for people to do."

People were treated with respect by staff who were polite and courteous. For example, a number of the people on Bramhall unit spent most of the day in their rooms, but came out for lunch. After they had finished eating, staff would ask them if they were ready to go back to their rooms or if they wished to stay in the lounge for a little longer. We also observed following lunch on one of the units staff sharing a joke with people who used the service, and people who used the service were prompted and encouraged to join in conversations over lunch. Where people were being assisted to eat and drink, care staff established eye contact and remained attentive and patient, following the person's lead rather than forcing them to eat at a different pace.

All rooms were en-suite and were personalised with objects and pictures displayed that were clearly highly personal and important to the people who used the service. We did not see personal care being given inappropriately, and all people appeared cleanly dressed and generally well presented. Wardrobes and drawers in bedrooms were well stocked with people's own clothing.

Requires Improvement

Is the service responsive?

Our findings

We saw during our inspection that where a person had had two falls in a short period of time, that the Unit manager placed the person on half hourly observation and requested a full review of their care and medical condition, referring to the GP for a general check-up. We looked at seven care files and observed that where untoward incidents had occurred there was appropriate recording of the incident along with body maps that might indicate an injury. However, there was no evidence to show that this led to any processed planning to help prevent a similar incident, such as the use of ABC charts. This is a format used to help analyse incidents by reviewing the antecedents, behaviour and consequence of the incident, and can help to determine any preventative measures. Where incidents occurred this sometimes led to an external referral, for example, when a person had difficulty with mobilising a physiotherapist was asked to review their care, the new assessment was added to care files but care plans did not reflect the change in need.

Actions were not always followed up, and evaluation records did not match the assessed risk. In one file we looked at we saw that the person had been classed as at extreme risk of falls according to a scoring system which aggregated various triggers such as number of falls, posture and gait, underlying medical conditions, and sensory loss. There was no corresponding plan of care to minimise the risk, and consequently the person continued to have accidents. Another file contained a letter from an optician which stated that the person was registered blind (macular degeneration and detached retina). We looked through his care plan which did not contain this information, and did not acknowledge any difficulties with vision. A new member of care staff was unaware of this when we asked them about it.

We were reassured to learn that an entirely new recording and care planning system was being introduced to Cherry Tree House and was being rolled out across all people who use the service, replacing old systems. We looked at two of these files and saw that records would be simpler to follow and easier to complete, showing bullet point assessment forms from which care plans can be identified, risks assessed and followed, with simple and straightforward facts about what the person might require.

The new system provided a front page detailing the person and their main needs, and had been written in a person centred way focussing on ability to maximise independence. They provided a good pen picture of the individual, so that anyone new to the service could quickly understand how to work with the person, and meet basic requirements. In the plans we looked at we saw completed assessments for a number of needs, including how the person expresses needs; communicates, mood and emotion; adapting to change; support for the future; sensing; keeping safe ; breathing; eating and drinking; coping with pain; pressure care; coping with pain; behaviours which affect others.

We saw in the new plans that where a risk was identified the care plan reflected the risk, for instance, in one care file a Waterlow risk assessment, which measures the risk to skin integrity, showed a high risk of developing pressure sores, so a corresponding care plan was inserted to guide staff in monitoring and providing support to minimise the risk

We were told that as the new files were completed they would become a working document, with the older

files archived. In practice however, this was not the case. Some staff had continued to use the older recording systems which meant that the information compiled did not contain the most up to date information and changes in condition were lost.

We saw that for each section a date was set for the following review dependent on the level of need, so where a higher risk was identified, a review would be scheduled for one week, with a longer time scale where risk was lower. However, we saw in both the files we looked at that some risk assessments did not contain a review date. As these files had only just been put into place it was too early to say if they were regularly updated or reviewed.

We saw that the service had a written complaints policy and a procedure which was visible at the entrance to all units. One visiting relative told us that when they had made a complaint they believed this was investigated, and a satisfactory outcome was reached. However, when we asked the manager about complaints they were unable to produce a complaints file and so we were unable to determine if all complaints were responded to in an appropriate manner. The service did not have an appropriate system to manage and track complaints meaning that there was a danger that they could be lost or not responded to.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: there must be an accessible system for identifying, receiving, recording, handling and responding to complaints.

