ADL Plc

Cherry Tree House

Inspection report

Collum Avenue
Ashby
Scunthorpe
Lincolnshire
DN16 2TF

Tel: 01724867879

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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

This inspection of Cherry Tree House took place on 8 and 14 May 2018 and was unannounced. At the last inspection in February 2017 the service did not meet all of the regulations we assessed under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. That was because the provider had not deployed sufficient staff to meet people's needs, ensured people were occupied and entertained or notified the Care Quality Commission (CQC) of a serious accident. They were in breach of two regulations relating to staffing and sending notifications. At that inspection the service was rated 'Requires Improvement'.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions Is the service safe?, Is the service responsive? and Is the service well-led?, to at least good. They sent us an action plan stating when and how they would achieve the improvements needed.

At this inspection the provider's deployment of staff was sufficient to meet people's needs, activities were taking place and we had been told about all events that required a notification being sent to us. However, there was some improvement needed with regard to medicines management, to ensure the store room remained below the recommended temperature for storing medicines and those to be returned were safely accounted for. The registered manager assured us these would be addressed. The service was rated as Good.

Cherry Tree House is situated in the Ashby area of Scunthorpe close to local shops and amenities. The home is registered to provide accommodation and personal care for up to 34 people, some of whom may be living with dementia. Communal rooms: lounge, dining and bathroom, are located on two floors along with people's bedrooms, so that the premises are sectioned into four wings. Staff, catering and laundry facilities are all on the ground floor. An enclosed garden provides a safe outdoor space where sheltered seating is available. At the time of this inspection there were 12 people permanently living at Cherry Tree House and three people staying there on respite.

Cherry Tree House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a registered manager who had been in post for the last 25 years. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were protected from the risk of harm. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of safeguarding concerns. The premises were safely maintained. Accidents and incidents were appropriately managed and equipment was safely used. Recruitment policies, procedures and practices ensured staff were suitable to care for and support vulnerable people. People were protected from the risks of infection and disease by good infection control management. Lessons were learnt when things went wrong.

People made choices and decisions wherever possible in order to exercise control over their lives. They were supported by qualified and competent staff that were regularly supervised and received annual appraisals of their personal performance. Staff respected people's diversity and met their individual needs. People's nutrition and hydration needs were met. The provider worked well with other health and social care professionals. People were supported with their health care.

The premises were suitable for providing care to people with dementia but needed improved signage to aid people's orientation around the building. People's mental capacity was appropriately assessed and their rights were protected. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Consent from people was appropriately obtained before they were supported.

People received compassionate care from kind staff who knew about people's needs and preferences. People were involved in their care and the right to express their views was respected. People's wellbeing, privacy, dignity and independence were monitored and respected.

People were supported according to individual person-centred care plans, which reflected their needs well. These were regularly reviewed. People maintained family connections and support networks and their communication needs were assessed and met. There was an effective complaints procedure in place and people's complaints were addressed. Staff sensitively managed people's needs with regard to end of life preferences, wishes and care.

Quality assurance systems were effective. Audits, satisfaction surveys, meetings and handovers ensured there was effective monitoring of service delivery. The culture was person-centred, open and inclusive and ensured good outcomes for people. The registered manager understood their responsibilities with regard to good governance and practiced a management style, which was open and approachable. Engagement and involvement of people, public and staff was evident.

The registered manager looked for new ideas around best practice, updated their learning and practice whenever possible and improved the service delivery. They fostered good relationships with other agencies and organisations.

Further information is in the detailed findings below.

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 numbers were now sufficient to meet people's needs.

People were protected from the risk of harm. Staff were trained in this area and understood their responsibilities. Risks were managed and reduced.

The premises were safe. Recruitment procedures were safe. Infection control practices were effectively followed.

Improvements were needed with the management of medicines, but these were being addressed by the registered manager.

The provider and staff learnt lessons when events went wrong so that mistakes were not repeated.

Is the service effective?

Good

The service was effective.

People's needs were assessed and staff were skilled and trained to carry out their roles.

Adequate nutrition and hydration ensured people's health and wellbeing. Information sharing and communication was effective.

Premises were maintained and plans were in place to improve facilities. People's rights were protected and their consent was obtained.

Is the service caring?

Good

The service was caring.

People received compassionate care from kind staff.

