Cherryfield Homes Limited

Cherryfield House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
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 28 and 29 October 2016 and was unannounced.

Cherryfield House provides accommodation and personal care for up to 29 people. It has 21 single and four shared rooms. There are 18 bedrooms that have an en-suite with shower and the remaining rooms have washing facilities. The home is a two storey detached property located in the Edgeley area of Stockport. It has a small front garden and is situated in a residential area within walking distance of a local park. The home was registered to provide nursing care. However, we found nursing care had not been provided at the home for some time, and the home did not employ nursing staff. We requested the provider submit an application to cancel their registration for 'treatment of disease, disorder or injury', which they did shortly after the inspection. At the time of our inspection there were 28 people living at the home.

We last inspected Cherryfield House on 01 July 2014 when we found the home was meeting the standards for all areas we inspected. At this inspection we identified two breaches of the regulations, which were in relation to the safe management of medicines and governance systems. You can see what action we told the provider to take at the back of this report. We have also made recommendations about reviewing guidance in relation to reviewing processes for determining staffing levels, developing dementia friendly environments and reviewing practices in relation to agreement for shared rooms.

During our inspection we found lots of examples of good practice, and positive and caring support. However, we also identified several areas where improvements were required. The registered manager was responsive to our feedback and had started to take actions to make some of the required changes during our inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People living at the home, relatives and visiting professionals all described staff as being kind and caring. There was a long-standing staff team in place, with low levels of turnover. This meant that staff knew the people they provided care and support to very well. People spoke about there being a 'warm' environment at the home.

There were sufficient numbers of staff on duty in the day to meet people's needs in a timely way. The registered manager worked 'on the floor', which they told us helped determine the required staffing levels. We found the level of staffing on the night shift varied between two or three staff. The provider told us this was due to people's vary level of needs. We made a recommendation that the provider uses a documented process to demonstrate staffing levels were based on assessed needs.

Care plans were detailed and person-centred. Sufficient information was provided to allow staff to deliver care to people in accordance with their needs and preferences. People's social histories were recorded, which enabled staff get to know people.

The service actively identified and recorded complaints, whether raised formally or informally. Actions taken to resolve complaints and concerns were recorded, and written responses were provided to any complaints raised formally. People we spoke with told us they had not raised any complaints, but would feel comfortable doing so if required.

Staff told us they received adequate training to carry out their roles competently. We saw training had been provided in a variety of topic areas including safeguarding, dementia, communication and first aid.
One staff member described taking an approach that showed a lack of understanding and was based on staff convenience rather than being centred on people's needs and preferences. We raised these concerns with the registered manager who told us the appropriate steps they planned to take to address this concern.

Medicines were stored and administered safely. However, we found there were no written instructions (protocols) for staff to follow in relation to the administration of 'when required' (PRN) medicines. This would increase the risk that such medicines were not administered in response to a person's need for them, and there was evidence of these medicines being administered on a routine basis. The registered manager took action to put PRN protocols in place and sent us evidence of this shortly after the inspection.

We received positive feedback from professionals who worked with the home, including a district nurse and a social worker. They told us they found the home was open minded, and acted upon any advice given. We saw a range of health professionals had been involved in people's care.

We received mixed responses when we asked people whether there were sufficient activities to keep them occupied. The home had employed an activity co-ordinator who had recently left, and was in the process of recruiting a replacement. During the inspection we saw staff had time to spend talking with people and we saw they arranged a number of ad-hoc activities, including karaoke and a quiz. We saw staff actively encouraged people to engage in these activities and people appeared to enjoy them.

There were systems in place to monitor the quality and safety of the service. We saw appropriate actions were taken in response to any accidents and the service had investigated incidents to consider potential causes of any accidents or injuries, and how they might reduce any future potential risk.

Staff and people living at the home spoke positively about the registered manager. They told us the registered manager was hard working, supportive and approachable. Staff told us they enjoyed their jobs and felt valued for the work they did.

We found records in place to track the frequency of supervision and the training provided were not always accurate or up-to-date. The provider had not ensured their statement of purpose contained the required information. A statement of purpose is a document that provides specified details about the service and is required by CQC.

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 home was not consistently safe.

There were no instructions available for staff to inform them when to administer 'when required' medicines.

