The Fremantle Trust

Cherry Garth

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 14 and 15 August 2018 and was unannounced on the first day. We previously inspected the service in April 2016 and rated the service good at that time.

Cherry Garth is a 'care home'. People in care homes receive accommodation and nursing or personal 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.

Cherry Garth provides care and accommodation for up to 60 predominantly older people, including those who live with dementia. The service accommodates people across three floors, each of which have separate adapted facilities. There were five 'houses' or 'units' three of which specialised in providing care to people living with dementia. At the time of our inspection there were 58 people living at the service.

At the time of our inspection the service did not have a registered manager in post.
A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, a new manager was in the process of applying to become the new registered manager.

Medicines were not managed effectively at the service. We found some people were without their medicines due to insufficient stock.

Risk assessments were in place for people with an identified risk such as repositioning due to frail skin and or fluid monitoring for people at risk of dehydration. However, some charts were inconsistent and some had not been completed for some time.

The service did not follow the requirements of the Mental Capacity Act 2005 (MCA). We did not find clear information in relation to people's applications, reviews and expiry dates for standard Deprivation of Liberty Safeguards (DoLS). This meant people were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

We observed there were not always sufficient staff available to support people. We noted that staff were rushed and not able to spend time with people. Staff reported sometimes they do not get time for a break. We saw on one unit two members of staff were assisting a person in their room which left the floor unattended for some length of time. We pointed this out to the member of staff managing the service and they told us someone (member of staff) had gone off sick which left them short. However, people told us there were usually enough staff to attend to them.

Staff received training in safeguarding people from abuse and staff told us they would not hesitate to report any concerns regarding people's welfare to the relevant authority.

Staff told us they felt supported and had received supervisions from their line manager. Appraisals had been carried out in line with the providers policy and procedures.

Auditing of the service and quality of care was completed. However, at the time of our inspection there were several incomplete actions outstanding.

People's nutritional needs were met and appropriate measures were in place where people were at risk of malnutrition. However, some recording of people's intake was not always documented. There was good partnership working with community specialists to monitor people's well-being.

Some care plans we viewed were not current and specific to people's current needs. We found conflicting information and changes to people's support needs were not always documented.

People could attend activities and social events to provide social stimulation. The service employed activity coordinators to provide a programme of social events.

The service was cleaned to high standards to ensure people were protected from infection.

During this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines were not managed in a way that promoted people's safety and welfare.

Identified risks to people were not always managed with actions taken.

Recruitment procedures ensured suitable staff were appointed.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported by staff with relevant training to perform their role effectively.

People did not always have an application made to deprive them of their liberty.

Staff received regular supervisions and appraisals.

Is the service caring?

Good

The service was caring.

People's dignity was protected and staff treated them with respect.

People and their families were involved in treatment plans.

People were encouraged to personalise their rooms with furnishings of their choice.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care that met their needs and

preferences.
Records detailing the care people received were not always completed.

People and their relatives knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems for monitoring, assessing and improving the quality of the service were not operating effectively.

Audits were still outstanding and actions had not been completed.

Statutory notifications to Care Quality Commission were made when required

Cherry Garth

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 was prompted in part by notification of an incident following which a person using the service died. This incident is subject to ongoing investigation by the police and coroner and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk and risk assessments. This inspection examined those risks.

This inspection took place on 14th and 15th August 2018 and was unannounced. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. Their area of expertise was dementia care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what it does well and any improvements they plan to make. We reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We spoke with the person currently managing the service, the director of quality and governance, the deputy manager, the activity coordinators, and eight members of the care staff. In addition, we spoke with three visiting relatives and six people who lived at Cherry Garth.

We observed medicine administration and checked each person's medicine administration record (MAR). We viewed records relating to food and fluid intake and repositioning records. We looked at eight people's care plans and related risk assessments. In addition, we looked at people's Deprivation of Liberty

safeguards, (DoLS) applications, four recruitment files, supervision records, minutes of staff meetings, accident records, and quality assurance documentation and other documents relating to the service provided.

