Cherry Trees I.W. Limited

Cherry Tree Care Home

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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Cherry Trees Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation for up to 25 people. There were 23 people living at the home at the time of the inspection.

The home was based over two floors, connected by a passenger lift and stairwells. Not all bedrooms had en-suite facilities but there were toilets available on each floor. There was one communal space available for people to socialise.

The inspection was conducted on 27 April and 2 May 2018 and was unannounced.

At the time of the inspection there was not a registered manager in post at the service, there was a manager who had taken over the overall running of the service and was planning to apply to become registered to manage the home. 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 and associated Regulations about how the service is run.

At our last inspection, in April 2017, we gave the service an overall rating of 'Requires improvement' and identified a breach of regulation12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to mitigate risks to the health and safety of people using the service effectively. The provider wrote to us, detailing the action they would take to address the concerns.

At this inspection we recorded two breaches of Regulations in relation to Safe Care and Treatment and Good Governance . You can see what action we told the provider to take at the back of the full version of this report.

Systems and processes used to monitor the quality and safety of the service had not been fully effective in preventing the shortfalls found at this inspection.

Risks to people had been assessed; however information within people's risk assessments and care records was not always followed by staff and guidance from professionals to keep people safe was not always followed.

Action had not been taken to ensure the laundry area was free from clutter or that the flooring was appropriate to mitigate the risk of infection and cross contamination.

Where accidents, incidents, and near misses had occurred there was a process in place which recorded the incident. However, the information provided of the incident/accident or near miss was not always detailed

and ideas of how to mitigate risks or prevent reoccurrence had not always been considered, followed up or implemented. Medicines were not kept secure at all times or administered safely.

Consent to care was not always obtained in line with the Mental Capacity Act 2005.

People were protected from the risk of abuse and staff knew how to identify, prevent and report abuse. Staff understood how to keep people safe in an emergency.

There were enough staff to meet people's needs in a timely way. Appropriate recruitment procedures were in place to help ensure only suitable staff were employed.

People's needs were met by staff who were competent, trained and supported appropriately in their role. Staff followed the principles of the Mental Capacity Act 2005 (MCA) and sought verbal consent from people before providing care.

People were supported to have enough to eat and drink and had access to health professionals and other specialists if they needed them. Staff worked in partnership with healthcare professionals to support people at the end of their lives to have a comfortable, dignified and pain-free death.

Staff showed care, compassion and respect to the people and people spoke positively about the attitude and approach of staff. There was a relaxed and calm atmosphere within the home. People were cared for with dignity and respect and their privacy was respected.

People were encouraged to be independent and the staff supported people to meet there cultural and spiritual needs.

The service was responsive to people's needs. Staff demonstrated that they know people well, understood their needs and had knowledge of their likes and dislikes. There was a person centred, individualised approach to care.

People told us they were provided with appropriate mental and physical stimulation through a range of varied activities they enjoyed. People were listened to by staff and their views and wishes were respected. People were encouraged to make decisions about their care.

People and their relatives felt the service was run well. Staff were organised, motivated and worked well as a team. There was a clear management structure in place and the manager had access to appropriate support.

People described an open and transparent culture within the home, where they had ready access to the management and visitors were welcomed at any time.

We identified two breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back 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 always safe.

Environmental and individual risks to people were not always managed and mitigated effectively.

Medicines were not kept secure at all times or administered safely.

People felt safe at the home and staff knew how to identify, prevent and report abuse.

There were enough staff to meet people's needs and recruiting practices helped ensure that all appropriate checks had been completed.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act (2005) were not being fully adhered to.

People received effective care from staff who were competent, suitably trained and supported in their roles.

People were supported to have enough to eat and drink.

People had access to health professionals and other specialists if they needed them.

Procedures were in place to help ensure that people received consistent support if they were admitted to hospital.

Adaptations had been made to the environment to meet the needs of people living in the home.

Staff made appropriate use of technology to support people.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

People's specific communication needs were understood by staff.

Staff understood the importance of respecting people's privacy.

Staff respected people's independence and encouraged people to do things for themselves.

Is the service responsive?

Good

The service was responsive.

People received personal care in line with their personal preferences. Care plans contained detailed information to enable staff to provide care and support in a personalised way.