There were sufficient numbers of staff to meet people's needs during the inspection. However, there was no formal method used for determining staffing requirements based on people's needs.

Risks to people's safety and well-being were assessed and measures to reduce potential risks had been identified. Any accidents were recorded and investigated when required.

Is the service effective?

Good

The home was effective.

Staff sought consent from people before providing care or support. Staff understood requirements in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.

Other health and social care professionals gave positive feedback about the service. We were told the service sought and acted on advice.

Staff had received training in a variety of topics, which included dementia care, safeguarding, moving and handling and equality and diversity. Staff told us the training was of good quality.

Is the service caring?

Good

The home was caring.

There was a long-standing staff team, with some of the staff having worked at the home for eight or more years. Staff and people living at the home knew each other well.

Staff told us they would be happy for a friend or family member to move to the home because of the caring approach.

People and their relatives told us that staff were kind, caring and respectful. We observed clear communication and positive interactions between staff and people living at the home.

Is the service responsive?

Requires Improvement

The home was not consistently responsive.

Care plans were comprehensive, person-centred and regularly reviewed.

The service was pro-active at recognising and recording complaints. People told us they would be confident to raise a complaint.

Staff did not consistently demonstrate that they worked in a person-centred and responsive manner.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Staff and people using the service spoke positively about the registered manager who they told us was hard working and approachable.

There were systems in place to monitor the quality and safety of the service. However, these had not been effective at identifying the issues we found.

The provider had not submitted the required information to CQC in relation to changes to the service.

Cherryfield 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.

This inspection took place on 28 and 29 October 2016 and was unannounced. The inspection team consisted of one adult social care inspector.

Prior to the inspection we reviewed information we held about the service. This included previous inspection reports and notifications that the provider is required to send to CQC about safeguarding, serious injuries and other significant events. 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 improvements they plan to make. We reviewed the PIR as part of the planning for this inspection.

We sought feedback on the service from the local authority quality assurance team, Stockport Healthwatch and Stockport safeguarding. We did not receive any feedback relevant to the inspection process.

During the inspection we spoke with four people who were living at Cherryfield House and three relatives who were visiting at the time of the inspection. 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 spoke with nine staff members. This included the Registered Manager, the Nominated Individual, six care staff and the cook. We spoke with two district nurses and a social worker who were visiting the home at the time of the inspection.

We reviewed records relating to people's care including, seven care files, 10 medication administration records (MARs) and daily records of care provided. We also reviewed records related to the running of a care home including three staff personnel files, records of supervisions and records of audits, checks and

maintenance.

Requires Improvement

Is the service safe?

Our findings

We observed staff administering medicines and saw they followed safe practices. Medicines were kept in a locked trolley and the staff member administering medicines observed people taking their medicines before signing the administration records. Medicines were stored in a locked cupboard, controlled drugs cabinet or fridge as required. Controlled drugs are medicines that are subject to additional legal requirements in relation to their safe storage, administration and disposal to help prevent any misuse.

We looked at records of medicine administration and saw these had been completed consistently. We checked stocks of medicines and these corresponded with the expected stock level indicated by the administration records. We saw that some people were prescribed medicines such as pain relief and medicines for sleep or anxiety to be administered on a 'when required' (PRN) basis. There were no protocols in place to inform staff under what conditions these medicines should be administered, and the administration records showed four PRN medicines had been administered on a routine basis. The lack of PRN protocols would increase the risk that medicines were not administered responsively to people when they required them and that their efficacy would not be monitored. We raised this concern with the registered manager and saw by the second day of our inspection that they had started to put PRN protocols in place. Shortly after our inspection we received evidence that PRN protocols had been completed for people that required them.

We looked at the training staff had received to administer medicines. The registered manager told us only senior carers administered medicines, and that if there was not a senior member of staff on the night shift that the day senior would administer night time medicines at the end of their shift. We raised concerns that this would prevent people who required PRN medicines during the night from receiving them in a timely manner. The registered manager told us most staff, including staff who were not senior carers had been trained in medicines administration, and therefore could administer medicines if there was an urgent requirement during the night period. They told us they would re-look at the arrangements in place in relation to the administration of medicines.
We saw evidence that staff had received training in medicines administration, although for some staff this training was nearly three years old. There were no individual checks of staff competence to administer medicines, although the registered manager completed a weekly spot check on medicines that included staff practice. However, this would not have covered staff who were not seniors and were not administering medicines on a routine basis. On the second day of our inspection the registered manager showed us a pro-forma they would use to carry out competency checks, and we saw a sign had been put up informing staff of medicines training arranged for October 2016.