Some people were unable to tell us about their experience of living at Cherry Garth because of communication difficulties. We therefore used the Short Observational Framework for Inspecting (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked throughout the premises and observed care practices and people's interactions with staff during the inspection.

We asked the provider to send further documents after the inspection for use as additional evidence. The provider sent documents to us after the inspection.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us they had confidence in staff and felt safe living at Cherry Garth. One person told us, "Oh definitely yes, there is always one carer around I feel safe with all of them." Relatives said, "Pretty good on the whole, he [the person] likes being here" and "Carers are very involved. There are at least six who are excellent."

Staff demonstrated knowledge of what to do if they witnessed or had concerns about allegations of abuse. We saw that policies in relation to safeguarding reflected local procedures and relevant contact information. Staff told us they would not hesitate to report any concerns they had.

During our inspection we observed medicines administration and viewed medication administration records (MAR) for each person. We also completed a stock check of some medicines which included controlled drugs. Controlled drugs are medicines subject to strict control by legislation. We found the stock checks we completed were correct at the time of our visit. However, when checking the MAR charts, we found some people had been without their medicines. For example, three people had been without their regular pain relief, two people for one day and another person for two days. Another person had been without their fluid reducing medicine for two days. In addition, one person was without their barrier cream for one day. We also noted that a prescribed powder agent to thicken fluids used to help people swallow safely was left unsecured in the kitchen cupboard. It is important that this is safely stored as it presents a risk to people in the home living with dementia who may accidentally ingest it. We discussed stock levels with the person managing the service and they considered this during our inspection and confirmed this had been an oversight in the ordering process. We also noted that the morning medicine round was still being carried out on one unit at 11.30am. This would impact on the afternoon medicines which would need to be adjusted in relation to the time the medicines were given. We spoke with the member of staff administering the medicines and they told us they would not be able to give some people their afternoon medicines due to the late morning round. We fed this back to the director of quality and governance and the staff member managing the service during our feedback. They said they would look into this.

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

Accidents and incidents were not always reported according to the provider's policy and procedure. Staff we spoke with could discuss how they reported incidents and the process for follow up. However, one accident form we saw dated 23 January 2018 stated under 'details': "Heard a loud bang from his bedroom, went to check and found (person) on the floor. Staff tried to assist him but he was angry and would not let staff help." The action plan stated, "senior informed…checked…no visible injuries." We did not see any reference to follow up or observations. This meant that the person may have had bruising or pain in the following days after the event and staff would have been unaware. In addition, we were aware that one person fell and had an x-ray to determine if they had sustained a fracture. The x-ray was carried out on 15 August 2018 and the

service did not request the results until 24 August from the surgery. The results showed the person had sustained a fracture when they fell and had to go back to the hospital for treatment. This meant the service was unaware the person had a fracture for 10 days. We discussed this with the staff member managing the service and they told us, it was the GP's responsibility to inform the person of the fracture and that the surgery was aware the service was waiting for the results. However, the service had a duty of care where responsibility for the care and treatment of people using the service is shared to ensure that timely care planning takes place.

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

Risks to people were identified and risk assessments had been undertaken on admission to the service. The risk assessments included maintenance of skin integrity, nutrition, challenging behaviour and mobility. Some people had frail skin and were unable to reposition themselves and required regular repositioning. We saw some of the repositioning records were incomplete and some had not been completed for several days. This put people at risk of skin damage if their position was not changed at regular intervals. However, staff told us this was carried out but they had not had time to document this. People who were at risk of malnutrition had a food chart in place to confirm the amount of nutrition they had consumed. The charts we saw were inconsistent which meant people not being monitored effectively to alert staff the need for further intervention. We also saw a Waterlow assessment (for skin integrity) that was scored incorrectly and the incorrect level of risk cited. This may be a potential risk to someone who has fragile skin. We informed the director of quality and governance and the staff member that managed the service during feedback about the inconsistency of the records we viewed. The service did not maintain accurate records relating to people's health and welfare.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were robust plans in place for fire evacuation. Each person had a personal emergency evacuation plan in place (PEEP). A fire risk assessment was carried out during our inspection. The fire risk assessor made visual checks of equipment and reviewed records including PEEPs and records of staff training in this area. We saw a 'fire plan and evacuation strategy' that identified alternative accommodation to be used in the event that the building was not safe. A member of staff told us, "We have to go through training with them periodically."