Staff responded promptly when people's needs or preferences changed.

People received appropriate mental and physical stimulation and had access to activities they enjoyed.

People were supported at the end of their lives to have a comfortable, dignified and pain-free death.

People knew how to raise a complaint and the manager had a process in place to deal with any complaints or concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

The systems and processes in place to monitor the quality and safety of the service, were not always robust.

The provider's values were clear and understood by staff. The manager adopted an open and inclusive style of leadership.

Staff were organised, motivated and worked well as a team. They felt supported and valued by the manager.

People, their families and staff had the opportunity to become involved in developing the service.

Cherry Tree Care Home

Detailed findings

Background to this inspection

We carried out this comprehensive inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 27 April and 2 May 2018 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 care service.

The home was last inspected in March 2017 when it was rated as 'Requires improvement' overall with a breach of Regulation 12 of the Health and Social Care Act 2008 relating to Safe Care and Treatment.

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 the service does well and any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. Notifications are information about specific important events the service is legally required to send to us.

During the inspection we spoke with ten people who use the service and five family members. We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the provider's representative, the manager, six care staff, the cook and a member of the domestic team. We also received feedback from three health care professionals and two social care professionals who had contact with the service.

We looked at care plans and associated records for ten people and records relating to the management of the service. These included staff duty records, three staff recruitment files, records of complaints, accidents and incidents and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection, in March 2017 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The provider had failed to ensure risks relating to the safety and welfare of people using the service were assessed and managed appropriately. At this inspection, we found action had been taken in relation to the concerns highlighted at the previous inspection. Doors had now been fitted with an automatic door release system which meant that they would close automatically in the event of a fire and fluid thickener was stored safety with appropriate risk assessments in place.

However, at this inspection we found that not all other risks were managed safety. For example, some people were at risk of developing pressure injuries and we saw special pressure-relieving mattresses had been provided. We found one of these mattresses had not been set correctly in accordance to the person's weight which placed them at increased risk of developing pressure sores. When we raised this with the manager they corrected this immediately. The manager stated that the settings of these mattresses were checked weekly, but agreed that this needed to be done daily. Other preventative measures to mitigate the risk of people developing pressure sores were in place; where one person was reluctant to move in bed there was a daily pressure area checklist in place, which demonstrated that staff supported this person regularly. Additionally people were provided with pressure relieving cushions as required.

The manager had assessed the risks associated with providing care to each individual. These risk assessments highlighted potential risks and provided information for staff to help them avoid or reduce the risks of harm. Each person's care file contained specific risk assessments for their individual needs. Risk assessments in place included; falls, medicines, swallowing, challenging behaviour, food and fluid intake and safe use of equipment such as electric beds and bed rails. However, guidance was not always being followed to mitigate risks to people. For example, one person had an individual risk assessment in place stating that footplates should be used when they sat in their wheelchair. On the first day of the inspection we saw that these were not being used which meant that the person could not sit safely or comfortably. We raised this with the manager. On day two of the inspection we saw that the guidance in the risk assessment was being followed by staff at breakfast and lunch time, however we noted that again these footplates were not being used later in the afternoon.

One person was at risk of choking and guidance had been provided by a Speech and Language therapist (SALT) highlighting how this person should best be supported to help ensure their safety. We found that this guidance was not always followed by staff. For example, the SALT guidance stated that a person should be, 'fed with a tea spoon', but during lunch time we observed a larger, softer spoon was being used. Staff told us they were using a softer spoon as there was a risk that the person may bite down on a metal spoon and injury themselves. However the risk assessment had not been updated and staff were putting more than a teaspoonful of food on the spoon at a time. SALT guidance also stated that a person should be supervised with all meals; at lunch time a staff member was in the room, however they were not specifically supervising this person. The person's risk assessment stated staff were to make regular checks but that was not the type of supervision specified by the SALT.

These issues were discussed with the manager and provider's representative who agreed to update the risk assessment as required and discuss with staff. By the end of the second day of the inspection risk assessments had been updated.