These issues in relation to the safe management of medicines were a breach of Regulation 12(1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

During the inspection we saw there were sufficient numbers of staff to meet people's needs in a timely manner. Call bells were responded to promptly and one person told us; "It's brilliant. They do everything for you. You just put your hand up and they come." We spoke with a visiting professional who told us there were

always staff available to support their visits to people if required. However, one relative told us that when the manager had been on leave that they had visited on several occasions and found no staff present in the home as they had taken breaks together. We were not able to find evidence that would confirm nor contradict this concern. We made the registered manager aware of this who told us they would address this with the staff team.

The registered manager told us there was no formal assessment of staffing requirements based on people's needs. However, they told us that as the home was relatively small, and as they frequently worked alongside staff 'on the floor' that they had a good understanding as to whether staffing levels were adequate. Staff we spoke with told us they felt there were sufficient numbers of staff on duty to allow them to meet people's needs. The rotas indicated that during the night shift there were either two or three members of staff on duty, and an on-call member of staff in addition. Staff told us the reason for there being either two or three staff on duty at night was due to staff sickness and annual leave, although the provider told us staffing had varied based on people's needs. Night staff we spoke with told us they found two staff on duty was sufficient.

We recommend the provider reviews procedures in place for determining and reviewing staffing level requirements.

We asked a relative whether they felt their family member was safe living at the home. They told us; "Yes, they are kept safe. [Person] was not safe at home and was falling a lot. They have not had an accident since moving here. [Person] feels safe here." We noticed that several people at the home were not wearing any foot-ware. This could potentially increase risks relating to falls or in some cases present risks in relation to infection control. We discussed this with the registered manager who told us the lack of foot-ware was people's personal choices. The registered manager told us some of these people had been advised to wear slippers or other foot-ware but had declined to do so. We were able to speak with one person who confirmed they were not wearing slippers through choice.

We looked at records of accidents and injuries, which demonstrated appropriate actions had been taken in the event of anyone falling or sustaining an injury. For example, staff had made referrals to other professionals including physiotherapists and GPs and post-accident observations had been carried out to monitor for any signs of potential injury not initially recognised. Documents showed the potential cause of any fall had been investigated, and measures to reduce any future risk had been identified and put in place.

Risks to people's health and well-being had been assessed. There were risk assessments in place in relation to falls, moving and handling, choking, malnutrition, skin integrity, finances and people's rooms. Risk assessments had been regularly reviewed, and where concerns had been identified, there were care plans in place to inform staff how to provide care in a way that reduced any potential risks.

Staff had received training in safeguarding and were able to tell us how they would identify and report any signs of potential abuse or neglect. One staff member told us; "Abuse could be physical or verbal. I would look for signs such as weight loss or if a person looked withdrawn." Records showed the registered manager had reported any concerns to the local authority safeguarding team in accordance with their procedures. The provider's safeguarding log showed that appropriate actions were taken in response to any safeguarding concerns to help ensure people were kept safe. This included an analysis and 'lessons learned' exercise that had been carried out for any more serious concerns. This showed the provider had a pro-active approach to learning from any incidents to make improvements to the safety of the service.

We looked at staff personnel records and saw safe procedures had been followed when recruiting staff, such

as seeking references, obtaining a disclosure and barring service (DBS) check and verifying an applicant's identity. A DBS check shows whether the applicant has a criminal record or is barred from working with vulnerable people. This helps employers make safer recruitment decisions. We saw staff had completed applications forms when applying for their jobs that included a full employment history. There was also evidence that staff had been invited to attend interviews, although records of interviews had not always been made or retained. The provider had introduced a recruitment audit tool and had also recognised this shortfall. They told us this tool would also help to ensure all required documents were in place for future applicants.

