Cherry Lodge Rest Home Limited

Cherry Lodge Rest Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Cherry Lodge Rest Home (Cherry Lodge) is a care home which provides accommodation and personal care to a maximum of 19 older people. Some people may also be living with a dementia type illness. There were 17 people living at the service at the time of this inspection.

The inspection took place on 12 September 2016 and was unannounced.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (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. The registered manager was also the provider of Cherry Lodge.

At the last inspection on 23 July 2015 we asked the provider to make improvements to staffing levels, the way staff were supported, how consent was sought, nutrition and how people received personalised support. We found at this inspection that the provider had taken appropriate action in each of these areas. We made one recommendation as a result of this inspection. As such we asked the provider to consider ways of capturing people's concerns in order to identify and possible trends and themes.

Cherry Lodge is a small service that provides residential care for people no longer able to live in their own homes. Many of the people accommodated previously lived in the local area and the service prides itself as being part of the community. As such, people benefitted from the ability to maintain previous networks and friendships.

People's needs were met by a core of staff who worked effectively together as a team. Staffing levels were sufficient to meet people's needs and provide them with appropriate levels of support. There were systems in place to ensure the appropriate recruitment and continuous monitoring of staff. This helped to ensure that only suitable staff worked at the service.

Staff received on-going training and support from the management team in order to deliver their roles effectively. People were protected by staff who understood their role in safeguarding them from the risk of harm or abuse.

People had good relationships with staff who took steps to ensure care was provided in a way that protected their privacy and dignity. People were encouraged and supported to both maintain and develop their independence and spend their time doing things that were meaningful to them.

People were supported to maintain good health and the service linked with other external professionals to ensure their healthcare needs were met. There were systems in place to ensure that people received their medicines safely and at the right times. People had choice over their meals and were supported to maintain

a healthy and balanced diet.

People were involved in making decisions about their care and had choice and control over their daily routines. People and their representatives were able to share their feelings and staff ensured that when people raised issues that they were listened to and people's opinions were valued.

The management team worked effectively together to ensure the smooth running of the service. Regular monitoring and auditing of the service provided mechanisms for on-going development and improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staffing levels were sufficient to meet people's assessed needs. Appropriate checks were undertaken to ensure only suitable staff were employed.

People were protected from the risk of abuse, avoidable harm or discrimination because staff understood their roles and responsibilities in safeguarding them.

There were systems in place to manage risks to people and the service.

Medicines were managed safely and there were appropriate systems in place to ensure people received the right medicines at the right time.

Is the service effective?

Good

The service was effective.

Staff had the skills and knowledge to meet people's needs. Training and supervision were provided to ensure care staff supported people effectively.

There were systems in place to gain consent from people with regard to their care and treatment.

People were appropriately supported to maintain adequate hydration and a balanced diet.

The service linked with other health care professionals to help keep people in good health.

Is the service caring?

Good

The service was caring.

People had positive and caring relationships with the staff that supported them.

People were involved in making decisions about their care and staff understood the importance of respecting people's choices and individual preferences.

Staff respected people's privacy and took appropriate steps to ensure their dignity was promoted.

Is the service responsive?

Good

The service was responsive.

People received individual care that was responsive to their needs.

People's personal routines were respected. People had opportunities to engage in activities and outings that were meaningful to them.

People were confident about expressing their feelings and staff ensured that when people raised issues that they were listened to and acted upon.

Is the service well-led?

Good

The service was well-led.

People benefitted from a leadership and staff team who were committed to providing them with a good service.

There were systems in place to gather feedback from interested parties and involve people in the running of the service.

Quality assurance audits were regularly carried out to maintain quality and the safe running of the service.

Cherry Lodge Rest Home

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 12 September 2016. The inspection was unannounced. The inspection team consisted of two inspectors with experience of services for older people.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. We asked the provider to complete a Provider Information Return (PIR) before our inspection. 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.

As part of our inspection we spoke individually with seven people who lived at the service and met with others and observed their support in the communal areas. We also gained feedback from three visitors and two healthcare professionals who had regular involvement with the service. We interviewed four care staff, the registered manager and deputy manager. We reviewed a variety of documents which included the care plans for six people, four staff files, medicines records and various other documentation relevant to the management of the service.

We asked how medicines were acquired, administered and disposed of. We examined the Medicines Administration Records (MAR) for all people living at the home. We also observed the dispensing of medicines and examined the provider's policy for managing medicines.

Good

Is the service safe?