People were provided with the information they needed to stay in control of their lives and maintain their independence.

Their wellbeing, privacy and dignity were monitored and respected.

Is the service responsive?

Good

The service was responsive.

Person-centred care plans provided a robust tool to assist staff to meet people's care needs.

People engaged in pastimes and activities and maintained connections with family and friends.

An effective procedure ensured complaints were appropriately investigated.

End of life care was sensitively provided.

Is the service well-led?

Good

The service was well led.

The culture and management style of the service were positive.

An effective quality assurance system identified shortfalls in service delivery.

Experiences of transition between services were well managed, as partnership working was efficient.

People made their views known. Recording systems protected people's privacy and confidentiality of information and records were securely held.

Cherry Tree House

Detailed findings

Background to this inspection

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

This inspection of Cherry Tree House took place on 8 and 14 May 2018 and was unannounced. Two adult social care inspectors carried out the inspection. Information had been gathered before the inspection from notifications that had been sent to the Care Quality Commission (CQC). Notifications are when registered providers send us information about certain changes, events or incidents that occur. We received feedback from local authorities that contracted services with Cherry Tree House and reviewed information from people who had contacted CQC to make their views known about the service. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with five people that used the service, two relatives and the registered manager. We spoke with three staff that worked at Cherry Tree House. We looked at care files for four people that used the service and at recruitment files and training records for three staff. We viewed records and documentation relating to the running of the service, including those for quality assurance, medication management and premises safety. We also looked at equipment maintenance records and records held in respect of complaints and compliments.

We observed staff providing support to people in communal areas of the premises and the interactions between people that used the service and staff. We looked around the premises and saw communal areas and people's bedrooms.

Good

Our findings

People told us they felt safe living at Cherry tree House, that there were sufficient staff to support them, their medicines were well managed and the premises were safe and clean. They said, "I like it here and feel safe", "It is wonderful", "Staff are always available", "I get my tablets when I need them and the home is lovely and clean" and "I am perfectly happy here." Relatives told us they and their family members were quite satisfied with the safety in the service, the staffing levels and the support they received.

At the last inspection the provider was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with regard to staffing. This was because there were insufficient numbers deployed to meet people's needs. The staffing tool, which was based on people's dependencies, was confusing and not used regularly to determine levels required.

At this inspection while some minor reductions had occurred in staffing numbers, there had also been a reduction in people that used the service; so the staff deployed were sufficient to meet people's needs. Rosters confirmed those on duty and their work times. The staffing tool had been reviewed and updated and was now used to show people's dependencies, which then determined the staffing numbers required. People's comments about staffing confirmed their needs were appropriately met.

Medicines were safely managed and securely stored. The storage rooms' temperatures were monitored so that medicines did not get too warm. However, on the first day we inspected the thermometer in the upstairs store was reading 27 degrees centigrade, which was two degrees higher than medicines should be stored at. The registered manager was told about this so they could take action to install a means of keeping the room temperature lower than 25 degrees centigrade. They assured us this would be attended to.

Of those people that were on insulin to control their diabetes, one self-medicated after staff drew up the required amount. Staff had been trained to do this and their competence assessed by the district nursing service, which maintained overall responsibility for the preparation of the medicine for this person.

Medicines were stock controlled, recorded in and out of the building and signed for on medication administration records (MARs) when administered to people. Medicines for returning to the pharmacy were kept together but some had not been entered in the returns book at the point of taking them out of stock, which meant they could not always be accounted for. The registered manager was informed and assured us they would address this.

Safe systems were in place to manage safeguarding incidents and staff were trained in safeguarding people from abuse. Staff demonstrated they understood their responsibilities on this subject. Referrals had been made to the local authority and records were accurately maintained.

Risks within the service were appropriately managed using risk assessments and following these and other guidelines for people's safety. They provided guidance on reduction and removal of risk in areas of support, for example, in relation to mobility, nutrition, equipment used, skin integrity and falls. Equipment was seen to be used safely. If a problem or concern arose or something went wrong with a person's care and support or any aspect of service delivery, which required resolution, then lessons were learnt from the experience to prevent any reoccurrence.