The home was clean and systems were in place to ensure that all areas and equipment were cleaned on a regular basis. Cleaning staff told us they felt they had sufficient time to complete their daily cleaning routines. However, on the first day of the inspection we found that the laundry room was not organised appropriately to support staff to prevent risks of cross contamination. Soiled items of clothing or linens were placed in specific dissolvable red bags which could then be placed directly into the washing machines. There was no container for these and on several occasions we saw these had been placed directly onto the floor in front of the washing machines. The floor area on which the washing machine, tumble dryer and the red bags were placed on was untreated floorboards; this meant the flooring would not be able to be disinfected if it came into contact with soiled laundry. We also noted that staff would have been unable to reach the hand washing sink as it was blocked with items of furniture. This meant staff would be unable to wash their hands when leaving the laundry room or between handling dirty and clean laundry. This was discussed with the manager and provider's representative and by day two of the inspection the laundry room was less cluttered and more organised, although the flooring still posed an infection control risk.

Medicines were not kept secure at all times or always administered safely. We saw a pot containing prescribed tablets in a person's bedroom. No staff were present. We checked the Medicine Administration records (MARs) for this person and these showed they had been signed to show the person had received these medicines although staff would not know this until they returned to check. There was no risk assessment to show that it was safe to leave medicines with the person. We found staff had failed to lock away morning medicine 'blister packs' which had been left on top of the medicines trolley in a communal hallway. We also found an unboxed foil package of pain relief tablets left on a shelf which people could have accessed. The manager took immediate action when we raised these concerns to them. However this meant that people, staff or other visitors may have had access to medicines that were not prescribed for them.

The failure to prevent and control the risk of infection, safely manage medicines and to ensure risks relating to the safety and welfare of people using the service are assessed and managed is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Appropriate arrangements were in place for obtaining, recording and disposing of prescribed medicines. With the exception of the issue described above, all other MAR charts documented that people had received their medicines as prescribed. Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them. Safe systems were in place for people who had been prescribed topical creams. A record was kept of when tubes or containers of topical creams were opened. This meant staff were aware of when the topical cream would no longer be safe to use.

People and their family members told us they felt safe. A person said, "I feel very safe here." A family member told us they visited daily and had never seen anything to cause them concern. They said they thought people were safe and that they could, "Go home and relax, knowing [person] is safe."

Staff had the knowledge and confidence to identify safeguarding concerns and acted to keep people safe. Staff had received training in safeguarding, which helped them identify, report and prevent abuse. Staff told us about how they would safeguard people and actions they would take if they thought someone was experiencing abuse. A staff member said that if they had any safeguarding concerns they would, "report it to

the senior on shift or the manager." This staff member also told us, "I would take it (concern) higher if I needed to; to the safeguarding team or CQC. Some of the people here are vulnerable, their safety is my priority." Another staff member said they, "would not accept abuse of any sort and would tell [name of manager] or go to you [CQC]." Records showed the manager had worked effectively with the local safeguarding team to undertake investigations and appropriate action had been taken to protect people from the risk of abuse.

People and family members felt there were enough staff deployed to meet people's needs. They also confirmed these were usually staff they knew. One person told us, "Yes, there is enough staff. They usually come straight away (when person presses their call bell), although if they are dealing with someone else I might have to wait a short while, not often though." Another person said, "There is plenty of staff around." A visiting health professional stated there were always staff around to support them and staff were able to answer their questions about people. Staffing levels in the home provided an opportunity for staff to interact with the people they were supporting in a relaxed and unhurried manner. We saw that staff responded to people's needs promptly. Staff also felt there were adequate staffing levels and that staffing levels had been increased when required.

The manager and provider's representative told us that staffing levels were based on the needs of the people using the service. They said that they listened to feedback from people and staff and observed care and the time it took staff to respond to the needs of people to help inform them on the number of staff required. The provider's representative told us that staffing levels would always be adjusted if people's needs increased. This was confirmed by staff members.

There was a duty roster system in place, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime or cover from staff employed by the provider at another home nearby. The manager and head of care were also available to provide extra support when required. From viewing the duty rotas and observations, we saw that staffing levels were provided as required. The service also provided a cook each day as well as cleaning staff six days per week, a maintenance person as required and an activities co-ordinator. This ensured that care staff could focus their time on supporting people and their needs.

The provider had a safe and effective recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. Relevant checks were carried out before a new member of staff started working at the service. These included the completion of Disclosure and Barring Service (DBS) checks, which will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff files included application forms, records of interview and references.

