Runwood Homes Limited

Cherry Tree Lodge

Inspection report

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Warwickshire
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Date of inspection visit:
19 February 2019
28 February 2019

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21 March 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Cherry Tree Lodge provides accommodation and personal care for up to 72 people, some who are living with dementia and some who are very frail and have physical support needs. The service consists of four separate units over two floors. There were 53 people living in the home on the first day of our inspection visit, the 19 February 2019. There were 52 people living in the home when we returned on 28 February 2019.

People's experience of using this service:
•Systems to identify people's individual safety risks and to promote people's safety were inadequate.
•Good governance of the service had not been maintained because too often there had been inconsistency in the management team which meant there was a lack of responsibility to identify the shortfalls we found, including risks to people's safety and welfare.
•The provider's quality assurance systems were not effective in identifying, responding and maintaining a good standard of service that people deserved.
•No or limited action had been taken when quality assurance checks identified people could be exposed to unnecessary risk, such as potential skin damage because risk assessment tools were not being completed accurately or staff were not recording care interventions to manage identified risks.
•There were not enough sufficiently-skilled, senior staff to review everyone's risk assessments to ensure effective preventative measures were in place for people.
•Staff had not had the training or support they needed to assist them in accurately identify emerging risks so support could be sought from community healthcare professionals.
•Community healthcare professionals raised concerns about the timeliness of referrals and the accuracy of the information they were given when a referral was made.
•On the first day of our inspection visit there were not enough staff with the appropriate skills, experience and knowledge of people's individual needs to provide safe and effective care. Staff were not always available in communal areas so people could get assistance when needed. On the second day, staffing numbers had increased but there was still a reliance on agency or very new senior staff.
•Overall, people received their medicines as prescribed but improvements were required in the management of prescribed medicines applied directly to people's skin.
•People's dietary needs, preferences, likes and any allergies, were assessed and recorded when they moved into the home. However, people on modified diets did not always get a choice of what they wanted to eat and there was a lack of fortified snacks for those people identified as being at risk of losing weight.
•Improvements were needed to ensure people were supported to enjoy a wider range of activities on the individual units which reflected their interests, and enhanced their lives.
•Overall staff worked within the principles of the MCA in their interactions with people.
•Most staff were caring in their approach, but the main interaction with people was focussed on when they offered support or completed a care task.
•People's privacy and dignity was not always upheld.
•Improvements were required in the oversight and management of staff's practice to ensure people received a quality service.

Following our inspection, we notified relevant stakeholders such as the Local Authority Quality Team about the areas of concern we identified.

We reported that the registered provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were:
Regulation 9 Regulated Activities Regulations 2014 - Person centred-care
Regulation 12 Regulated Activities Regulations 2014 - Safe care and treatment
Regulation 17 Regulated Activities Regulations 2014 - Good governance
Regulation 18 Regulated Activities Regulations 2014 – Staffing

Rating at last inspection: Requires Improvement. The last report for Cherry Tree Loge was published on 6 March 2018.

Why we inspected: This was a planned inspection based on the rating at the last inspection. The provider had failed to improve on the previous 'requires improvement' rating and the quality and safety of the service had declined further. At this inspection the rating is now Inadequate overall.

Enforcement: Please see the 'action we have told provider to take' section towards the end of the report. Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Follow up: We will continue to monitor progress made against the provider's action plan and any regulatory action as an outcome of this full inspection report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our Responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led..

Details are in our Well-led findings below.

Inadequate

Cherry Tree Lodge

Detailed findings

Background to this inspection

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

Inspection team:
The inspection took place over two days. The first day of the inspection was carried out by two adult social care inspectors, a bank inspector and a specialist advisor. A specialist advisor is a qualified health professional. One adult social care inspector and a bank inspector returned on the second day.

Service and service type:
Cherry Tree Lodge 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 did not have a registered manager. 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. A new manager had been appointed but was not due to take up their position until mid-March 2019. The provider had appointed an 'interim manager' until that time. They were on annual leave at the time of our first inspection visit, but available at our second visit.

Notice of inspection:
This inspection visit was unannounced and took place on 19 February 2019. Due to concerns identified on the 19 February 2019, we returned unannounced on 28 February 2019 to check whether the provider had taken any action to mitigate the risks identified. We found limited action had been taken.

What we did:

Before the inspection, the registered provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The registered provider returned the PIR and we took this into account when we made our judgements in this report. We reviewed other information we held about the service such as notifications. These are events that happen in the service that the registered provider is required to tell us about. We considered the last inspection report and information that had been sent to us by other agencies.