The provider had systems in place to assess the suitability and character of staff before they commenced employment. We looked at four recruitment files and found relevant documentation was in place which included Disclosure and Barring Service (DBS) checks.

The premises were cleaned to high standards and appeared clean and free from obvious hazards during our inspection. We observed staff using personal protective equipment (PPE) for example plastic aprons and gloves were worn when required.

Requires Improvement

Is the service effective?

Our findings

Staff received mandatory training and regular updates in subjects such as fire safety, infection control, safeguarding adults and moving and handling. The induction for new staff covered the Care Certificate, legislation, policies and procedures, codes of practice and organisational requirements. The Care Certificate is a set of standards that social care and health workers use in their daily working life. It is the minimum standard that should be covered as part of the induction process training for new care workers.

We saw that senior staff assisted two people to administer their insulin. Senior staff drew up the insulin and assisted administration of the insulin. However, we had no evidence the members of staff had received training in this area and had been competency checked by a qualified nurse to draw up insulin. We discussed this with the staff member managing the service and the director of quality and governance on the first day of our inspection. They told us the district nurse had checked staff competency "years ago", but there was no evidence of this. This practice did not follow the provider's medication policy and procedure, which stated that, "the GP or nurse should give a written agreement and has directly trained the member of staff". In addition, this placed the person at risk of receiving medicines by staff who had not been assessed as competent to do so. We discussed this during feedback with the person managing the service and the director of quality and governance. They told us they would look into this.

We observed the senior staff administering the insulin during our inspection. We saw that two members of staff checked the dosage and offered the person the syringe to enable them to inject themselves. However, the members of staff signed the MAR chart following administration. The provider's policy stated that the person would be encouraged to maintain their own MAR chart records in order for the service to remain compliant. We discussed this during feedback with the person managing the service and the director of quality and governance. They told us this is how they had always done this and it works well.

We asked people living at Cherry Garth if they felt staff were skilled to support them. They told us, "Personality comes into it. Some of the residents can be difficult I'd say ninety eight percent are very skilled", "They know how to look after me", "I would say so. They are in within two minutes [away]. Very, very good." One relative told us, "I come in on a regular basis. [The person] can be quite difficult. Yes, I think they are well trained."

We received mixed views form staff about the support they received. Some said they felt they were not supported. Others said they were supported by the staff member managing the service and had faith they would succeed in getting the service where it should be. Supervisions and appraisals were carried out on a regular basis and records we viewed confirmed this.

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, 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 so they can receive care and treatment when it is in their best interests and legally authorised under the MCA. The application procedure for this in

care homes is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

MCA assessments had been completed. However, we noted that, while whether the person could understand, retain, weigh and communicate the decision in question was established, this was not supported by details. We saw that 'no' was recorded for each of the four questions. We also observed that multiple decisions, for instance, 'consent to care and treatment; providing, withholding or stopping services; giving medication; giving medication covertly; and control of personal finances' were included on the same form. Mental capacity assessments should be decision specific and acknowledge the sometimes fluctuating nature of people's capacity.

We saw that four people's DoLS applications had expired and there was no evidence that another application had been applied for. We requested further information about this following our inspection. We received information following our inspection that confirmed there was no evidence that applications had been applied for. This meant that if a deprivation of liberty was still occurring after the authorisation ended the service would be unlawfully depriving someone of their liberty.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people who were at risk of malnutrition had food charts in their rooms for staff to complete to monitor people's intake. However, some charts we viewed were incomplete and inconsistent. We spoke with staff who told us, "Sometimes we don't have time to fill them in. It's getting to the point where its residents or paperwork." We discussed this with the staff member managing the service during feedback. They told us this will be addressed with staff.