Equipment, such as hoists and lifts were serviced and checked regularly. The temperature of hot water at water outlets was monitored regularly by staff and fitted with a temperature control valve. This helped protect people from the risk of scalding. Gas and electrical safety certificates were up to date and the service took appropriate action to reduce potential risks relating to Legionella disease. There were plans in place to deal with foreseeable emergencies. Staff were aware of the action to take in the event of a fire and fire safety equipment was checked regularly. Personal evacuation and escape plans had been completed for each person, detailing action needed to support people to evacuate the building in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

People, their families, healthcare professionals and social care professionals all told us they felt the service was effective. A person said, "I have everything I need, the staff take me to hospital appointments when I need them to; I have my hair done every week, what more can I tell you. I have no complaints whatsoever." Another person told us, "They (staff) give me all the help I need; I am having a bath this morning so that's nice." This person went on to confirm that this was their 'planned' bath day but they could always ask staff for a bath at other times and this was provided. A social care professional told us, "This seems to be a good home, people appear happy and well looked after." A healthcare professional said, "The staff know what's going on, they are very on top of things."

Staff followed the principles of the Mental Capacity Act 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. We found assessments of people's capacity had been completed where needed, together with best interest decisions. However, in one person's file we saw that a thorough MCA assessment had been completed for all aspects of the best interest decision being made, although it was not clear who had been involved in discussions around the best interest decision or what the outcome of the best interest decision was. This was discussed with the manager who agreed to review this person's care file.

Written consent forms were in place and held within peoples care files. These covered consent for sharing information and photographs. We saw that where people had capacity these had been signed by the person. However for two people who lacked the capacity to consent their forms had been signed by family members. The manager was unable to clarify if these family members had the legal authority to sign these on the person's behalf. The manager and the provider's representative were aware of issues with consent forms as this had been identified the previous week. The provider's representative told us that since this had been identified a new consent form had been developed and was due to be implemented imminently. We viewed copies of this new consent form which clearly stated that only people with capacity could sign consent form and only those for whom the home has seen LPA can sign on behalf of a person. Once in place this new consent form will be appropriate to ensure only those legally able can give consent.

People told us that staff sought verbal consent before providing care or support, such as offering to provide support to help them mobilise or supporting with personal care. A person said, "I'm always asked." We heard care and other staff seeking verbal consent from people using simple questions and giving them time to respond throughout the inspection. Staff were aware of people's rights to refuse care and were able to explain the action they would take if care was declined. Staff told us that if people declined care and support they would return later or ask another staff member to try if care was essential such as continence needs. One staff member told us that they wouldn't make someone get out of bed if they didn't want to. They added, "It would be up to them and we need to respect their wishes."

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of the inspection no one living at the home was subject to a DoLs; however we found that DoLS applications had been made by the manager appropriately where required and were awaiting assessment by the local authority.

Staff were appropriately trained and people and their families had confidence in the staff's abilities. One person said, "The staff are very good and they have good regular training." Another person told us, "I think the staff are very kind and generally know what they are doing." A healthcare professional said, "The staff are well trained, I'm confident that they know what they are doing."

Since the last inspection in March 2017 improvements had been made in the monitoring of staff training. This has resulted in staff receiving new and refresher training in a timely way. A training manager has been employed by the provider to monitor and arrange staff training and there is now a robust training system in place to help ensure training is provided when required. In addition to this the provider has implemented processes to help ensure that staff understand the importance of completing and attending required training. This has had a positive impact on staff completing training as required.

The training staff had received included safeguarding, diet and nutrition, moving and positioning, mental health, health and safety, infection control and first aid. In addition, some staff had completed other training relevant to their role, including diabetes awareness, dementia awareness and end of life care. Staff demonstrated an understanding of the training they had received and how to apply it. For example, they used moving and positioning equipment in line with best practice guidance.

At the last inspection in March 2017 we found that staff did not receive regular supervision. At this inspection we found improvements had been made and staff were now provided with face to face supervision from the manager on an eight weekly basis. There were robust systems in place to monitor that supervision was provided when required. This supervision provided an opportunity for the manager to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. The training manager was also in the process of arranging regular observational supervisions, (where staff would be observed while completing their care tasks). Feedback from these observed supervisions would be given to staff about their performance and any identify learning needs would be addressed. The manager was in the process of completing annual appraisals with staff where they discussed their performance and development needs. Staff confirmed they received regular supervision and annual appraisals.