The service had commissioned an anonymous staff survey shortly before our inspection, and was in the process of analysing the results. However, there had not been any staff meeting since we last inspected the service in December 2015.

The service had not conducted any surveys to determine the views of people who used the service or their relatives over the previous six months. People who lived in the home had not had the opportunity to give their views or opinions of the care provided as there had been no resident meetings or service user questionnaires, although we were informed that the provider's have signed up to complete a survey for people who used the service and relatives in the summer of 2016.

The above examples demonstrate a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the provider did not have suitable arrangements to seek and act on feedback.

Inadequate

Is the service well-led?

Our findings

It is a requirement under The Health and Social Care Act that the manager of a service like Cherry Tree House is registered with the Care Quality Commission (CQC). When we visited, the manager had only recently been appointed, having started work at Cherry Tree House in the previous week. She informed us that an application to register with CQC had been made. Since opening in 2013 there had been six managers, of whom only two have been registered with CQC.

Some of the people we spoke with felt that the manager was well equipped to meet the challenges of the role. For example, one member of staff told us, "She's got her work cut out but I have absolutely no doubt she will do it. I have already seen a big change in attitude. Carers want to care and they are beginning to take responsibility and use their initiative." A health professional we spoke to said, "She appears determined. That's good; it needs someone with the stamina."

We were aware that there had been a succession of managerial changes at Cherry Tree House. The service has had three managers in the past year with periods in between where there has been an interim manager in charge. When we inspected, the manager of the sister home was also working in a full time capacity at Cherry Tree House. At the time of our inspection we learnt that that the management team had undergone a number of very recent changes; the Interim Deputy Manager had been in post for four weeks and one of the unit managers had been seconded from the sister home the previous week. The provider had also employed a Director of Operations and a Quality and Governance Lead.

Confidence in the new manager, followed by frustration at lack of improvement has been a recurring theme. For instance, an Infection Control Audit in June 2014 concluded, "[XX] has now been made permanent manager and is making improvements. However a lot of what we identified on our first visit still needs addressing so we have arranged to go back again in September." Then in July 2015 a further Infection control audit states "Unfortunately things seemed to have slipped somewhat. However the new manager does seem to be enthusiastic and willing to improve matters." Following a medicine audit in December 2015, the auditor reported 'some improvement under the new manager' but when this person returned in March this year they summarise: "As there are so many on-going issues with this home I will be calling up on a frequent basis to check medication stock and MAR charts."

Successive changes of managers had led to a lack of consistency in managerial style and consequently any sense of responsibility or accountability. Coupled with an over-reliance on agency and bank workers to ensure that enough staff were available on a day-to-day basis, a culture of complacency had evolved. We asked a nurse if we could look at a record to show that a cream had been applied, and were told to look in the file. When we informed the person it was not there, they said, "If they aren't put back in patient's notes, that's nothing to do with me."

A member of the management team told us that they believed the service needed to change. They said, "The main problem is culture. People are complacent and not managed properly. If they are given standards the job will get done." This person went on to say that tasks had not been delegated, so it became unclear

who was responsible for specific actions, and consequently these would sometimes not be completed. Similarly when we discussed an issue relating to un-prescribed ear drops being administered, we were told "professional judgement is missing, some of the nurses have either not had the opportunity or this is not the culture to question. This has led to a blasé attitude amongst some staff. They think it is OK because the family want it and they don't question it." Another member of the management team agreed that the culture needed to change. They told us "I have observed some poor practice, particularly with moving and handling. When I tried to show [the staff] how to do it, I have been told 'we don't do it that way.' This is a challenge, when staff are set in their ways it's hard to break out of the routine." They told us that they found a lack of organisation and order, for example, there was no guidance or instruction, and tasks were not delegated to individuals. They did not receive an induction or orientation to the service, and said to us "There is nobody there who knows. This is how it is. People are just left to get on with it. We have inherited a system with no structure and no one knows anyone or what to do. Slap dash."

