Barchester Healthcare Homes Limited

Cherry Trees

Inspection report

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Date of inspection visit:
06 September 2017
08 September 2017

Date of publication:
11 October 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 6 September 2017 which was unannounced and we agreed to return on 8 September 2017 so we could speak with staff and to look at the governance systems and audits.

Cherry Trees is a nursing home which provides accommodation and personal care to older people living with dementia, young adults and people with physical disabilities. Cherry Trees is registered to provide care for up to 81 people. At the time of our inspection visit there were 61people living at the home. The home provides nursing care across two floors. On the ground floor were people with physical disabilities and people living with dementia. On the first floor, referred to as 'Memory Lane', staff supported people living with dementia.

There was no registered manager in post. The registered manager left the service in April 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had ensured the home was supported by an 'interim' manager from within the organisation in the absence of a registered manager. The new manager who is referred to throughout this report as the "manager" had been in post since July 2017. The manager was in the processing of registering with us.

Cherry Trees was last inspected in April 2016 and was rated as 'Good'. Prior to this inspection we received information that staffing levels did not always meet people's needs. At this inspection, we found staffing levels impacted on the quality of care and service people received.

Staffing levels were unsafe because there were not enough of them to support people in line with their preferred choices and assessed needs. Some staff told us they enjoyed working at the home, however low staff numbers affected their morale because the service they provided was not to the standard they wanted. Before our second inspection visit, we received written confirmation from a senior regional director that staffing levels were increased by one staff member to support people living on 'Memory Lane'. When we returned on 8 September 2017, staff said this had already made a positive difference and they were able to monitor people more responsively and not rush.

People living at Cherry Trees told us they felt safe. Care staff understood their responsibilities in being observant at all times to keep people safe. However, there were periods of time when communal lounges and areas of the home were not occupied because staff needed to support people elsewhere in the home. This placed some people at increased risk of not receiving support and assistance when required. We found information related to risks associated with people's care was not always clearly recorded or consistently managed.

Staff knew how to recognise abuse or poor practice and told us they would report abuse if they observed

this happening. We found that not all reportable incidents related to people's health and safety had been reported to us.

Staff had been supported with training to help ensure they understood how people who lacked capacity could be supported to make decisions. Staff knew they could not undertake care practices against the wishes of people in the home. The management team had a good understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). People had been assessed to determine how decisions could be made in their best interests and applications for DoLS had been completed. Authorisations that had expired had been reapplied for.

People and our observations showed staff were mostly caring in their approach and people told us staff were kind and considerate. When staff were available in the communal areas, it was more reactive support rather than identifying situations were escalating so they could prevent things from happening. People had limited opportunities to pursue their hobbies and interests and staff had limited time to sit, talk, listen and involve them.

Staff knew about people's wishes and preferences in relation to their care and worked to support people in accordance with their wishes. People were provided with a choice of food and drinks and people had their main meal at lunchtime. However, staff pressures meant some people did not always receive support with their meal when needed and some people were only given their lunch at 3.00pm, which was not their choice.

Nursing and care staff understood the importance of hydration and drinks were regularly provided throughout the day, however inconsistent records and relatives comments meant we were unsure this always took place. Where people had lost weight and there were concerns regarding their health, support from dieticians was sought.

People and relatives were not always positive in their comments of the management team and provider. Relatives who raised complaints with the provider told us they felt they were not always listened to and saw limited action taken to improve the delivery of service.

The home has experienced periods of managerial instability, such as changes to the registered manager and senior management. We found speaking with the senior management team, most of whom were new to this home, they were unable to account for what may have caused these issues. The senior management team were committed to driving improvements so people received a good standard of care, delivered by a staff team who felt valued and supported.

We found there were two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

You can see what action we told the provider to take at the back of the full version of the 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.

People told us they felt safe living at the home, however, staffing arrangements meant people were not consistently safe and did not always receive support when needed. Potential risks to people's health were assessed and recorded did not show consistency in how they were managed or actions taken. Staff understood how to recognise abuse and how to report it. People received medicines from trained staff with checks completed to ensure medicines were administered and stored safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People were cared for and supported by staff who had the relevant training and skills for their roles. However time constraints meant the service people received was not always effective and when needed. The manager and staff understood the principles of the Mental Capacity Act (MCA) and made sure people's freedoms were not unnecessarily restricted. Staff respected people's decisions and gained people's consent before they provided personal care, but this was not always timely. Some people were assessed as requiring their food and fluids to be monitored but staff did not always accurately record what people had consumed. People had access to and were referred to other healthcare professionals when their health needs changed.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were mostly kind and compassionate towards people who felt confident asking staff for support. Staff knew people well but time pressures meant they did not always protect people's privacy and dignity and observe people sufficiently to ensure their overall health and welfare was maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff understood people's preferences, likes and dislikes and how they wanted to spend their time but there was minimal physical and mental stimulation for people, which did not always meet their needs. People said if they needed to make complaints, they knew how to do this and who to approach but some lacked confidence improvements would be made and sustained.