Accidents and incidents were recorded and monitored to reduce the risk of any reoccurrence and these were reported to the Care Quality Commission as required. People had personal safety documentation for evacuating them from the building in an emergency or in case of fire. Maintenance safety certificates were in place for utilities and equipment used in the service, and these were all up-to-date. One bedroom floor needed attention to make the surface level and safe. We spoke with the registered manager and they agreed to address this. Safety audits were carried out and all of this ensured people, staff and visitor's safety.

A robust recruitment system ensured staff were suitable for the job. Staff files contained consistent documentation for the selection of staff, including vetting and screening of candidates. The system helped the provider to make safe recruitment decisions. Many staff had worked at Cherry Tree House for several years, sometimes breaking employment and retuning again. Even those recruited last had been in their posts for more than five years.

The premises were clean and there were no unpleasant odours. Cleaning schedules were followed. Waste management was appropriate and followed guidelines and contractual arrangements. Staff were trained in infection control and prevention and appropriate personal protective equipment was used. People had individual hoist slings to ensure safe infection control. The kitchen staff were trained in basic food hygiene and had suitable means of keeping the kitchen and equipment clean, all of which was recorded.

Good

Our findings

People told us that staff at Cherry Tree House understood them and had the knowledge needed to support them. They said, "Staff are ever so good when I need support in the bath" and "I am treated very well by the staff who know what they are doing." They also said, "It is lovely food here and we get whatever we want" and "Staff are very supportive and understand my needs." Relatives told us they found staff to be skilled, knowledgeable and approachable.

People's needs were assessed and met according to appropriate legislation to protect their rights. They were encouraged to exercise choice and control with regard to care planning, receiving support and relationships. People's rights to vote in elections were championed, they took part in reviews of their care and were enabled to access local community resources and services when necessary.

Staff received training to enable them to support people. They completed induction, received regular one-to-one supervision and took part in a staff appraisal scheme. Staff confirmed they had completed training required of them by the provider to ensure their competence and studied for qualifications.

People made their choices known regarding nutritional needs in residents' meetings, reviews and daily conversations. Information was recorded in their care plans. Anyone expressing a diverse requirement with regard to nutritional needs was catered for and preferences respected: cultural, religious, healthy or with protection of animals in mind.

Discussion with the cook on duty revealed people chose meals from a selection on offer, had their specialist dietary needs met and were supported to eat if needed. The cook was keen to support people with specialist diets and particularly weight reduction while offering healthy balanced meals. Nutritional risk assessments helped protect people from choking or unwanted weight loss. Staff accessed the services of the speech and language therapist and dietician when required.

Staff worked with other organisations to provide optimum support to people and we received confirmation of this from a healthcare professional that visited the service at the time of our inspection. We saw evidence in people's files that information sharing took place with other providers.

Staff consulted people and their relatives about medical conditions and confirmed they liaised with healthcare professionals to offer people good health care support. Information was collated and reviewed with changes in people's conditions and passed over in handovers, between staff at the beginning or end of

their shift or during staff meetings. People saw their doctor on request and a district nurse, chiropodist, dentist and optician whenever necessary. Health care records contained guidance on how to support people with health needs and confirmed when they had seen a professional and the reason why. Diary notes recorded the support people were given.

People living with dementia had some signage and colour schemes that aided their orientation and helped reduce confusion, but there were no design features, for example, in relation to mood lighting, piped music or immediately accessible toilets that aided them. No technology was used, for example, to monitor people that may be at risk of falls. There were some keypad door locks to the main entrance and to the staff / utility area. People at risk, if they left the building unaccompanied, had appropriate documentation in place to protect their rights.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interest 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 interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Several people had DoLS applications pending with the local authority and best interests' decisions were discussed and agreed. We found that documentation was suitable for the recording of assessments and decisions made. When we spoke with staff they confirmed the use of the best interest process. People gave consent to receiving care and support either by verbally agreeing or cooperating through their body language when help was offered. Where they couldn't give signed consent the registered managed addressed this using the best interest process. Some people signed documents that gave permission for their care plan to be implemented, photographs to be taken or medication to be handled.

Good

Our findings

People told us they were happy at Cherry Tree House as they had friends there and were often visited by their families. They said, "Staff are helpful and caring", "I think everyone here is very nice" and "Staff have a laugh with us. I like a bit of fun, as it makes the day interesting."