New staff completed an effective induction into their role. This included time spent, working alongside experienced staff, known as shadowing, for all shift patterns until they felt confident they could meet people's needs. The provider's representative told us the length of the induction period was dependent on the job role and the experience and abilities of the staff member. Staff who were new to care work were supported to complete training that followed the standards of the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life.

People received food and drinks of their choice. Throughout the inspection we saw people had cold drinks within reach at all times. People were also provided with hot drinks at regular intervals in addition to when they requested these. Staff recorded people's food and fluid intake for those people who were at risk of malnutrition and dehydration. However, we found that these records were not always fully completed and

daily amounts were not added up meaning staff may not always note that the person had not received adequate amounts of food or fluids. On reviewing people's daily records we saw that people were receiving adequate amounts of food and fluids and this was further supported by staff who regularly monitored people's weight. We saw that action had been taken when people were identified as suffering from unplanned weight loss. We observed that people were encouraged to drink which was done in a kind and caring way. Where assistance was required with eating or drinking this was provided in a respectful, gentle way and staff did not hurry the person.

Most people told us they enjoyed the food provided at Cherry Trees. One person said, "The food is very good." Another person told us, "The food is fine." Some people needed a special diet and we saw this was provided consistently with the cook able to state who required specific diets and how these were met. One person had specific dietary needs which were catered for and the person told us that, "They [staff] have no problem with this, the food is still good." We noted that where people required their meals in a softer form due to the risk of choking these were provided. Staff were attentive to people during meals which people could eat either in the lounge, dining room or in their bedrooms according to their personal preference. When people did not want what was on the menu for the main cooked meal an alternative such as a salad or jacket potato was offered. Where people needed support to eat, this was done in a dignified way. Each person had a nutritional assessment to identify their dietary needs.

People were supported to access appropriate healthcare services when required. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. All the healthcare professionals we spoke to were positive about the home and the care that people received. Information in relation to people's health needs and how these should be managed was clearly documented within people's care files. Staff knew people's health needs well and were able to describe the action they would take in medical emergency, for example if they suspected a person had had a stroke or if a person had suffered a head injury.

There were clear procedures in place to help ensure that people received consistent support when they moved between services. The manager told us that new services are provided with an up to date information form about the person and if required the person would be accompanied by a member of staff.

Cherry Trees Care Home is a large domestic house converted into a residential home. As it is consistent with conversions of this type, the rooms vary in size and aspect and some corridors were narrow. There was also only one communal area available to people, which was used as both a sitting and dining room. This was also where activities were provided. This meant that before people moved to the home a robust assessment of their needs was completed to ensure the environment was suitable to meet their needs effectively. People and family members described the environment as "homely" and inspectors noted a calm and relaxed atmosphere. People's bedrooms had been decorated to their tastes, together with some of their furniture and important possessions. Some adaptations had been made to the home to meet the needs of people living there. For example, signs were used to helped people to find the bathrooms and their bedrooms.

A request had been made by some people living at the home to convert the downstairs bathroom into a wet room. This was being carefully considered by the provider who had sent questionnaires to people for their views on this. The provider's representative told us that this would result in no bath being available to people on the ground floor resulting in people having to travel in the lift and up two stairs to access a bath. This demonstrated that people were listened to and their views and wishes were considered.

Staff made appropriate use of technology to support people. For example, pressure mats were used to alert

staff of the need to support people when they moved to unsafe positions. Special pressure relieving mattresses had been installed to support people at risk of pressure injuries and an electronic call bell system allowed people to call for assistance when needed. Wi-Fi had also been installed to allow people or their visitors to connect to the internet.

Good

Is the service caring?

Our findings

Staff showed care, compassion and respect to the people living at Cherry Trees Care Home. People spoke positively about the attitude and approach of staff. Comments from people included, "The care here is excellent, I have everything I need" and "I think the staff are very kind." A healthcare professional said, "It's a friendly and personal home, the people always seem happy and I think they are well cared for, the staff do care."