Is the service well-led?

Requires Improvement

The service was not always well led.

Recent managerial changes had affected the quality of the care people received. We identified a number of concerns during our visit which had not been identified by the provider's own internal auditing system. People, relatives and staff said the management changes gave them limited confidence that their voice and feedback was heard, and acted upon. A programme of audits was in place and commitment from the senior managers was to use their audits and people's feedback to improve how people's care and support was delivered.

Cherry Trees

Detailed findings

Background to this inspection

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

The inspection was prompted in part by notification of an incident following which some people using the service were at potential risk of harm and mistreatment. This incident is subject to investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management and culture of the home. This inspection examined those concerns.

This inspection took place on 6 September 2017, was unannounced and consisted of two inspectors, two experts by experience (an expert by experience is someone who has experience of caring for people who use this type of service) and two specialist advisors. One specialist advisor was a nurse and the second was an occupational therapist. Two inspectors returned announced on 8 September 2017 to speak with staff and to check governance systems and processes.

We reviewed the information we held about the service. We looked at information received from people, relatives and other agencies involved in people's care. Prior to this inspection, we received information from the public telling us staffing levels were not meeting people's needs.

We looked at the statutory notifications the registered manager had sent us following our last inspection visit. A statutory notification is information about important events which the provider is required to send to us by law.

We reviewed the information in the provider's information return (PIR). This is a form we asked the provider to send to us before we visited. The PIR asked the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information when conducting our inspection, and found some information reflected what we saw during our inspection visit.

To help us understand people's experiences of the service, we spent time during the inspection visit talking with people and relatives in the communal areas and in their own rooms with their permission. This was to see how people spent their time, how staff involved them, how staff provided their care and support and what they thought about the service.

During our inspection visit we spoke with 10 people who lived at Cherry Trees to get their experiences of what it was like living there. We also spoke with nine visiting relatives. We spoke with the manager, two heads of unit, three nurses, seven care staff, a cook and one domestic staff. From the provider's visiting management team, we spoke with two clinical development nurses, a senior regional director, a regional director and a dementia care specialist. After the inspection visit, we spoke with the interim manager who temporarily managed this service.

We looked at five people's care records and other records including quality assurance checks, training records, observation records for people, medicines and incident and accident records and health and safety checks.

Requires Improvement

Is the service safe?

Our findings

Prior to this inspection visit we received information that suggested staffing levels did not always meet people's needs. People and relatives across both floors gave us mixed views about staff arrangements. Some felt there were enough staff, but for others, a shortage of staff affected them on a regular basis. For example, one relative told us when their relation called for help it could take 20 minutes for a member of staff to come. Their relation did not want personal care from male staff, and if a male member of staff came, they would turn the bell off and their relative would have to wait a further amount of time until a female member of staff could support them. Another relative said, "Staffing is not good, [name] has rung the bell… waited 30 minutes. Once, staff came in, switched it off, they go and [person] waits again." The person or relative said staff were usually supporting others and would return when free. Some people felt staff did meet their needs.

People and relatives on both floors commented on the high use of agency staff and how this had a negative effect on the care received. One relative whose family member had been at the home for less than 12 months explained, "No end of staff have left since (person) came in and there's a lot of agency staff." Most people and relatives supported this, saying a high number of agency staff did have an impact on how they were supported. One relative told us, "The regular carers are great but the agency carers are not so good, I don't think there are enough regular staff and the agency carers don't know the people they are looking after." One person who lived in the home said, "It's all gone to pot." The manager told us they were currently using 400 agency hours per week to support the service which had decreased and they used the same agency staff for continuity. However, one agency worker told us they had not worked at the home before the day of our visit.

We found there were not sufficient staff to meet people's needs and to support them in how they wanted their care delivered. On the first day of our visit we found people on the first floor (Memory Lane) were at risk because there were insufficient staff to monitor them safely. The layout of the floor meant it was not easy to see or attend to people quickly. For example, we saw one person who was blind, in a lounge by themselves for over 30 minutes. They got up several times and walked behind the television cabinet where there were several trailing wires which presented a substantial trip hazard. We also saw this person went into people's bedrooms and pushed chairs and beds away from the walls. Staff confirmed the person had been known to do this when people were in bed. This not only presented a risk to the person, but also to other people. Staff were aware of this person's behaviours but said they did not have time to give them the attention and support they needed to keep them safe. One staff member told us, "We are not able to monitor people walking around because we are in bedrooms with other people. People are falling, especially at this time of the day (early evening) when they are getting tired." The manager confirmed they wanted a staff member to supervise the lounge area at all times, but we saw numerous occasions when this was not done. In this lounge, on one occasion, we saw a person begun urinating, with another person present but we were unable to find staff to assist. Staff knew the person was prone to doing this, but there were not enough staff available to prevent this from happening.