People told us they found the environment was kept clean and tidy at the home. We saw there was cover from domestic staff on the rota seven days per week. During the inspection we observed staff using personal protective equipment (PPE) such as gloves and aprons when required, and there was hand washing guidance displayed in the bathrooms. We noted that the carpet in the ground floor lounge had some staining, and the registered manager told us they were considering replacing this.

We looked at records of servicing and maintenance carried out. We saw the required checks of gas, electrical systems and lifting equipment (such as hoists) had been completed as required. Regular checks were also made of the call bell system, water temperatures, fire alarm and environment. During our tour of the building we noticed a window restrictor on a first floor bedroom window had come loose, although the actual opening of the window was still restricted. The registered manager requested that maintenance saw to this matter immediately.

Environmental and fire risk assessments had been completed and there was a business continuity plan in place, which would help staff know the appropriate actions to take in the event of an emergency, such as a required evacuation due to fire or flood. We saw people living at the home had personal emergency evacuation plans (PEEPs) in place that detailed the support they would require to evacuate the building in the case of an emergency.

Good

Is the service effective?

Our findings

People told us the home would contact a doctor or other health professional if there were any concerns in relation to their health. One person told us; "I'm seen by the doctor when needed. I'm really well looked after." Records showed a range of health professionals had been involved in people's care. This included district nurses, GPs and dieticians. We spoke with the 'link' district nurse for the home who told us the district nurses and the home worked 'really well together'. They said the home regularly asked for input and advice from the district nurses, and acted on any advice or instructions given. The link district nurse and registered manager met from time to time to discuss the care of anyone with more complex needs, and any changes in their health.

Daily records showed that people who had been identified as being at risk of skin breakdown were supported to re-position frequently, in-line with guidance in their care files. We also saw records of food and fluid intake and people's weights were kept and regularly updated. Where any weight loss was identified, the records indicated that staff had considered any potential cause of the weight loss and had contacted other professionals such as a dietician for advice if required.

People's care plans contained information on food preferences, allergies and any dietary requirements. We saw this information was also displayed in the kitchen area, and the cook was aware of how to prepare meals, such as those that needed to be of a particular consistency, or fortified for example. We received positive comments from the people we spoke with about the food provided. These included; "The food is excellent. I can request an alternative if I want;" "The food is lovely, but I'd like a chop;" and "The food is wonderful, I couldn't complain about anything." We observed the mid-day meal on the second day of our inspection and saw that people received the support they required to eat and drink in a dignified manner and at a pace that was suitable to the individual. People were asked if they had had enough to eat and drink and were offered alternatives if they didn't want the option on the menu.

Staff told us they received adequate training to enable them to carry out their roles competently. Staff said the training they received was good quality and that the trainers always provided them with the opportunity to ask follow-up questions and to receive further explanation should they require this. Staff told us, and records confirmed, that they had received training in a range of topic areas including health and safety, fire safety, first aid, equality and diversity, moving and handling and the Mental Capacity Act and Deprivation of Liberty Safeguards. We found some training, including medicines administration and training in diabetes care had also been provided, although this was not reflected on the training matrix.

We looked at records of staff supervisions and saw these took place approximately every other month. Supervisions were undertaken on both a group and one to one basis. Staff we spoke with told us they found supervisions useful and said they felt they received sufficient support from their manager. However, we found one member of staff had not received recent or regular supervision. We have discussed this further in the 'responsive' section of this report.

We found staff were supporting one person with the administration of insulin by injection. There was no

record available at the time of inspection to evidence that staff had received training and instruction to enable them to competently administer insulin. However, following the inspection we received confirmation from a health professional that this training had been provided to staff. We also saw the registered manager had arranged a refresher course for staff in diabetes through the district nurse team. Staff we spoke with were aware of the support needs of people with diabetes and of the signs to look for that might indicate a person had a high or low blood sugar level. We saw there were diabetes care plans in place, and blood sugar levels were monitored on a routine basis.

Staff told us they had received training in dementia care, and were able to explain how dementia could affect people, and how they would effectively support them. We spoke with the training provider who told us the training promoted a person-centred approach with a focus on effective communication. We saw there were some limited adaptions to the home that would make it more accessible to people living with dementia to enable people to orientate themselves around the home and to locate communal areas and their own rooms. This included photos on the doors of some people's rooms and some pictorial signs indicating the use of different rooms. We discussed the potential for further adaptations to be made to make the environment more 'dementia friendly'.