The service catered for people's dietary requirements. This included people who were at risk of malnutrition or required a specific consistency of foods. For example, for people that had difficulty in swallowing, diets were modified so that food was soft and palatable. This was as recommended by health professionals such as speech and language therapists (SALT). There was a menu on each floor for choices of meals being prepared that day. People had a choice of where to eat. People commented, "They come 'round and ask for our choices every morning. I don't go into the dining room…they bring my meals to me", "Food is fine, drinks are available at all times", "Very nice, reasonable choices and plenty to drink." We observed meal time and saw staff supported people to eat and drink where required and noted the consistency of the food was as directed under the individual's nutritional records.

Do not attempt resuscitation (DNAR) orders were in place where appropriate. Discussions were held with relevant others when required.

The premises were well-designed and provided people with an environment which promoted their independence. The main reception area had a community lounge and coffee area for people to join in social events or to meet with family and friends.

A range of professionals were involved in providing additional care and support for people who required this. We saw that the community nurse visited the service and evidence that the speech and language therapists were part of the referral service. The GP visited on a regular basis.

Good

Is the service caring?

Our findings

We received positive comments from people and their relatives about the caring nature of staff comments we received were, "The majority are very good caring and friendly. Occasionally one can be a little abrupt, but we all can", "Most are kind and caring and do what I need, "They are pretty good; we are a funny lot." Relatives told us staff were kind and considered their relative's dignity. We saw many positive interactions and acts of kindness between staff and the people living at Cherry Garth.

The care and support we observed was given with attention to people's dignity and was provided in a respectful manner. For example, staff knocked on people's doors before entering. One person told us, "When you are unable to do things for yourself you are quite grateful for the help. They always knock on my door before they come in and always close the door when I am in the bathroom."

Staff we spoke with understood the importance of treating people as individuals irrespective of their gender, ethnicity or their physical or cognitive abilities. We observed staff giving explanations to people who were unable to communicate with them. One person who was frail and required full support from staff was given full explanations of the support they were about to receive. For example, the person required repositioning and staff explained what they were doing even though the person was not able to respond.

The service enabled people and their families to be involved in decisions about their care and support. We saw regular reviews took place with people and their families where appropriate. People told us, "I am quite capable to make my own decisions", "I am totally independent and able to make my own decisions", "This is usually discussed with my sister present; they always explain what is happening." One relative told us, "She [the person] is quite unable to make her own decisions; everything is discussed with me." Staff demonstrated an understanding of how to encourage and support people to make or be involved in day-to-day decisions that affected them. This included supporting people to make choices about what they wore, and how they would like to spend their time.

The service supported people to access external bodies such as advocacy services when required. We saw advocacy service details displayed in the service. Advocates are people independent of services who help people make decisions about their care and promote their rights.

People could be assured that information held about them was treated confidentially which complied with the General Data Protection Regulation (GDPR). Records were stored securely on each floor of the service.

Relatives and friends could visit without restriction. We saw visitors in the lounge area in the main reception to meet with their family member.

Requires Improvement

Is the service responsive?

Our findings

Care plans gave information for staff on how meet the needs of people. For example, they provided information in relation to how to support people with mobility and personal care. They also provided specific information on health conditions. However, a manual handling care plan we saw stated that 'one/two' staff were required to assist and that the person was 'very reluctant to receive personal care' dated 16 May 2018. This had not been updated to reflect the person's changing needs as stated in the 'preferred routine' dated 5 August 2018 which said, '[The person] will need three staff to assist with personal care.'

We found the service did not respond to people's changing needs to ensure their well-being. For example, we saw that one person fell from their chair three days before being admitted to hospital where it was found the person had sustained a fracture of their femur. We discussed this with the staff member managing the service and they told us that the person had not complained of pain following the fall. However, we saw it was documented they had a graze to their knee following the fall. We were told the person was admitted to hospital with other symptoms such as increased confusion and poor oral intake. During their hospital stay, the person complained of pain in their knee which later showed on x-ray as a fracture sustained in the fall.

An assessment of people's support needs was carried out prior to people moving into Cherry Garth. The assessment reflected people's physical, emotional, mental and social needs. This included people's preferences in relation to care staff. People could choose whether they preferred a male or female member of staff to support them. The service used key workers to support people. A key worker is the first point of contact for people should they have any needs outside of their day-to-day routine. For example, the key worker would help arrange a visit to shops or hospital visits.