A relative explained the previous weekend stretched staff because they could not meet their relative's needs.

They said, "The other weekend there were three (staff) on and they were told to get on with it." They told us when they visited on a recent Sunday, their relation was still in bed. Staff told them there was not enough staff to help him out of bed. They said this had happened a few times. Another relative shared their concerns with us, "I don't think the carers (staff) have enough time to record significant events in detail when they occur. My [relative] has been refusing showers and it hasn't been recorded…also we have been to visit and he has been lying in bed with just a pad on and I have asked for him to have some trousers on at the very least. I have also asked them to give him a shower or something and a shave too. I know it's what he would want."

During our first inspection visit, a relative complained to staff that their family member was still in bed at 2.50pm when they were normally up. Lunch took over two and half hours to serve and some people were still eating lunch past 3.00pm and supper was served at 5.00pm. When we asked a member of nursing staff what the challenges were when they worked short staffed they responded, "To be able to make sure everything is done on time, like the lunches were late today." We saw some people had not eaten their meals and these were collected and discarded by staff. We asked one staff member why the person had not eaten their meal. They said they were not sure because they had not asked them, or offered an alternative. They told us it was because they were busy. Some people told us staff did not have time to sit with them and chat, take them outside into the garden area or get them up, dressed and ready for the day when they wanted. During our first inspection day, on the first floor staffing levels were at times reduced to three staff because of an agency staff member not attending and staff going on planned breaks. This meant staff levels were only at 50% of what had been identified as a safe level.

Staff on the first floor raised concerns to us about the level of staffing. We were told there used to be six care staff on this floor, but the number of staff had been reduced to five despite there being no significant change in people's dependency levels. A member of staff told us, "Even with five carers, that is still not enough because ideally you need a carer in the lounge which brings you down to four. Six is the ideal number. Two carers working each side, one in the lounge and one to help out. When I first did a shift up here it was those numbers and it worked really well." Another said, "We started with six and then one just disappeared. Nobody said anything official, it just happened." We were told 26 people needed the support of two care staff to help people transfer safely. Staff told us the decrease in staffing levels meant people could not be observed as required and some people's personal care or emotional needs could not be met. Staff said they had to prioritise who they supported first and who had to wait.

Staff told us they frequently worked below the identified staffing level with a high reliance on agency staff because of the numbers of staff who had left the service. On the first day of our inspection visit, there were only four care staff on duty on the first floor. We asked staff how only having four care staff impacted on people's health and wellbeing. One told us, "We just have to go as quickly as we possibly can." Another said, "Some residents have been slightly neglected because there has been a delay in them receiving personal care." Other comments included: "If we don't get them up by lunch time we may have to get them washed and changed after lunch." "We are tired. I don't feel as if I am in control of things. It is really challenging. We finished lunch at 3.00pm and we couldn't get everybody up." One person told us they ate in their room rather than the dining room because, "It takes so long to be taken back to my room after." During our visit we saw some people were still in bed until after lunch because staff had not had time to get them up.

During the first inspection visit, we walked past one person's room on the ground floor and saw they attempted to climb over their bed rails. The person told us they were 'getting up'. The person had a call bell, yet this was out of reach so the person was unable to summon help. A staff member walked past saying, "This happens every day." They told us they had spoken with the manager about the person having a hi-lo bed but nothing had happened. Staff said this person was at risk of falls, "He will suddenly walk places but

he's unsafe." Staff attended and settled the person back in bed. Staff told us they felt frustrated at times that when issues were raised, they saw no action was taken.

On the first day of our inspection visit, we raised our concerns about staffing levels, staff deployment, and staff management with the manager. They explained they completed staff rotas based on people's dependencies, most of which were assessed as 'high'. The dependency calculations showed six care staff were needed on Memory Lane, and five care staff on the ground floor, with two nurses on each floor. The manager had instead provided five care staff for Memory Lane and six on the ground floor. When asked why they were not working to their dependency tool they told us the ground floor was, "More demanding." We asked why they did not have the six staff on Memory Lane, the manager said, "It's what I have got to work with." The clinical lead nurse and regional director said the provider used a dependency tool to determine safe staffing levels which we found, staffed to the exact care minutes required. We discussed the challenges the layout of the home presented and we were told there was separate dependency tool that assessed the environment and how this could increase staffing levels. We checked this and found no additional staff time had been included to cope with environmental challenges, such as observing people as they explored their surroundings.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

The manager said they used around 400 hours of agency work per week. Recruitment campaigns were underway to recruit more care staff, night staff and some ancillary staff to limit agency use. Following feedback from our inspectors, before the second day of our visit, senior management increased the number of care staff on the first floor. We saw there was an immediate improvement that had a positive effect on the people who lived on that floor and the staff who supported them.