Our findings

Our last inspection identified that staffing levels were not sufficient to meet people's needs and a requirement action was set. At this inspection we found that staffing levels had been increased and were appropriate and therefore this requirement action had been met.

People told us that there were enough staff to support them safely. One person commented, "I don't think about the number of staff around really, so it must be okay!" Two further people both told us "If I press my bell, the staff come straight away." Visitors echoed this view, with one telling us, "I've never noticed any problem with staffing and they are always very quick to answer the call bells."

Staffing levels were sufficient to meet people's needs. When we arrived at the service there were four care staff on duty. The registered manager and deputy manager were in addition to this number. Throughout the inspection we observed that people received support in a timely way and no one was left waiting for support. Staff said that this was typical of the usual staffing levels in the service and the rotas confirmed the same. Staff told us that there were enough staff to support people safely and effectively. One member of care staff commented, "There are plenty of staff for the number of residents." Similarly, another said that staffing levels enabled them to do their job properly without rushing. A visiting professional told us that staffing levels had increased and that a member of staff was always available to support them with their visits.

In addition to care staff, designated staff were responsible for the preparation of meals, laundry and cleaning. The registered manager informed us that the chef had recently left employment at the service and they were in the processing of recruiting to that role. In the interim period, an additional member of senior staff had been allocated to the role of cook each day. An external cleaning company was responsible for the cleaning of the home. Staff and external people providing activities within the service were in addition to care staffing levels for four days each week. We observed that staff had adequate time to undertake the roles for which they were allocated.

Appropriate checks were undertaken before staff began work. We saw criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). There were also copies of other relevant documentation including character and professional references, interview notes, proof of identification, such as passports in staff files. This demonstrated that steps had been undertaken to help ensure staff were safe to work with people who used care and support services.

People told us that they felt the home offered a safe environment and that they were treated with kindness. One person told us, "Yes its fine. I do feel very safe here". Another person said, "Oh yes I'm safe. I don't go to bed worrying about that." Visitors also told us that they felt their family members or friends were kept safe at Cherry Lodge.

People were protected from the risk of abuse. Staff were confident about their role in keeping people safe from avoidable harm. They also demonstrated that they knew what to do if they thought someone was at

risk of abuse. Staff received ongoing refresher training in safeguarding and knew what to do if they suspected abuse. All staff confirmed that the management team operated an 'open door' policy and that they felt able to share any concerns they may have. Staff also expressed that they would report abuse to outside agencies such the local authority safeguarding team, the police or CQC if necessary. One staff member told us, "I know my manager would do something if there was abuse going on."

Risks to people were identified and managed appropriately. People told us the service offered a good balance between safety and independence. Staff demonstrated a positive approach to managing risks with one staff member commenting, "We would never stop someone doing something for themselves if they can." We found that staff had recently been supported by a community matron to try and reduce the number of falls people at risk experienced at the service. Accident records showed that the new measures in place for one person in particular had significantly reduced the number admissions to hospital in the previous month.

A clear record of accidents and incidents were maintained. We saw that electronic forms were completed after each incident. These contained information about how the incident occurred, witnesses to it and action taken and referrals made as a result of it. We noted possible triggers to the incident were recorded, for example call bells not being within easy reach. There were also details of investigations undertaken and proposed action needed to prevent a reoccurrence. We saw that the furniture in one person's room (who was at high risk of falls) had been re-arranged to reduce the risk of harm if they did fall.

Each person had a plan of care that identified their risks and action was taken to reduce the likelihood of occurrence. For example, where people were at risk of weight loss or dehydration we saw that staff were monitoring their food and fluid intake. Similarly, those people who had been assessed at being at risk of developing pressure wounds had positioning charts in place and staff were clear about their role in reducing this risk. Each person also had a Personal Emergency Evacuation Plan (PEEP) that provided guidance to staff in the event of an emergency situation.

Medicines were managed safely and there were processes in place to ensure people received their medicines appropriately. We spoke with a senior member of care staff about medicine management. Staff confirmed that they had received regular in medicines management and the training records confirmed this. We noted that the manager also had a system for regularly checking the competency of staff that dispensed medicines.

The administration of medicines followed guidance from the Royal Pharmaceutical Society. Medicines trollies were locked when left unattended. Staff did not sign MAR charts until medicines had been taken by the person. There were no gaps in the MAR charts. MAR charts contained relevant information about the administration of certain drugs, for example in the management of anti-coagulant drugs, such as warfarin. In addition, each person taking 'as needed' medicines, such as pain killers, had an individual protocol held with their 'Personal care File'. This described the reason for the medicines use, the maximum dose, minimum time between doses and possible side effects. Staff were knowledgeable about the medicines they were giving.