We saw this lack of organisation and oversight reflected throughout our inspection, for example, at the start and end of each shift a handover will ensure that staff are given an update on people's condition. Moreover, handovers provide an opportunity to delegate specific tasks such as bathing and personal care, but when we observed one handover, this did not happen. We did not see a system to negotiate and agree break times for staff, so on one unit we had difficulty finding a member of care staff because two staff had taken their break at the same time. Care staff who were unfamiliar with the care home or the people who used the service were unclear of their duties, for example, one member of the care staff, letting us onto one of the units said to us "I'm not really sure what to do; nobody has told me".

The service had completed a number of internal audits which identified required improvements. We saw appropriate action had not always been taken to address the issues identified. Following our inspection, we contacted the provider to request copies of all care file audits completed between December 2015 and May 2016. We were given over 50 audit records of individual files, audited between January and March 2016. Every file audited showed incomplete, missing or inaccurate data, and in two it was noted that there were no care plans in place. Most had no life history written, and the auditor noted that care plans had not been reviewed in many of the files audited, with further instruction to ensure care plans were reviewed regularly in many of the other feedback notes. We saw that several audits were re-audited. Whilst this had led to some improvement, identified gaps in records were left incomplete and no follow up action was noted.

When we spoke with the manager of the service she acknowledged that systems of quality management and governance had not been implemented. She informed us that the first priority had been to manage the issues with regard to medicines, and with the help of the CCG a new system was being implemented to minimise the risk of medication errors. This included reassessment of nurse capabilities. However, she informed us that there were no other audits in place, and acknowledged that systems for clinical governance were currently absent.

The above examples demonstrate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the provider did not have suitable arrangements to assess monitor and improve the quality of the service provided.

Due to the number of concerns raised about the service, the local authority had suspended placements to the home in October 2015, and this suspension was still in place at the time of our visit. In March 2016 the Local Authority and the CCG took the decision to create a team of health and social care professionals to work with the management and staff of Cherry Tree House to try and identify and improve poor practice.

We saw some evidence that the new manager was making attempts to improve the service. For example,

she had arranged for regular staff meetings and had implemented weekly Unit Manager Meetings and daily meetings for unit managers to quickly meet together with senior domestic, maintenance and kitchen staff. This will allow for continuity, improve communication between the units and general staff and help address and identify common issues. We observed one meeting where maintenance tasks, staff absences, food and drink and resident concerns were discussed.

The manager has also implemented new sickness procedures to provide a better response to covering staff sick leave, and has begun to liaise with agencies to provide greater consistency with the use of agency staff. She had also revised senior staff rotas to ensure that there is a senior member of staff on duty during day and evening hours and including weekends, and drawn up a timetable for staff meetings. The manager was keen to begin the new medicines procedure and was proactive in ensuring the new record keeping system would be rolled out as soon as possible. She told us that she recognised the size of the task ahead, and wanted to ensure that people receive good quality care. She told us that the structure is taking shape, and the systems are coming together.

People who know the service told us they believed that with the right backing, the new manager would be able to improve the home, but one health professional said to us "She has the right attitude and aptitude but I have never experienced this level of difficulty in a care home. It's too soon to say if it'll be OK or not."

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not always reflect their individual needs and preferences. Regulation 9 (1) (b) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Steps to help manage and reduce risks ensuring the health, safety and welfare of people were not always taken . Regulation 12 (1) (2) (b) Medicines were not being managed safely. Regulation 12 (1) (2) (g

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not operated effectively to raise and investigate safeguarding concerns to protect people from abuse and improper treatment. Regulation 13 (1) (2) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints A record of complaints received and actions taken in response had not been maintained. Regulation 16 (2).

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place were not adequately robust to ensure the effective monitoring and improvement of the quality and safety of the service. Regulation 17 (1). Accurate, complete and contemporaneous records of the care needs of people and care delivered were not kept. Regulation 17 (1) (2) (c). Systems were not in place to seek and act on feedback from people who use the service to evaluate and improve services. Regulation 17 (2) (e).

The enforcement action we took:

WN

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified competent skilled and experienced staff were not always deployed. Regulation 18 (1). Staff were not provided with adequate training and supervision. Regulation 18(2) (a).

The enforcement action we took:

WN