On our second inspection day, we spoke with staff who said this had already made a difference and they were able to meet people's needs and personal care routines. One staff member said, "We are staffed today so everything is running beautifully. It is fantastic…happier staff means happier residents and a happier home." Senior management confirmed the additional staff member would be retained so further analysis would be made to see if this was sufficient, or if other options such as deployment and more effective shift management was required. We spoke with a relative who visits regularly at our second visit, once staffing had increased to six. They said, "They (staff) are more relaxed and they are not chasing their tails."

Care plans contained risk assessments to support staff provide care to people that did not put them at risk. For example, these assessments included how people could be moved safely, and how the staff could reduce the risks of a person choking falling, or getting skin damage. One person was at a high risk of damaging their skin. The care provided was reflective of this as it stated the person required regular repositioning to take the pressure off their skin, a pressure-relieving mattress, a pressure relieving cushion and a repose boot (these boots are designed to reduce pressure on the heels when the person is in bed). This was appropriate preventative care for someone identified at very high risk. This person had pressure ulcers to their heels and there was information in the care record how to manage this, as well as ensuring the pressure mattress was set correctly to their weight. All risk assessments were completed within the last month and had been reviewed on a monthly basis. For one person, there was a risk assessment for a person, 'not using the call bell' and staff checked this person every one, to two hours at night. For people with epilepsy or seizures, risk assessments were used for moving and handling equipment, potential choking risks and risks around the use of bed rails. For people at risk of falling, people had equipment to reduce the potential of further falls, such as alarm mats, hi-lo beds and crash mats. Since these were introduced, some people's falls had reduced.

People told us they felt safe living at the home. Staff received safeguarding training and understood the signs that might indicate a person was at risk of harm or abuse. Staff had confidence to challenge poor practice and to share any concerns with the manager or CQC. One staff member said they would, "Report it to the nurse on duty or to the manager." Where a safeguarding concern or incident had been identified, the manager had taken action to report this to the relevant organisations who have responsibility for investigating safeguarding issues. However, we found one incident where a person had unexplained bruising which had not been referred to us. The manager accepted this was an oversight and would ensure we were notified without delay. We asked them to submit to us a statutory notification so we could monitor the risks around this service effectively.

People received their medicines as prescribed. Medicines Administration Records (MARs) were used to record when people had taken their medicines and daily counts by trained staff made sure medicines were given as prescribed. MARs were accurately completed. Some people were prescribed insulin once a day. Staff checked blood sugar levels prior to administrating the insulin. For people who received medicines for seizures, protocols provided information for staff about how to provide medicines safely to control the seizure.

Medicines were stored in line with manufacturer's guidance and fridge temperatures were checked to ensure medicines remained effective and fit for use. Topical creams required further checks to ensure they were administered consistently. For example, a nurse told us a prescribed cream should be applied after each personal care intervention. In the last 47 days it had only been applied 28 days in the morning and 13 days in the evening. In the last 38 days another person only had a prescribed cream applied 24 days in the morning and three times in the evening. The nurse confirmed another cream should be applied after every personal care intervention as well. There was no evidence of either cream being applied at any other times of the day. We also found some creams recorded 'as directed' without being specific about where, or how to apply them. We told the manager about this and they assured us this would be addressed with the local GP surgery.

Requires Improvement

Is the service effective?

Our findings

Overall, people using the service said staff knew how and when to provide their care and support. One relative said, "They do have a good training programme from what I have heard and the carers (staff) seem to know what they are doing."

Staff said they had the skills, experience and training needed to look after people they cared for. A new member of staff said they had a comprehensive induction to the service. They told us they had all the training considered by the provider to be essential before they started working at the home. They told us they felt confident in their role after their induction, "It also helped shadowing (working alongside) to actually see the job done." Staff told us they received training to support their everyday practice in the home. "When I did my training it was good. It did give me an insight into how the job was going to be." However one staff member told us they had not had any training for some time and none this year. After the inspection, the manager sent us their training schedule they used to ensure staff received training. This showed a number of staff's training had not been refreshed in line with the provider's expectations. We were not given any reasons why training had lapsed, indications suggested the previous registered manager had not kept this updated. The manager told us they were responding to this by booking staff training over the next few months.

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). 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. Where people lack mental capacity to take particular decisions, any decisions made must be in their best interests and in the least restrictive way 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 registered manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They had submitted DoLS applications where they believed people lacked capacity. The applications were to restrict people's freedoms in certain areas, such as not leaving the home unsupervised. Where applications had expired, these had been reviewed and requested to ensure the restrictions were still necessary.