We recommend the provider reviews good practice guidance in relation to developing dementia friendly environments.

During the inspection, a relative we spoke with noted that there was a step between the lounge and garden area. They told us this made the garden more difficult to access for people who used wheelchairs. We informed the provider of this feedback who told us they would look to obtain a suitable ramp. During our tour of the building we found the toilet on the first floor was out of order. The registered manager told us most people's rooms on the first floor were en-suite, and that those in rooms without an en-suite used a commode at night, which was in accordance with their preferences. We saw people in this area of the home were using the communal lounges on the ground floor during the day where they had access to a toilet. The registered manager told us the issue had been reported to maintenance and repair of the toilet was being arranged.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had a good understanding of the MCA and DoLS and had submitted DoLS applications, including applications for urgent authorisations as required. We saw several DoLS applications had been due to expire and the registered manager had submitted new applications in a timely manner to help ensure the authorisations did not lapse and that people were not deprived of their liberty without the legal safeguards being in place.

We saw people who had an authorised DoLS had a DoLS care plan in place. This would help ensure staff were aware of what the DoLS authorisation meant in relation to that person's care. Staff we spoke with were able to explain the basic requirements of the MCA and DoLS, and were aware of which people they provided support to had an authorised DoLS. Staff told us they would seek to support people in the least restrictive

ways possible; for example, by accompanying a person to the shop if they wanted to leave and were not able to do so alone as they had a DoLS in place.

During the inspection we observed that staff asked for consent before providing any care or support to people. Where people had capacity, we saw they had signed consent forms in relation to their care plans, records and use of photos. Staff were able to describe how they would seek consent from people who did not communicate verbally, such as observing body language and facial expressions. Staff also talked about the importance of getting to know people and how they liked things to be done.

Good

Is the service caring?

Our findings

People and relatives spoke positively about the kind and caring approach of staff. One person told us; "I was frightened when I first came here, but after the first 12 hours I realised everyone was very kind." One of the visiting professionals we spoke with told us; "There is a warm and friendly atmosphere. Families love it." This view was reflected in comments we received from relatives who told us they thought staff were very caring, and said the environment didn't feel 'clinical'.

There was a long-standing staff team at the home with some of the staff having worked at the home for up to 20 years. The most recently recruited member of care staff had started approximately two years previously, and the home did not use agency staff. This meant people were cared for by staff they knew well and who had a good understanding of their needs and preferences. Staff we spoke with, including the registered manager were able to discuss people's care needs, interests and social histories in-depth with us. One relative told us; "[My relative] thinks the world of the staff. I think they know him very well." Another relative told us they thought their family member who did not communicate verbally, liked the staff as they smiled at them.

Staff told us they had time to spend with people. One staff member told us they had spent a long period of time providing emotional support to a person who had been feeling down. A visiting health professional we spoke with also spoke positively about the time staff had spent supporting this person. During the inspection we saw staff interacted naturally with people, with both staff and people using the service initiating conversations.

People we spoke with told us staff respected their privacy and dignity as far as was possible. One member of staff said; "We treat people like we would want to be treated." We saw that staff were discreet when offering people support with personal care. At one point during the inspection we observed staff supporting a person using a hoist. We saw the staff communicated what they were doing clearly to the person, and they adjusted the person's clothing to help maintain their dignity as they were lifted.

Care plans contained information in relation to supporting effective communication with individuals. This included information on any communication aids such as glasses or hearing aids that the person might require. The service had recently introduced pictorial menus, which they said had been useful at helping present meal choices to people who might have otherwise not been able to understand or indicate their choices.

Care plans detailed the level of support people required with tasks, but also indicated what people were able to do independently or with minimal support. Staff told us they would first prompt people rather than doing everything for a person. They told us they would encourage people to make choices, such as in relation to the clothing they wore as another way of supporting independence.

Relatives we spoke with told us there were no restrictions on visiting and said the home communicated well with them. We saw where appropriate that relatives had been involved in pre-admission assessments and

developing care plans. We asked three staff whether they would be happy for a friend or family member to receive support at Cherryfield House. All three staff member's answered positively. One staff member told us they had recommended the home to people they knew, and another staff member responded; "Yes definitely. People are loved and taken care of. People are considered like parents and we treat people with love and respect.''