There was a relaxed and calm atmosphere within the home and people, their families and staff described the home as having a family atmosphere. People, family members and professionals confirmed that they would be happy to recommend the home to others. Staff expressed a commitment to treating people according to their individual needs, wishes and preferences. A staff member said, "We will always put the residents first." This staff member added, "Just because these people are in a care home they still have a life; they are still important and what they want and need still matters."

People were cared for with dignity and respect and all interactions we observed between people and staff were positive and supportive. Staff were heard speaking to people in a kind and caring way and would interact with people in a positive, friendly and cheerful manner. We saw staff kneeling down to people's eye level to communicate with them. People were listened to by staff who gave them the time they needed to communicate their views and wishes. We heard good-natured interactions between people and staff, showing they knew people well. When people needed assistance to mobilise, staff provided support in a relaxed and calm way while giving the person reassurance and encouragement. Staff took care to look after people's property and keep their rooms tidy; for example, people's clothes were hung neatly in wardrobes. Some people had asked to receive personal care from female staff only and they confirmed this wish was always respected.

Where people had specific communication needs, these were recorded in their care plans and known by staff. One care plan stated that a person who had a hearing impairment had chosen not to wear their hearing aids and we saw that staff respected this. Staff followed the guidance within people's care plans, including speaking clearly and giving people time to answer. Other people with sight impairments had been supported to access talking books and newspapers and were provided with written information in large font if required.

People's privacy was respected when they were supported with personal care. During the inspection we saw a staff member approach a person and whisper something to them which we were unable to hear. The person responded to the staff member and said, "Yes I think I will" and they left together to visit the bathroom. This was all done very discreetly to ensure the person's privacy and dignity was maintained. Staff were able to describe the practical steps they took to preserve people's dignity and privacy when providing personal care. This included ensuring doors and curtains were closed and making sure people were covered when providing personal care. We observed staff knocking on doors, and asking people's permission before entering their bedrooms. A staff member told us, "I would always make sure the person is covered. I would explain what I am doing and also ask them if they would like me to wait outside the room while they are

doing specific personal tasks."

Information regarding confidentiality, dignity and respect formed a key part of the induction training for staff. Confidential information, such as care records, were kept in in the manager's office and only accessed by staff authorised to view it. Any information which was kept on the computer was also secure and password protected.

Staff respected people's independence and encouraged people to do things for themselves when able. A person told us, "I still value my independence. The staff respect this and give me the help I need; with a light touch." At meal times we saw that staff would encourage people to feed themselves and people had access to appropriate specialist equipment where required. We saw people being encouraged to stand and walk on their own using walking aids, such as frames and sticks. Staff did not rush them and allowed people to go at their pace. Comments in care plans highlighted to staff what people could do for themselves and when support may be needed. For example one care plan stated, 'I can wash my hands and face if staff give me the flannel.'

The manager told us they explored people's cultural and diversity needs by talking to them and their families and by getting to know them and their backgrounds. This information was then documented within the person's care file. The manager added that if a person followed a particular faith that they and the staff lacked knowledge of, they would research this by looking for information on the internet and speaking to followers of that faith to help ensure that people could be effectively supported.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs. Staff provided flexible and individualised care and support to people. One person told us, "The staff here are very good, I have some mobility problems; the staff know how to help me though." Another person said, "I am looked after very well by all the staff." A healthcare professional told us, "Whichever staff member I ask about a person, they are always able to answer my questions; I think staff know people well."

During the inspection staff demonstrated that they know people well, understood their needs and had knowledge of their likes and dislikes. For example, at breakfast a staff member asked one person if they wanted another cup of coffee then looked at person next to them and said 'tea'? We then heard another staff member offer a person biscuits, this staff member said to the person, "There is one of your favourites, but would you like a different one today?" This showed that staff knew what people usually liked, but still gave them a choice.

Care and support were centred on the individual needs of each person. Assessments of people's needs were completed by the manager, before they moved to the home. This information was then used to develop an appropriate care plan in consultation with the person and their relatives where appropriate. Care plans contained detailed information to enable staff to provide care and support in a personalised way according to people's individual needs. They included people's normal daily routines, their backgrounds, hobbies, interests and personal preferences; such as when they would usually like to get up or go to bed and when they would prefer have a bath. Most people confirmed that although this information was recorded in their care plans they were able to receive care at chosen times. This demonstrated that staff were adaptable to meet people's wishes. Records showed there were regular formal review meetings with people using the service and relatives. At these meetings people's care was discussed and reviewed to ensure people's needs were being met effectively.