Capacity assessments were recorded in people's care records that recorded what support people required. We saw staff asked people for consent, "Are you happy with this (clothes protector), Can I put this round your neck and protect your clothes?" Staff gave people choice to make their own decisions, regardless of their capacity. We saw staff offer choices such as, "You can sit down and watch the television for a while or you can go for a walk. It is up to you."

One person had a DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) in place which had been signed by the GP in the person's best interests on the basis the person did not have capacity to make their own decision. The DNACPR was dated 24 March 2017. The person had been assessed as having capacity by

the DoLS assessor on 16 March 2016 and the person's mental health care plan dated 23 July 2017 stated "Has capacity and able to tell staff how he feels emotionally." It had not been identified that this person had the capacity to make their own decision re DNACPR. We told the manager who agreed to review all DNACPRs to ensure they continued to respect people's decisions.

People described the food as, "Very nice"; "I like it." Those people not needing assistance, said there were enough staff to support them eating in the dining room. People were given two choices of main meal and dessert. The cook told us they knew about people's special or dietary requirements because, "Staff tell me." They were confident people received their meals in line with their preferences. However, because of a lack of staff support, the mealtime experience for those who ate in their room or who needed assistance was not as expected. Meals continued to be given to people after 3.00pm and some hot meals had gone cold, by the time they were given to people. On the first floor, at lunch time we saw one person was served fish in a sauce and mashed potato. The person ate their food with their fingers. No member of staff encouraged the person to use a fork or spoon. When we asked if there was any specialist cutlery or dishes to support people to eat independently, we were told there wasn't any.

The manager told us that our observations of lunchtime on the first inspection visit was not usual and a senior regional director said they had visited the home previously and had no concerns with how mealtimes were organised and delivered. The manager said two hostesses who supported mealtimes had left which had some impact, but nursing staff helped out. They were recruiting additional hostess staff and agreed to monitor lunchtimes to ensure delays were kept to a minimum and other duties or tasks from those who helped, such as nurses, were not delayed or neglected. The manager told us the day after our first inspection visit, lunchtime went well and without delay.

We found systems were not effective to ensure staff responded to people's changing needs. We checked examples of fluid records, repositioning charts, bowel movement charts and found a number of examples were records were not always completed or that supported the actions taken. We saw one record for a person who required fluids to 'be pushed' because they had a urinary tract infection. They had a target fluid intake of 1482mls every 24 hours. Yet records indicated they had not always been taking sufficient fluids and it was not clear whether staff had encouraged them to drink more. For example, a gap of over 13 hours between one person being offered their last drink at 8.25pm on 4 September and their first drink the following day at 9.40am. A relative told us they were not always confident people received enough to drink. They said, "Yesterday afternoon we were over on 'Cupcake' with the activity chap but he couldn't do drinks because he didn't know who had thickeners." We discussed one person with staff who was at risk of dehydration and had not drunk very much that day. A staff member felt they would not have been able to encourage the person to drink any more but said, "I don't feel I was in there often enough today, if I had I would feel more comfortable."

People's weight was monitored by staff and a dietician was involved to see what assistance people required to help maintain their health and wellbeing. However, we found some people had lost weight and these records did not correspond with the manager's own analysis. From our review of the recorded weights, we found 20% of people had lost weight, yet the deputy manager and manager said weights had improved. Following our inspection, the deputy manager told us, "Two people's weights have inaccuracies due to being weighed on different scales than usual. These were re-weighed on correct scales and weights were stable." They also told us, "The dietician had recently reviewed again on the 8 August 2017 and has taken a lot of residents off weekly weighs as their weights have stabilized."

People's healthcare was monitored and health professionals involved where necessary, such as speech and language therapy, podiatrist, tissue viability nurse and dieticians. People had access to a GP who visited the

home. Staff told us the GP was available for advice and would visit the home when required. Records showed that people were supported to attend health appointments to maintain their health and wellbeing.

Requires Improvement

Is the service caring?

Our findings

People on both floors were complimentary about staff who supported them in a caring way. People and relatives spoke positively about the staff, their caring attitudes and the care they provided. It was recognised staff were caring, despite time constraints that on occasions, prevented them spending as much time with people as they wanted. One relative said of staff, "There are some permanent carers that are amazing and do really care."

Staff understood the importance of caring for people and wanted to care for them to the best of their ability. However, staff felt time pressures meant they became more task focussed to ensure tasks were completed, which left less time for them to spend more quality time with people. People told us staff were extremely busy, hardworking and good to them. One person said of a care staff member, "[Name] is very good, [person] is lovely. I like them." Another person said they wanted more time from staff so they could sit and have a chat. We found relatives especially, recognised how hard the staff team worked to provide 'good care' and said staff had the skills and personalities to provide good, person centred care, but lacked time.