The service offered a range of activities for people to take part in which was displayed throughout the service. People told us, "I join in most of the activities. Usually there is something going on; today I went to the daily sparkle", "I have done activities when I first came in, nothing physical, I can't do much now. I am going to visit Buckingham Palace tomorrow", "Too old for all that. I like to just read my paper and watch TV now." Relatives commented, "They try to get her [the person] to join in but she is not interested" and "She [the person] did go to the barbeque recently. It's her choice to stay in her room; she very rarely gets dressed. It's her choice." We saw activities taking place during our inspection which was well attended.

There was a complaints procedure given to people and their families when they first joined the service. People told us they knew how to make a complaint. One person said, "I complained once about a girl on night shift and it was dealt with" and "I can't think of any reason to complain." Relatives told us they would complain if they had to but there were no concerns. We saw one complaint which was being investigated according to the service's policy and procedure.

The service enabled people to have access to information they needed in a way they could understand. The service complied with the Accessible Information Standard (AIS). The Access Information Standard is a

framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We saw notices displayed throughout the premises which enabled people to have access to information such as community events, recent meetings and activities taking place.

The service supported people at the end of their life. This was supported by the palliative care nurses and the GP. At the time of our inspection one person was receiving end of life support. We saw that anticipatory medicines were in place. Anticipatory medicines are designed to enable prompt relief at whatever time a person develops distressing symptoms.

Requires Improvement

Is the service well-led?

Our findings

We found that quality assurance systems had not maintained an oversight of the quality of care people received. We saw that systems were in place to monitor the quality of the service and audits were undertaken. However, these had not highlighted the shortfalls that we identified during our inspection. Quality audits undertaken in February 2018 still showed outstanding actions which were not completed by the time of our inspection. For example, actions regarding medication monitoring, updating risk assessments, DoLS verifications and ensuring care plans are more personalised to meet needs and preferences were still incomplete.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that record-keeping required improvements. Care plans we viewed were not always up to date and did not reflect people's current care needs. Medicines were not managed effectively. Some people had been without their medicine due to lack of stock and fluid thickener was not stored securely. Identified risks to people were not always monitored by staff and managers. Applications to the local authority to deprive people of their liberty had not been applied for when the current authorisation had expired.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have a registered manager at the time of our inspection. However, the staff member managing the service had submitted an application to us to become the new registered manager. They told us they already had an action plan in place to address issues they found. We were shown the action plan during our inspection which highlighted some of the issues we found.

We asked people about the management of the service. We received comments such as, "They are ok…not really approachable. I can get someone to pass a message on", "Boss lady is very brusque" and "I don't know who the manager is." Relatives told us, "Very nice; seems to be well-led" and "Pretty good. Both managers spend time on the floor if there is a staff shortage."

Staff told us they had confidence the new manager could make improvements. They told us they felt 'burnt out' (fatigued) and one comment was, "Sometimes we can't even take a break." However, they told us despite this, Cherry Garth was a good place to work and the team worked well together. Staff told us they were aware of the whistle-blowing policy and would not hesitate to report any concerns. Staff meetings provided an opportunity to encourage open communication and question practice. Records confirmed this. The staff member managing the service told us they had an open-door policy and were available to meet with people and relatives when required.

There was a daily meeting where a member of staff from each floor attended. Items discussed could be cascaded to the rest of the care staff. The service held regular 'residents' and family meetings to discuss concerns or changes in the service. Surveys were sent out to families to gain feedback on the way the service was run.

Providers are required to comply with the Duty of Candour statutory Regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The Regulation applies to registered persons when they are carrying on a regulated activity. The staff member managing the service was fully aware of the requirement and had described an occasion when it was utilised.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Procedures for obtaining consent did not reflect current legislation and guidance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems for the safe management and storage of medicines did not contribute to people receiving safe care and treatment. Accidents and incidents were not always investigated and monitored to make sure that action was taken as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not maintain accurate records relating to people's health and welfare. Quality systems and processes did not monitor and improve the quality of the service effectively.