Staff were kept up to date about people's needs through handover meetings which were held at the start of every shift. These meetings provided the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting. Inspectors attended one of these meetings and heard relevant individual information being provided to staff which included information about a person who had a reduced appetite and a person who had chosen to say in bed. During this meeting staff also discussed that a person may need some extra 'love' and encouragement to spend time in the lounge for the afternoon entertainment and sit with friends due to an upsetting event they had recently experienced.

The service was responsive to people's changing needs. Records showed that when people's health deteriorated, the service referred people to appropriate health care professionals. All healthcare professionals we spoke to confirmed they were contacted appropriately, in a timely way and that staff always followed any recommendations they made. One healthcare professional said, "If I give them advice, it will always be followed." Staff were knowledgeable about people's needs and were confident to report any changes in people's health.

People told us they were provided with appropriate mental and physical stimulation through a range of varied activities. One person said, "I really enjoy the activities, we have bingo, music, and true or false questions. We sometimes have stretching and keep fit." An activities co-ordinator was employed to provide activities which included quizzes, exercises and games to the people living at the home. In addition to this, other activities were provided by an external company who visit the home approximately twice a week to provide music and reminiscence. The manager told us when people remained in their bedrooms they were often visited by the activities co-ordinator who would provide them with a hand massage or nail care if they wished.

People's care plans highlighted their social interests and past hobbies. Staff were knowledgeable about people's right to choose the types of activities they liked to do, and respected their choice. On viewing the minutes from the recent 'resident and relatives meeting', we saw that discussions had taken place which involved people in making decisions about future activities. People were also supported to maintain important relationships. Family members confirmed they were able to visit at any time and were always made to feel welcome.

At the time of the inspection no one living at Cherry Trees Care Home was receiving end of life care. However, the manager and staff were able to provide us with assurances that people would be supported to receive good end of life care and effective support to help ensure a comfortable, dignified and pain-free death. Staff had received training in end of life care and demonstrated that they understood this. For example, one staff member told us, "I would do everything I could to ensure the person was comfortable [at the end of their life]." Care plans contained limited information about people's individual end of life wishes. We discussed this with the provider's representative and manager who were aware this was an area they needed to develop. They were completing a management course run by the local hospice. Whilst not specifically related to end of life care, they had had some sessions relating to this and had plans as to how they could improve their processes for seeking information about end of life wishes. They also identified that the course had strengthened their relationship with the hospice and meant they would be able to access support when required.

The provider had arrangements in place to deal with complaints. These provided detailed information on the action people could take if they were not satisfied with the service being provided. The manager told us they had received one complaint since the last inspection from a person living at the home. They explained the action they had taken to investigate the complaint and respond to the concern raised. People and their families told us that they would feel comfortable raising concerns with the manager or providers representative and felt confident these would be resolved. One person said, "I have never had to complain and I have no complaints now."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in April 2017 we found that management oversight of the home was not effective. For example, staff had not received regular supervision; not all staff had completed all essential training in a timely manner; not all risk assessments and care plans were person centred or sufficiently detailed and not all audits and checks were robust in highlighting issues or concerns. At this inspection we found that improvements in most of these areas had been made although further work was still required in some areas and time was needed to ensure that new practices were embedded to ensure that improvements made were sustained.

There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment. An infection control audit was in place, however this audit had failed to identify that an area of flooring in the laundry room posed a risk of cross contamination. Additionally, there was a process in place that required senior staff members to sign to say they had checked various things each day such as food and fluid and turning charts; on viewing these charts we found that although these had been signed by the staff gaps were identified. We found that there was not a system in place for the manager to check that these were being completed correctly. The audits had also failed to address the shortfalls we found in ensuring that staff followed guidance relating to people's risk assessments.