Our observations showed staff were caring in their interactions with people, but it was task focussed. Staff were kind, considerate and polite with people but on the first day of the inspection visit, people were not always supported by staff. On a number of occasions, the inspection team had to intervene and check people were comfortable. For example, we spoke with people who wanted to discuss their day, encourage people to leave other people's rooms and escort people back to their own rooms, or communal areas. Some people wanted to have a conversation and when we spent a few minutes with people, they became more settled and went about their usual routines. For example we saw one person in the corridor and was upset. They talked with us and when we had a conversation with them, a few minutes later they were more settled, not upset and continued walking to their room.

When staff had time, they were interested in how people were feeling and commented from their own observations of people, showing concern. For example, we heard staff say, "Are you alright [person's name], you look tired today." And, "Are you alright, you look very smart in your red shirt today." "Did you sleep alright last night [person's name]?" Staff knew about people's backgrounds. They were able to tell us one person was a farmer, another was a fireman and another was a local football supporter. We saw a nurse use this information when she was encouraging a person to drink. She said to the person, "You used to be a farmer. What do you think of the field? Is it ready to be harvested now?" Staff told people what they were going to do when they left people for example, "I'm going to talk to [name] for a while" so people understood they had not been left for no reason.

We saw some people's privacy and dignity was compromised. For example, we saw a person with the zip on their trousers open exposing their underclothes. The staff member eventually noticed and went to do it up but it was broken. They pulled the person's shirt over the zip but the staff member who had dressed them that morning had not considered how this might affect the person's dignity. The person remained in the trousers throughout our visit on the first day and wore them again on the second day of our inspection visit. We saw another person urinate in a communal lounge, whilst other people were present. Staff told us this

happened frequently, yet there was no monitoring or supervision of this person to ensure the person's and other people's dignity was maintained. We saw other people's dignity was compromised. For example one person was seen in bed, half covered with bedclothes showing them only wearing a continence pad, another person was seen wearing a continence pad with faeces stains on the waistband.

On the first floor, people or visitors could not access the dining area. The dining room was accessed by two doors which were both locked with a coded lock. We saw at 11:00am all the tables were laid out with glasses, table cloths and cutlery ready for lunchtime service. The manager was unaware these doors were locked and a staff member said relatives used this room to make hot and cold drinks. The manager was not aware this room was not accessible but made sure the doors were opened up and the locks removed to prevent this happening again.

We saw a person on the first floor calling out from their bedroom with the door open. A member of staff passed by without making any interaction. The person called again but received no response. Another person was seen looking distressed in the dining room, with his head in his hands. A staff member went into the dining room to clear away dirty cups after lunch and made no attempt to check how this person was.

The registered manager was confident in staff's abilities and said they were getting the right staff in place with the caring nature and responsibilities they expected. They told us they were proud of their team and said staff were committed to caring for people. They told us they regularly walked around the home and on occasions helped support staff on the floor. They said this gave them opportunity to watch staff with people and observe staff practice and how staff engaged people. The feedback we gave to the manager about our visit was not their normal experience of how people were cared for.

Relatives told us they could visit any time, without restriction and felt comfortable using all areas of the home.

Requires Improvement

Is the service responsive?

Our findings

People gave mixed responses in how staff responded to meet their needs. Some people and relatives felt their requests for support was timely, others did not. Staff said they were not always able to respond to people's needs. On both floors we saw staff unable to offer immediate support. On our first inspection visit, during the morning from 10.30am to 1.00pm, we saw only one member of staff used a mobile hoist. We asked a nurse how many people needed help to move with the aid of a hoist. They said 'most' people on the first floor required hoisting for transfers from their bed into a chair but due to staff shortages, not all people were able to be transferred in to chairs that morning. This supported what some people and relatives told us that staff could not always respond to their needs.

Staff said they had limited time to spend with people so they could respond to their emotional and social needs for engagement. "We used to, but not anymore." "We don't have time to spend quality time with people. Some people need more time than others but you can't give that comfort." Some people told us staff were unresponsive to meet personal care routines. We looked at one person's bathing records. There were no records they had received a bath or shower between 13 July and 8 August 2017. There was no evidence this was their preference or choice. Another person told us they preferred a bath, but said they had not had one for two years. Their care plan recorded a bath was their preference, yet personal care records and staff were unable to tell us the last time they had a bath. The person told us they had a strip and bed wash.

Care plans were detailed and contained details about people's preferences for how their care was delivered. Some relatives told us they were not involved in care plans reviews. One relative told us they had not been involved in any reviews or meetings in the nine months their relative had been at the home. Other relatives shared different experiences and said they were involved in making care decisions.