Our observations and discussions with staff revealed they were caring, considerate, understanding and cheerful in their work. Staff provided people with support in a sensitive way with regard to their personal care needs. They spoke discreetly and always directed people to a bathroom or their bedroom to provide support with personal care. Staff gave reassurance to people and chatted to them about their family members, interests or topics of the day. One person expressed a wish to see absent family members more often and this was passed to the registered manager who supported the view that the use of video calling would enable them to contact family living abroad. The registered manager led by example and was polite, attentive and informative in their daily approach to people and their families. They were also happy to stand in whenever required to help support people.

People were asked their opinions on everyday topics such as food, the weather, clothing, activities and relationships as well as anything in the news, television programmes and local events. Discussions were impromptu and relevant to people's needs or expectations. Staff enabled people to make choices wherever possible, so that people continued to make decisions for themselves and stayed in control of their lives. People chose their meals each day and if they changed their mind the cook provided an alternative. They chose where they sat, who with, when they got up and went to bed, what they wore and whether they went out or stayed in.

While those living at Cherry Tree House had relatives or friends to represent them, advocacy services were available if required. They provided independent support and impartial information for people when their best interests were being discussed.

People's diverse needs were adequately provided for. Everyone had the same opportunities in the service to receive the support they required. They were spoken to by staff in the same polite, but friendly way and were treated as individuals with particular needs. Their wishes, preferences and choices were met. For example, care plans recorded people's individual daily routines, activities and family relationships. They described people's religion, sexual orientation, any disability due to age or illness and recorded their preferences, for example for food and ritual, in relation to all of these. Staff knew about these details and responded to them accordingly in order to meet people's needs.

People had been consulted about their wishes and choices following illness and when faced with the end of life decisions. Some had 'do not attempt cardiopulmonary resuscitation' documents in place to be protected from any unnecessary and unpleasant treatment, while those that did not were assured their right to life was protected and respected by the health and social care services they used.

People's privacy, dignity and independence were respected. Staff only provided personal care in privacy and knocked on doors before entering bedrooms and bathrooms. They ensured all doors were closed quickly when entering and exiting, so that people were never seen in an undignified situation. We saw evidence in people's files of the ways in which personal care was provided and instructions included how best and most appropriately support was to be given to ensure people's dignity and privacy.

Good

Our findings

People told us they thought the staff were receptive and attentive to their needs and that their concerns would be addressed promptly. They said, "I'm given all the support I need", "Staff seems to know when I need help" and "I'm very forward so if I had a complaint I wouldn't keep anything back." Relatives were satisfied with the response they received when they approached staff for any information or to pass on details they felt were important in the care of their family member.

At the last inspection the provider had not ensured people were sufficiently occupied or entertained. Activities and pastimes were few and people told us there was little to do.

At this inspection people were suitably occupied and entertained. On the first day we visited an exercise class to music was enjoyed. One person had their own hobby, spending time doing this in their bedroom and staff supported them with this. People read newspapers, magazines, listened to music or watched television in their bedrooms. On the second day we saw people sitting or walking in the garden and gathering before tea to have a 'natter'.

The registered manager had a set budget for entertainment and asked people how they wanted to use it. They liked to play a specific card game, visited a local memory centre, enjoyed board games and hired a bus from Age UK from time to time to visit garden centres, a local ice-cream parlour and take rides around nearby villages. One staff member often brought in cooking 'gadgets' to show to people and stimulate discussion. Staff were enthusiastic about engaging people. Everyone looked forward to the imminent Royal wedding and an afternoon tea party to celebrate.

The provider had plans to develop each of the four lounge areas so that they reflected a different theme: sports, library, pamper salon and sensory experience. A memorabilia corner had been set up in the past but was now looking unused in one of the upstairs lounges and being out of sight was of little benefit to people. The registered manager stated they wanted to revive it by adding new items and place it in a different part of the service, where more people could access it. Regarding activities and occupation, the registered manager was reminded by us of the benefits of video calls, email or text communications.

People had person-centred care plans, which reflected their needs and instructed staff on how to meet them. They contained risk assessments to show how risk to people was reduced, for example, with pressure relief, falls, moving and handling, nutrition and bathing. Care plans and risk assessments were reviewed monthly or as people's needs changed.

People were encouraged to maintain relationships with family and friends and to make new ones if they wished. People's communication needs were assessed before admission and during their first few days at the service and any particular communication aids / methods were used to enable them to make their views known. The Accessible Information Standard was known to the registered manager who provided information to people in any format they required. The accessible information standard is a legal requirement for health and social care providers to present accessible information in a way people with a disability or sensory loss can understand.