Requires Improvement

Is the service responsive?

Our findings

We saw pre-admission assessments were completed to help the home determine whether they were able to meet a person's needs prior to them moving in. The pre-admission assessments were then used to develop a temporary care plan that was kept in place whilst a full care plan was developed and staff got to know the person better. The registered manager told us they were in the process of updating care plans to a new more person-centred format. We saw this process was nearly complete, and all the care plans we requested to look at were in the new format.

Care plans were comprehensive and provided staff with the information they needed in order to provide people with care and support in accordance with their needs and preferences. Care plans covered areas including, health care, personal care, communication, activities and food and nutrition. They provided information on what people were able to do independently, as well as the assistance they required. There were also recorded social histories that provided staff with details of people's current and former interests, occupation and significant life events. This helped staff get to know the people they provided support to, and provided an opportunity for the service to explore and meet people's interests and preferences. Care plans had been recently and regularly reviewed to ensure they reflected people's current needs. We tracked some aspects of care provision as detailed in people's care plans and saw this was reflective of the support staff were providing to people.

Relatives we spoke with told us they had not had to raise a complaint, but would feel comfortable doing so if they felt this was necessary. We looked at records of complaints and saw the service was pro-active in recognising and recording complaints whether raised formally or otherwise. The complaints log detailed any complaint made and the actions taken to address the concern appropriately. There had been few formally raised complaints. However, we saw that where someone had raised a formal complaint, the provider had investigated the complaint, provided a response and issued apologies where appropriate.

The service had sought feedback from people though a survey. The most recent survey had been carried out in August 2016, and we saw comments and responses on the returned questionnaires were generally very positive. The findings from the survey had been analysed and were displayed on a notice board near the entrance to the home. We also saw that weekly feedback was sought and recorded in relation to the meals provided. This helped the cook adapt the menus to meet people's tastes and preferences.

Most staff we spoke with talked positively about supporting people to make choices and working around individual's preferences. However, one staff member we spoke with talked about the support they provided from the perspective of staff convenience rather than working to meet individual preferences. This staff member told us; "Some of them do complain and moan, and some of them can be difficult and try it on… You know when you need to take the firm upper hand if they are playing the game." This demonstrated an approach that was not person-centred and showed a lack of empathy and understanding. We raised these concerns with the registered manager who detailed the appropriate steps they would take to address this issue .

People we spoke with told us they were usually able to make choices about aspects of their care such as the time they got up and when they were supported with bathing or showering. One person said; "They know I like a shower every day, and they do offer support," whilst another person told us; "I need support to have a shower. Sometimes they say there are not enough staff to support me at the times I want. I understand that though." There were four rooms at the home that were provided as shared bedrooms. All four of these rooms were occupied by two people at the time of our inspection. We asked what consultation had been made to ensure these people were happy to share a bedroom. The provider told us people's suitability and acceptance of a shared room would be assessed by social workers involved in people's placement. However, the provider was not able to show us any evidence of such assessment by the home or other professionals, or that any review of these arrangements had taken place. We were unable to speak directly with any of the people who were sharing a room to ask for their feedback. However, we spoke with family members of one person who shared a room, who did not raise any concerns in relation to this arrangement.

We recommend the provider reviews arrangements for recording and reviewing decisions made in relation to shared rooms.

We asked people if there were sufficient activities provided to keep them occupied, and received a variable response. One person told us; "They take us out and around. Otherwise I can be sat here counting matchsticks. I do get bored." Another person said; "We had a quiz yesterday. It was very good;" and a third person told us; "I played bingo the other day. It was just something to do." The home had employed an activity co-ordinator who had recently left the service. The registered manager told us the service was in the process of recruiting a new activity co-ordinator.

During the inspection we saw staff arranged several ad-hoc activities, which included; card games, a bingo session, nail painting and a karaoke session. We also saw staff singing and dancing with people. They encouraged people to engage in this session and people appeared to enjoy the activity as they were smiling and laughing. At one point in the inspection we heard staff asking a person what they wanted on the TV and they asked if they wanted the news on as the staff member commented they usually enjoyed this. The person agreed, and the staff member encouraged discussion between a small group of people about the topics in the news. This showed staff considered people's interests and also encouraged social interaction.