Staff felt the time pressures meant they did not have time to always read care plans or assess themselves how people were feeling. One staff member said, "Lately it has got quite bad and working with three members of staff we can't give the care we want to give and it is just like a conveyer belt." Staff said they were focussed on the task and as such, meant there was potential for people to be placed at risk. For example, we saw a staff member pushed a person in a wheelchair. We saw that a set of footplates was missing from this wheelchair. The use of footplates reduces the potential for feet and legs not to become trapped during movement.
The nurse told us they had not reported this to wheelchair services but would now.

On the first day of our visit we did not see anyone engaged in activities or stimulated through engagement. Several people spent a lot of time asleep in communal areas. The provider's website states they had, 'one-to-one activities suited to their likes and dislikes, providing reminiscence work on our dedicated Memory Lane Community for people living with dementia'. We did not see this in practice. Staff told us more activities would be beneficial. There did not appear to be any activities especially for people who lived with dementia, nor did we see evidence of activities for people less able to join in with group activities. These people were observed to have no interaction or stimulus except at mealtimes and the radio or television.

There was no evidence of interaction for people who stayed in their bedrooms, other than provision of personal care and meals. Staff said helping people pursue their hobbies and interests were not met. Staff said people did go out on trips but, they, "Took people out who can communicate or won't cause any problems. It is always the same people."

There was no evidence of 'good dementia care' to enhance people's moods and encourage positive behaviours, such as using soft music, soft lighting or any other environmental changes that could assist in creating a more relaxing experience for people living with dementia. The dementia specialist told us they were new to post and this was their first time at this home. They were in the process of looking at the environmental challenges and bringing in recognised practice that supported 'good' dementia care but acknowledged this could only be developed over time.

There were some people who were active and spent most of their day walking around the unit. There was little to engage them and some people would have clearly benefited from the opportunity to walk and explore a different environment such as the gardens. For example, One person said it was important to them to walk with their frame, to keep active. They told us they enjoyed 'the outdoors' but said they did not go out as often as they wanted because staffing numbers did not always allow for this. Nobody was offered an opportunity to walk with staff in the garden because staff were too busy. Relatives confirmed this. Staff said, if they could they would but it was not always possible.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care

On the second inspection visit staff said they were able to respond to people's needs as staffing levels had increased. The manager changed the way staff were deployed. Instead, staff were responsible for meeting the needs of a specific group of people so they were accountable for the care that group of people received. One staff member told us their thoughts, "Yesterday they (management) changed the way we work. Six staff are each allocated five people for whom they are responsible and they have to complete all the records." The staff member explained, "We were a little bit wary of it yesterday but it actually worked really well, I had the time to give extra drinks, reposition when they needed it and do their nails." Both care staff we spoke with about this seemed more relaxed and had a much more positive attitude than when we spoke with them on our first inspection visit.

The manager who took over this service in July 2017 told us they had not received any complaints from people or relatives. They told us if a complaint was received, they would acknowledge the complaint, investigate and respond within the providers agreed timescales. If there was learning to be taken, this would be done to minimise the potential for similar complaints reoccurring. Complaints were monitored by the provider and regular checks ensured action would be taken to respond in a timely and satisfactory way.

Requires Improvement

Is the service well-led?

Our findings

People and relatives gave us mixed responses when we asked if they believed the home was well managed. Some comments were, "Great atmosphere, very friendly" and "I don't know a better one." A relative said, "Because the staff don't feel as supported as they were, morale is very low. They are endeavouring to do their best but it is wearing them down" and, "The care is generally good, I don't think the staff are well looked after by the management though, I don't think the management have a clue."

Some negative comments from people and relatives were about staffing and how that had at times, affected the quality of care they experienced. Relatives said their concerns had been over a sustained period of time and they had become disappointed their voice was not heard, especially when concerns were raised to the provider.

This home should have a registered manager in post. At the time of this inspection there was no registered manager in post. The registered manager left Cherry Trees in April 2017. The home had been managed temporarily by another manager from within the provider's organisation. This manager had been asked to take over the management of the home as an interim measure and spent time to induct the new manager who started in July 2017.

It is a legal requirement for the provider to display a 'ratings poster'. The regulation says that providers must 'conspicuously' and 'legibly' display their CQC rating at their premises. A ratings poster was not displayed in line with our regulations and we discussed this with the manager and regional director. By the end of our first inspection day, the regional director rectified this by displaying a poster of the previous inspection rating in the communal hallway. Prior to our inspection visit we checked the provider's website and found they displayed their rating and a link to the report on our CQC website.

After our inspection visit, we spoke with the interim manager who said when they managed the service, there were no real concerns. They recognised the managerial changes destabilised the staff team. One to one meetings with staff, people and relatives said in the main, there were no issues. Regards staffing, the interim manager said they used the providers dependency tool and staffed to the calculation of six care staff on the first floor and five care staff on the ground floor. They said shifts worked well, but high agency use did have an impact on permanent staff such as how they worked together. The interim manager said sometimes staffing was about deployment and effective management but if additional staff were needed, regional directors could approve requests. The interim manager continued to act as a 'buddy' for the manager.