All medicines were delivered and disposed of by an external provider. The management of this was safe and effective. All medicines, including those that required refrigeration were stored appropriately.

The provider undertook audits to ensure the safe and effective management of medicines which included ensuring stock levels were sufficient and all medicines were MARs were signed by staff after the administration of medicines.

Good

Is the service effective?

Our findings

Our last inspection identified that staff did not have a good understanding of the principles of the Mental Capacity Act and a requirement action was set. At this inspection we found that staff had a better awareness of their role in ensuring that care was provided in the least restrictive way. Steps had also been taken to ensure staff gained valid consent from people. This requirement action was therefore met.

We checked whether the service was working within 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 made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff demonstrated an understanding of the need to gain people's consent, people's right to take risks and the necessity to act in people's best interests when required. We observed that people were involved in their care and that staff always asked for their consent before providing care. Staff had recently undertaken training in mental capacity and could tell us the implications of the MCA and DoLS for the people they were supporting. One staff member told us, "We can't just assume people can't make decisions for themselves. If they can, they should be allowed to."

The keypad that was previously fitted to the front door had been removed because staff had recognised that this placed an unnecessary restriction on people living at the service. Similarly, where people were using bed rails to prevent them from falling from bed, we saw that assessments had been completed to show these were necessary and in the person's best interests. The management team showed as that DoLS applications had been submitted to the local authority for those that they believed were being deprived of their liberty.

We read in care records that people's consent had been considered in relation to a range of topics and that capacity assessments had been undertaken appropriately. For one person who was living with dementia their care plan provided guidance to staff about how to support them to make decisions. The management team had made it clear in these documents that people were giving on-going consent for these procedures. For example, the consent forms contained the phrase, 'Consent is a continuing process and not a one-off.' Staff were able to describe how a person's ability to make decisions might change and how they would manage this.

The management team showed us that people's representatives had been contacted to request details of whether they held the legal authority to make decisions on behalf of people and if so in respect of what. We saw that where people had a Do Not Attempt Resuscitation (DNAR) form in place, these were being reviewed in light of people's capacity and who had the legal authority to make decisions on their behalf.

Our last inspection identified improvements were needed in respect of the training and support available to staff and a requirement action was set. At this inspection we found that staff had the skills, knowledge and support to meet people's needs and therefore this requirement action was met.

People told us that they thought staff were well trained and knew what they were doing. Visitors also expressed that staff seemed competent and supported people appropriately. From our discussions with staff if was clear that they had a good knowledge of people and how to support them effectively.

Training and support were provided to ensure care staff undertook their roles and responsibilities in line with best practice. Staff told us that they had received training in areas such as safeguarding, moving and handling, infection control and fire safety. In addition to mandatory training, we also found that staff had the opportunity to undertake more specialised training in order to meet the needs of the people they cared for. As such, they had undertaken courses which included dementia awareness, nutrition and hydration and person centred care.

New staff were appropriately inducted. We found that new staff now completed the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers should adhere to in order to deliver caring, compassionate and quality care. Staff who had recently been recruited told us that in addition to completing training, they also shadowed a more experienced member of staff for the first week in order to get to know people, the service and what was expected of them.

Staff were appropriately supervised and told us they felt well supported in their roles. We found that all staff had received recent formal 1-1 supervision with one of the management team. They said in addition to discussions about their work, they also received regular spot checks and feedback about how to improve their practices.

Our last inspection found improvements were necessary in respect of managing people's nutrition and a requirement action was set. At this inspection we found that people were appropriately supported to maintain adequate hydration and a balanced diet. This requirement action was therefore met.

People were happy with the standard of food provided. One person told us, "The food is great and there's plenty of it too." Another person said, "The food here is really good, I must say. If you don't like something, they will make you something else." Visitors told us that they thought the food always looked very nice and that they had observed people being offered a choice about what they ate.

The menu was based on a four week rota. Staff told us that there was a choice of meals on offer and that care staff asked people about their food preferences shortly before providing it. Our observations on the day confirmed this. The lunchtime meal was a social occasion and we saw that where people required support this was provided sensitively and at the person's own pace.