There was not an effective system or processes in place to ensure that appropriate action was taken when incidents, accidents and near misses had occurred. For example, a person had sustained bruising on more than one occasion and staff had completed 'body maps' to highlight the origin of the bruising as required. However, no other information was available to demonstrate that the cause of these bruises had been investigated or to show that action had been taken to prevent future incidents. This was discussed with the manager and the provider's representative who agreed there was no information to show investigation of potential abuse or action to prevent further injuries.

The failures to ensure the quality and safety of the service is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other quality assurance systems in place were effective, including care plans, training, the cleanliness of the home, equipment and maintenance. We saw that where issues were identified actions were taken in a timely manner.

At the time of the inspection there was not a registered manager in place. The previous registered manager had left the service in March 2018. At this inspection there was a manager in place who had taken over the overall running of the service, with support from the provider's representative. The manager told us they were planning to commence the registration with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

Although there was no registered manager in place, there was still a clear management structure in place. This structure consisted of the provider's representative, the manager, a head of care, senior care staff and care staff. Each had clear roles and responsibilities which were understood by all staff. There was also an 'on call' rota in place to enable staff to access management advice out of hours.

People were happy living at Cherry Trees Care Home and felt the service was well-led. Comments from people and their family members included, "I don't think you will find any problems here" and "It's all very good here, you don't need to worry about that." A healthcare professional said, "I really like this home, it seems well organised." Additionally, although the manager had only been in post for a few weeks all people and family members we spoke to were able to tell us who the manager was and felt able to approach them if needed. This showed that the manager had been proactive in building relationships with people and their families.

The provider's representative was engaged in running the service and told us their vision and values were built around, "providing good quality care in a homely environment." They added they wanted the service to be "led by the residents; this is their home." The manager said, "I want the service to run smoothly, keep people safe and ensure that they have a high standard of care. I also want to ensure that the staff feel listened to and valued, staff morale is very important to us." Staff members understood the values of the service and many described Cherry Trees as family orientated. One staff member said, "We want a happy home and positive relationships with the people who live here." Another staff member told us that their goal was to, "keep people as happy as possible, this feels like their home; not an institution and that they can do what they want."

We saw evidence of regular staff meetings. Regular meetings kept staff up-to-date and reinforced the values of the organisation and their application in practice. Staff told us the meetings were useful and enabled them to contribute to the service development and improvement by sharing their ideas. Staff told us they felt well-supported, listened to and valued by the manager and providers representative. Staff comments included, "It's more relaxed now and the manager is very good. I think we all work well as a team and will always support each other" and "The manager will help out when needed." Staff also confirmed that they were able to raise issues with the manager and were confident these would be addressed.

The manager told us they felt well supported by the provider's representative who visited the service regularly, the training manager and a registered manager from a neighbouring home. When we spoke with the provider's representative, they expressed confidence and trust in the competence and abilities of the manager. The provider's representative and the manager was attending a five day course for home managers, commissioned by the local authority and run by the local hospice. They spoke positively about the course, including the opportunity to meet other home managers to share ideas and examples of best practice.

Positive links had been developed with the community, including with local churches, schools and charities, including one charity that supported people with hearing loss. Health and social care professionals confirmed that the service worked in partnership with the local authorities, healthcare professionals, GPs, a local hospice and social services.

The manager told us they sought feedback through the use of quality assurance survey questionnaires that were sent six monthly to people, their families and staff. We looked at comments received from the latest survey sent to people in February 2018 which were all positive in respect of the care people received and the safety of service. Residents meeting were held six monthly. We reviewed meeting minutes which demonstrated that people were actively involved in discussions about the service and care they received.

We also saw that during one residents meeting people had expressed views on a particular activity. This had been addressed by the manager and action had been taken as requested by the people living at the home. This demonstrated that people were listened to and their views were respected and acted upon. The manager also sought feedback from people and their families on an informal basis when they met with them at the home or during telephone contact.

There was an open and transparent culture within the home and people and families confirmed they felt able to approach the manager at any time. Duty of candour requirements were being followed; these required staff to act in an open and transparent way when accidents occurred. The manager understood their responsibilities and was aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed in the home and on the provider's website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to prevent and control the risk of infection, safely manage medicines and to ensure risks relating to the safety and welfare of people using the service were assessed and managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure there were effective processes in place to monitor the quality and safety of the service.