The home supported people with a wide range of needs, including some people who were cared for in bed due to their health needs, and also adults of working age who required social care support. We asked staff how they met these people's social needs. They told us they would spend time with people cared for in bed and would put their radio or TV on. Staff also told us they were planning to support one of the working age adults on a shopping trip. This person told us they recognised they were significantly younger than most of the people, but told us they liked spending time sitting outside with the staff. We asked one of the visiting professionals whether they thought the home was able to effectively meet the needs of working age adults. They told us the home were 'open minded', worked hard and did not use agency staff, which helped in this respect.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post at Cherryfield House, who had managed the home since 2004. The registered manager was supported by a deputy manager and a quality and compliance manager who also worked for two other homes owned by the directors of the company.

Staff and people living at the home spoke very positively about the registered manager's leadership of the service. One person told us; "[The registered manager] is great. They help out with everything and they are lovely." A staff member said; "The home is well-led. The manager is a grafter;" and a second staff member told us; "The home is good. [The registered manager] does a brilliant job." There was a low turnover of staff at the home, and we asked the registered manager why they thought this was. They told us they worked with staff and appreciated them. They also said they worked 'on the floor' and helped staff problem solve. Staff confirmed they felt valued for the work they did, with one staff member commenting; "I feel appreciated. [The registered manager] always says thank-you."

Relatives and people using the service expressed satisfaction with the service provided. One person we spoke with told us; "I love coming here. It is my favourite respite place, and I've been to a few." A relative told us; "[Family member] was at another home previously that I didn't like. He is happy here. I don't see any problems."

The service acted on advice and feedback provided by other professionals. The registered manager showed us a recent quality monitoring report undertaken by the local authority. The report was generally positive and the registered manager was able to discuss areas that had been identified where potential improvements could be made. They were able to tell us the actions they had taken in response to this feedback to make improvements. We also found the registered manager was responsive to the feedback we provided during and at the end of the inspection. They took prompt actions to address some of the areas of concern we identified, such as arranging for refresher training in medicines and completing PRN protocols for 'when required' medicines.

We saw there were systems in place to help monitor and improve the quality and safety of the service. Audits had been recently carried out of aspects of service provision including; infection control, health and safety, complaints, safeguarding, nutrition and medicines. We saw that where any shortfalls were identified, actions had been detailed to make the required improvements. Accidents were recorded on a monitoring log, and we saw that more serious accidents or incidents had been investigated. There were also regular provider visits, which looked at different, specific aspects of the service delivery during monthly visits. However, the governance systems had not been effective at identifying the issues in relation to the safe management of medicines we found.

The service had a training matrix in place. However this did not reflect all training undertaken, which would make it difficult to ensure an appropriate staff skill mix for each shift. For example, there was no record of medicines or diabetes training on the training matrix as the provider said these were non-mandatory training courses. However, training in these areas was important for staff to be able to provide effective

support to the people they provided care to.

These shortfalls in processes to ensure the service was operated in accordance with the requirements of the regulations of the Health and Social Care Act were a breach of Regulation 17(1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We checked the provider's statement of purpose and found the correct contact details were not recorded for the provider's business address. We highlighted this to the provider who said they would update the statement of purpose with this information. At the time of writing this report the provider informed us they had updated the statement of purpose and would send the required notification to us. We will check to ensure this action is completed.

We found the home was not providing nursing care, and did not employ nurses. The provider had informed CQC in August 2015 that they were no longer providing nursing care. We requested that the provider submitted an application to cancel the regulated activity of 'treatment of disease, disorder or injury' as this regulated activity had not been provided at the location for over one year. The provider submitted the required applications shortly after the inspection.

Staff told us they worked well together as a team. We saw there had been frequent team meetings, which the registered manager had used to update staff on developments within the service, and to discuss policies and procedures. This included provision of information to staff in relation to areas such as health and safety, DoLS and end of life care. This would ensure all staff were aware of correct procedures in relation to areas of key responsibilities, and also that care and support was provided consistently in-line with the provider's procedures.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely. Regulation 12(1)

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 to monitor the safety and quality of the service were not effective at ensuring compliance with the regulations. Regulation 17(1)