We also had contact with local authority commissioners who had a contract in place with the registered provider. The commissioners informed us they had received a number of concerns about the service in the weeks prior to our inspection visit. Those concerns related to the support people received to manage risks to their health and wellbeing.

Due to their needs, some people could not provide us with any information about the care they received or quality of the service provided. Therefore, we used different methods to gather experiences of what it was like to live there. For example, we saw how staff supported people throughout the inspection to help us understand people's experiences of living at the home. As part of our observations we also used the Short Observational Framework for Inspection tool (SOFI) in two separate lounges. SOFI is a way of observing care to help us understand the needs of people who could not talk with us.

We spoke with six people and six visiting relatives/friends to gather their views of the service. We also spoke with the deputy manager, a registered manager from one of the provider's other homes, the provider's new area operations director, the provider's director of dementia services, the interim manager, three care team managers, five care staff, one agency member of staff, two housekeeping staff, the bank cook, the maintenance person and seven visiting healthcare professionals.

We looked at specific parts of the care records of seven people and 23 people's medication records. We also looked at records in relation to the management of the home such as quality assurance checks, staff training, accidents and incident information and records of complaints and compliments the provider had received.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Inadequate: People were not always safe and at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management
•The provider used nationally recognised tools to assess risks to people's health and wellbeing. For example, the Waterlow assessment, to determine whether people were at risk, high risk or very high risk of developing sore skin. However, staff did not always identify the correct level of risk because they were not completing the tools accurately or in a timely way.
•We looked at one person's Waterlow and found it had not been completed or scored accurately. The record showed the person had a score of 12 which put them 'at risk' when district nurse notes showed their score was 34 which placed them 'at very high risk' of skin damage. The person had severe skin damage.
•A healthcare professional told us staff had scored another person's risk of sustaining skin damage as 19 when in fact it should have been 37 which put them at 'very high risk'.
•Where a risk in people's health had been identified, care plans had not always been implemented informing staff how that risk should be managed. For example, there were no specific skin care plans for two people whose Waterlow assessments had shown a high risk for at least six months. Staff were not instructed to be alert to the specific risks, and were not guided to take appropriate action to minimise the risks.
•A healthcare professional told us when people had equipment in place to minimise the risks of skin damage, staff were not always using it correctly. For example, they told us on the day before our inspection one person's pressure relieving mattress was set at 75 kilos and this should have been set at 35.5 kilos. Records confirmed this. It is important mattresses are at the right setting to relieve pressure from vulnerable areas.
•There were gaps in the records staff completed to demonstrate how they minimised risks to people's skin. Records did not demonstrate that people received pressure relief in accordance with their care plans. There were significant gaps in repositioning charts, often for periods of over six hours.
•Another person who was at risk of sore skin should have been supported to reposition themselves every two hours, on their left and right. Their records showed they had been placed on their back on four occasions on the 13 February 2019 and twice on the 14 February 2019 which increased the risk of sore skin developing.
•When people are at risk of sore skin it is important their personal care is maintained and their skin is kept dry and clean. Healthcare professional records showed they had found one person at risk of skin damage in a wet and/or soiled bed on three separate occasions in the 12 days before our inspection visit.
•Good nutritional intake is a vital aspect of maintaining good skin integrity for those identified as being at risk. However, nutritional risks were not always being identified. One person had lost 10 kilos between November 2018 and February 2019 and another person had lost 8 kilos in the same period. Neither person had been referred to the dietician and both had developed skin damage in this period.
•In total, five people had suffered varying levels of skin damage in the weeks prior to our inspection.
•We returned nine days after our initial inspection to check whether action had been taken to re-assess people's risks to their health and wellbeing. We found only four people had been re-assessed.

•In those nine days another person had developed a serious pressure wound to their skin. This person's risk of skin damage had not been assessed since 23 November 2018 when they had been scored as not being at risk. When the person's risks were re-assessed on the 26 February 2019, the day the skin damage was reported to the district nurses, they were scored as being at 'very high risk'. This meant escalating risks to this person's health had not been identified so actions could be taken to minimise the risk.
•Risks associated with specific health conditions were not being managed. One person had a catheter in place, but their care plan did not provide indicators of possible infection or emerging problems. The person's fluid input was being recorded but not their output. These records are important as reduced output can be an indicator of a blockage or urine retention.
•Risk assessments were not always reviewed accurately following incidents. One person had recently returned from hospital having fallen and sustained an injury to their arm. The person's moving and handling assessment had been updated, but did not correctly identify the support they needed to move in bed.
•We saw staff did not always use safe moving and handling techniques. We twice saw staff supporting people by transferring them to a wheelchair to mobilise, but staff had not put the brakes on to stop the wheelchair moving as the person's weight was transferred into it.