The provider had complaint systems in place and records showed complaints were handled within timescales. People said they were aware of how to complain and would simply speak to the registered manager. Staff understood the complaint procedure and resolved issues for people as soon as they were voiced. Compliments were also recorded in the form of letters and cards.

We assessed how people were cared for at the end of their life and found staff liaised with healthcare professionals to ensure people had a comfortable, pain-free and dignified death. All care and end of life arrangements were recorded within people's care plans. Staff were sensitive to people's needs and those of their relatives at this time. Records showed people received regular monitoring and support checks with regard to nutritional intake and output, pressure relief and application of topical creams and lotions. People and their relatives were treated respectfully, with compassion and dignity. Information about end of life care was provided when necessary.

Good

Our findings

People told us the registered manager was doing a good job and they were a lovely person. They said, "The manager is always there when you need them. They are lovely" and "[Name] is doing a grand job. You couldn't ask for a better person in charge." People could not recall completing satisfaction surveys but felt they must have done at some point. Relatives said they were pleased with how the service was run and found the registered manager informative and helpful. Staff said the culture of the service was, "Caring and supportive: from the heart."

At the last inspection the provider was in breach of regulation 18 of The Care Quality Commission (Registration) Regulations 2009 because they had not notified the CQC of a serious injury following an accident.

At this inspection we found that all notifications had been sent to the Commission over the last 12 months and so the service fulfilled its responsibility to ensure this requirement of their registration was followed. The registered manager was aware of the need to maintain a 'duty of candour, which is the responsibility to be honest and apologise for any mistakes made.

The provider was required to have a registered manager in post and on the day of the inspection the manager had been registered for approximately 25 years. The registered manager was aware of the need to maintain their 'duty of candour', which is the responsibility to be honest and to apologise for any mistake made.

The registered manager completed quality audits, for example, on care plans, staff competences, management of medicines, health and safety, staff files, infection control and training. These identified shortfalls and showed how action would be taken to address them.

Champions were nominated among the staff for dignity and infection control. It was their responsibility to monitor practice within the service and challenge staff if they deviated from policy and good practice. I was their responsibility to provide staff with information and learning around these subjects.

We saw that the culture of the service was respectful of people's differences and individual needs. People were enabled to express their differences and uniqueness in how they lived their lives. For example, those living with disabilities (physical and cognitive) were all encouraged to take part in individual daily life skills as well as the group events on offer, and staff spoke with people living with dementia about the issues that

mattered to them and they remembered. People of both genders shared things in common and were assisted in whatever they liked to do. For example, the males that used the service tended to sit together in one of the lounges and watched sports on the television, while some of the females gathered before tea in the dining room to chat.

Resident and staff meetings were held to seek people's views. Monthly team meetings for staff showed they discussed topics such as medication administration, correct procedure for expressing concerns and completion of handover records. Separate meetings were held for care, cleaning and kitchen staff. Satisfaction surveys were issued to people, relatives, visiting professionals and staff. They showed that positive comments were received from three health care professionals, a relative and all people that used the service early in 2018. The last staff surveys were issued in May 2017 so while these also contained positive comments they were a little dated and information in them was no longer relevant.

The registered manager was open to new learning in order to improve the service delivery to people. They had spent time updating care plans and mental capacity assessment documentation, so that it better accounted for people's situations and protected their rights. They had also enabled a student nurse in mental health and on college placement to have insight into how the needs of people living with dementia were met in the home, as well as how the management of the service delivered to them was carried out. The student nurse had spent time both supporting people with care and working in the office to understand the legal side in relation to people's rights. The registered manager acknowledged that despite 20 plus years in their role they were still learning.

The registered manager had been working with North Lincolnshire Council officers following the last CQC inspection and the Council's own contract monitoring visits, both of which had highlighted concerns about the service delivery. Improvements had been identified and made. The registered manager and staff worked with other organisations and agencies, such as district nursing services, occupational therapists, the falls team, chiropodists, dentists, opticians and doctors' surgeries to help improve support for people. Records were safely and securely maintained to protect the confidentiality of people's information and the requirements of the Information Commissioner's Office were adhered to.