We asked how special diets were managed and how people's opinions on food were sought. We noted people's likes and dislikes were documented and kept in the kitchen, accessible to staff. There were also 'Residents Catering Forms', held for each person, which contained detailed information about the individuals nutritional status. For example, one person was diabetic and we read that there was a clear plan in place for how this should be managed which staff were aware of. One visitor told us that they knew their friend had lost weight due to illness and that staff had spent a lot of time trying to tempt them with different things in order to boost their appetite. The care records for this person also confirmed this.

We saw that snacks and drinks were available throughout the day. Staff were aware which people were at

risk of dehydration or weight loss and we saw charts in place to monitor their food and fluid intake.

People were supported to maintain good health. The service had good links with other health care professionals to ensure people kept healthy and well. Care records documented that people received support from other healthcare professionals including doctors and district nurses. During the inspection we met with one visiting professional who told us that they had a "Good partnership working with the home" and that staff always followed the advice and guidance given.

Good

Is the service caring?

Our findings

People spoke positively about the staff who supported them and repeatedly told us that staff were "Nice" and "Kind." One person told us, "The staff are wonderful. They are so kind and caring." Another person told us, "It's the staff that matter….the girls are so kind and compassionate"." One relative commented that the best thing about Cherry Lodge was, "The friendliness throughout the home."

The atmosphere was homely and friendly and it was clear that people had been encouraged to personalise their rooms and make the service their own. We saw that one person's room was referred to as a 'hotel room.' Staff told us that the person liked to think they were in a hotel and this was respected. Visitors were seen calling in throughout the day and with most people having moved in from the local area, people referred to Cherry Lodge as being part of the local community. People told us that they appreciated the fact that they could continue their relationships with their friends outside the service.

People had good relationships with staff who consistently took care to ask permission before intervening or assisting them. There was a high level of engagement between people and staff. Consequently people, where possible, felt empowered to express their needs and receive appropriate care. We saw that staff were respectful and kind to people living at the home and observed many instances of genuine warmth between staff and people. For example, staff always stopped to talk with people each time they passed them and we saw that staff were professionally tactile in their approach.

Staff took appropriate steps to ensure people's dignity was protected. Staff had a good understanding about their role in providing dignified support and this was reflected in their practices. For example, we observed one person being moved with the use of a hoist in a communal area. Staff explained before the procedure was carried and included them in the process. The person's dignity was preserved and the procedure was carried out in a safe and effective manner.

People's privacy was always respected. We observed that staff respected people's private space and as such they routinely knocked on people's bedroom doors and sought permission before entering. We saw that where people preferred to spend time in their rooms, staff monitored these people in a thoughtful way that balanced safety and privacy considerations. Where people required personal support, this was offered sensitively and provided in a way that protected their privacy and dignity.

Cherry Lodge provides some accommodation in shared rooms. We saw that where people shared a bedroom, this was either with a spouse or with another person they were happy to share with. Adaptations to these rooms had also been made to ensure that people's privacy was promoted during personal care tasks. For those people who lived at the service as a couple, thought had been given to ensure they had privacy and opportunities to spend time together.

People were involved in making decisions about their care and staff understood the importance of respecting people's choices and individual preferences. We saw that people were able to follow their own daily routines and people told us that they were able to get up and go to bed when they wished. People

moved freely around the home spending their time as they chose. Care records were reviewed on a monthly basis and we saw that there were regular formal reviews which involved people and/or their representatives being consulted about their care. People told us that the support they received was as they wanted it to be.

Good

Is the service responsive?

Our findings

Our last inspection identified that people did not always experience care that was person centred and people lacked appropriate activities and outings. A requirement action was set to ensure the service improved. At this inspection we found that care was person centred and people had regular opportunities to engage in activities and outings that were meaningful to them. The requirement action was therefore met.

People received a good standard of care that was responsive to their needs. People and their relatives told us that they were well looked after at the service. One relative told us that they had "Total confidence in Cherry Lodge." The visitors for another person commented about how quick staff had been to respond to their friend's changing needs and how family members were always kept informed.

Each person had a personalised plan of care which provided information about people's support needs. Care plans contained detailed information about people's care needs and the actions required in order to provide safe and effective care. For example, one person had significant mobility needs and was at high risk of developing pressure wounds. The care plan for this person provided comprehensive guidance to staff about how to move this person safely and ensure they were regularly repositioned. We observed both being followed.

Staff responded to people's changing needs. For example, we found that where one person had lost weight, staff had recognised this and taken steps to seek an urgent referral from the dietician. The person's care plan had been updated to incorporate the advice provided by the dietician such as the use of food supplements and regular weight monitoring. Staff were fully aware of the need to monitor the food intake for this person and we saw they completed food record charts each day.