People and relatives gave mixed response regarding the new manager. Some found them visible and approachable, one relative said, "The carers (staff) do generally care, agency staff are pretty poor though. The manager has assured me they are trying to improve the situation. I am prepared to stick it out for a bit longer as she has some good ideas, she does seem to listen and empathise too." Others told us they had not met them yet. The manager had not held a meeting with people and relatives, but planned to do this shortly so they could introduce themselves. Relatives said this would be beneficial to them as some had not attended relatives meetings for 18 months so felt this would improve and open communication.

The manager had been in post seven weeks and had begun to address some of the issues within the home. There had been some staff changes which the manager said improved the culture and teamwork. They felt the staff team worked well together, was more cohesive but still required close management to ensure staff understood their roles and responsibilities and what was required from them. They wanted to reduce the high agency use and were currently recruiting for staff and were due to hold a job fair in October 2017 to stimulate interest. They had prioritised actions and were looking to implement structure, responsibility, stability, and an open management culture with better governance.

Staff told us they enjoyed caring for people who lived at Cherry Trees but were frustrated by the changes in management and leadership and how this impacted on their role. "It is good, the residents are lovely. It is just the way things are run. Changes seem to happen every two weeks and they are big changes. It doesn't make it easy for us and most importantly it doesn't make it easy for the residents." "I love it but we have had our ups and downs. At the moment I don't know where we are going. A shortage of staff now and again is normal but not most of the time."

We received mixed responses when we asked staff if they felt supported in their role. Some staff did not have regular opportunities to meet with managers or senior staff to discuss their role or professional development. One staff member told us, "I don't think they still do them anymore. My last one was maybe eight months ago and that was when I was working downstairs." "Not on a regular basis at all. My last one was with (interim manager) two months ago but that was my first one for a long time." The manager planned to commence supervisions shortly and would complete these on a regular basis so staff had opportunity to share feedback.

We asked staff if they felt they delivered high quality care that was safe, effective and responsive. "We all do our very best but with the staff it is a bit of an issue and it can prevent the standards of care being the best it possibly can." "We care and we try our best but it is not enough when there are not enough staff on board."

We asked staff if they saw much of the managers: "I don't really feel I cross a path with them that much" and "We don't have a strong leader." Regarding staff meetings and opportunities to share feedback, "They happen every now and again." A staff member who had worked at the home for three years had never attended a meeting because they were always on shift when they were held and was unable to leave the floor to attend. Because of this, they felt communication and delivering messages could be improved so all staff had the same consistent message.

We saw systems were implemented to monitor the quality of service. We looked at examples of completed audits such as health and safety, infection control and fire safety. Actions from each audit were collated to form 'one action plan' that the manager and regional director updated and monitored to ensure actions were taken. Internal quality improvement teams within the organisation visited and audited bi-monthly, and actions were put into an action plan that monitored progress. We checked one audit dated 23 May 2017 that identified creams were not prescriptive in where to apply. We found the actions rolled onto the next audit dated 16 August 2017 that showed improvement was still needed, plus they supported what we found. Further checks would ensure this was completed. The manager was identifying areas for improvement and would include these as part of their regular audit processes, such as health and safety checks and recording daily walk about and observations. Relatives meetings had not yet been held but were being planned. The manager said they would be held so people had opportunity to share their views to influence how the service was provided.

Senior management told us they were supporting the manager as she was new to post. They told us they visited regularly and walked around the home, undertook checks and spoke with staff and people during

their visits. They had not identified some of the issues we found, especially around staffing and mealtimes. They told us they had not witnessed the issues we found and if they had, would have addressed them. We spent time with the senior regional director, regional director and both clinical development nurses to see how they would improve this service. One clinical lead nurse said, "I will provide coaching, training and nurse leadership - Barchester had recognised this was an area for improvement." They said they were spending time with the deputy manager to provide them with leadership skills and accountability because this was part of their role being a deputy manager. They told us the deputy was a nurse, therefore should be involved in clinical governance and support to other nursing staff which is why they were offering support. The clinical lead nurse said, "I am enthusiastic and passionate about this, I want to see improvement." Regular visits from them would ensure improvement was made.

Senior managers gave us their commitment to improving standards and care within the home. During our inspection, they increased staffing on the first floor, agreed to improve dementia care and looked to improve the environment so it was more supportive of people living with dementia. They said when we do a return inspection, "You we will see the difference."

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 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care and treatment which supported their preferences to ensure their personal and individual needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing arrangements were not consistent to ensure there was sufficient numbers of suitably qualified, competent and skilled staff to meet people's care and welfare needs.