Another person occasionally presented with behaviour that could lead to verbal and possibly physical aggression. As such, staff had introduced a behavioural management plan for this person. This recorded possible triggers to behaviours and listed interventions staff should make to keep the person, other people and staff safe. There were also outcomes recorded which were linked to an action plan for future reference.

Where people had specialist needs these were well documented and the impact that this had on their other care needs was evident throughout the care plan. For example, one person was diabetic and the care plan contained guidelines and risk assessments in respect of how this also affected their personal care, mobility and risk of falls. We saw that staff had followed the care plan and were monitoring the person's blood glucose levels and physical wellbeing.

People had opportunities to engage in activities and outings that were meaningful to them. As many people had moved from the local area to Cherry Lodge, they benefitted from their on-going contact with their families and friends. We also saw that people enjoyed spending time chatting with each other. A couple lived at the service and staff were supporting these people with 'date days' out together as well as supporting them to also pursue their own interests.

More formal activities were also available and visitors told us that they appreciated the fact that they too could join in with the quizzes, music and exercise sessions. Since the last inspection, staff had researched opportunities for people to participate in some external activities. For example, one person was enrolled to join the local 'Men in Sheds' group. This is a community group which enables older men to meet, share and learn new skills. Two people also attended a nearby day service and one person enjoyed monthly trips to the theatre.

People were confident about expressing their feelings and staff ensured that when people raised issues that they were listened to. For example, one person was unhappy that one of the baths was currently out of action. Staff were aware that this was upsetting for the person and the provider was actively seeking a repair. In the interim, staff were reassuring the person and offering alternative bathing arrangements. Care plans included information for staff about the individual support people may require in making complaints.

There was a complaints policy and procedure which outlined how people should raise concerns if they were unhappy. Whilst no formal complaints had been made to the service, it was clear that people and relatives had raised minor issues that had been satisfactorily resolved. Details of these concerns however had not been documented.

It is recommended that the provider consider ways of capturing these concerns to enable any themes or trends to be identified.

Good

Is the service well-led?

Our findings

Our last inspection identified that staff did not always feel supported and a requirement action was set. At this inspection, staff told us that they received good support and that the service was managed well. As such the requirement action was met. People told us they had a good relationship with the managers and visitors said that there was good communication from the management team with whom they had confidence in.

The management of Cherry Lodge was undertaken by the registered manager, who was supported by a manager and deputy manager who were responsible for the daily running of the service. Staff told us that this arrangement worked well and meant that they always had someone they could go to for advice or support. Staff said that the management team were approachable and that they could go to them with any concerns. One staff member told us, "The manager is really good and they will always listen."

There were good systems in place to ensure that staff received on-going supervision and appraisal. Staff were involved in the decisions about the service and their feedback was regularly sought. There were regular staff meetings and we read in the minutes how these were used to discuss ideas and improve staff practices. For example new guidelines for people were explained.

The registered manager had a good understanding of their legal responsibilities as a registered person. For example sending in notifications to the CQC when certain accidents or incidents took place and making safeguarding referrals where necessary. Records relating to the management of the home were well maintained and confidential information was stored securely.

People living at the Cherry Lodge, their families or representatives were involved in the running of the service and their views sought and listened to. Regular residents' meetings were held and records showed that people's opinions were respected and acted on. Each set of minutes included an action plan that detailed how people's suggestions would be incorporated in to the service. For example, we saw that new crockery had been purchased; an external activity session increased to weekly and menu changes were all introduced as a direct result of feedback from people.

The management team told us that they had attempted to hold relatives' meetings, but that these had been poorly attended with relatives preferring to call in casually or meet with one of the managers on a 1-1 basis. Throughout the inspection we observed that relatives had good relationships with the management team and the letters of thanks we read highlighted the same.

Regular satisfaction surveys provided formal feedback about the views from people and relatives. We examined the latest survey results taken from 12 recently returned forms. They showed a high degree of satisfaction in all areas, particularly in the quality of care and staff attitudes. The provider also asked the opinions of visiting professionals. Only one questionnaire had been returned, but it too expressed a high degree of satisfaction with the home.

Internal audits were used to improve care provision. There were a variety of these being undertaken, in the

areas of care overview, health and safety, infection control and home maintenance. There were detailed audits which focused on the health and welfare of people living at the home. For example, audits were undertaken on the admission process to the home, care planning, pressure area care and the management of challenging behaviours. We noted issues arising as a result of these were dealt with within an allotted time span.