Learning lessons when things go wrong
•There had recently been an increase in the number of people whose skin had become sore, and required treatment by the community nurse team. However, there were not enough sufficiently-skilled, senior staff to review everyone's skin risk assessments to ensure effective preventative measures were in place for other people. Two people who were identified as at high risk of skin breakdown, did not have skin care plans in place.
•We found the actions taken in response to the feedback from ourselves and members of the community health team following our first inspection visit were inadequate.
•We looked at the latest analysis of falls completed by the deputy manager. We found the information they were working from was often not detailed enough to provide information about how the fall had occurred. Whilst the deputy manager had analysed the time of falls, there was no analysis of where the falls occurred or whether they were witnessed or not. This meant there was no accurate analysis of whether changes were needed to the environment or staff numbers or practice.
•Thickeners and supplements were not stored appropriately. Thickeners are added to fluids for those people who have been identified as being at high risk of choking. Thickener was found on an open shelf in the upstairs kitchenette and a further container was found on the worktop in an open kitchen downstairs. NHS England issued a safety alert in February 2015 of the need for proper storage and management of thickening powders; this was in response to an incident where a care home resident died following the accidental ingestion of thickening powder.

The above concerns demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Staffing and recruitment
•There were insufficient staff with the skills, experience and knowledge of people's individual needs to provide safe care.
•On the first day of our inspection there were eight care staff on duty. Three of those staff were agency staff, two who had never worked in the home before and one who had worked there once before. Of the five permanent care staff on duty, one had only been working in the home for two weeks and another was still in their probationary period.
•Although staff numbers had been maintained, there was a lack of cohesion among the staff team. At times people had to wait for assistance and did not receive the care or support they needed which put them at increased risk. For example, one person told us they were in considerable pain. When we pressed the call

bell on their behalf, no care staff responded. After 10 minutes a member of the management team came into the room. It was later identified the person's pain required immediate care.
•There were not enough staff to maintain a staff presence in those communal lounges where some people required close observation and supervision. During our SOFI in one lounge, there was no staff presence for 15 minutes.
•Staff told us the risks of not maintaining a staff presence in the lounge on a unit where people's needs were more complex, had directly impacted on people's safety. They told us one person had recently sustained a serious injury following a fall in the lounge because staff were busy in other areas of the home.
•We were told by the management team that staffing levels were based on an assessment of people's needs. However, we were concerned this did not accurately reflect the number of staff required to keep people safe because we found the analysis of people's dependency levels was incorrect. Also, it did not take into account the competence, skills and knowledge staff had of the individual needs of people living in the home. A healthcare professional told us staff did not have time to get the 'basics' right because staffing levels were reflective of people who were much more able.
•Three days a week, the home provided a day service for between three to five people. Staffing levels were not adjusted to meet the extra demands of meeting those people's needs.
•Staff told us staffing levels impacted on the quality of care they could provide. One staff member told us, "There should always be two staff on Sunflower and two on Lily but a lot of the time we run on three between us, one each side and a floater." When we asked what this meant for people's care they responded, "We can't do repositioning, I am not surprised they have developed pressure sores. Even with two staff by the time you have got round them all, you have missed something in their care with the first person."
•On the second day of our visit staffing numbers had been increased and there were three extra care staff in the home. Members of the community health team said people looked cleaner and more comfortable on that day.

The above concerns demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

Using medicines safely
Staff who gave medicines had been trained to do so safely. We observed a member of staff giving people their medicines in the morning. They followed good medicines administration practice to ensure people had taken their medicines.
•Overall, documents to support the administration of 'as and when' required medicines were detailed enough to ensure these medicines were given safely and consistently. However, there was limited information about how people who were not able to verbally express they were in pain may indicate non-verbally they required pain relief.
•Whilst records demonstrated people received most of their medicines as prescribed, we found this was not the case for topical medicines that were applied directly to the skin or medicated toothpastes. There were significant gaps in the application records of these medicines and issues with people's skin and oral healthcare indicated they were not always being applied as prescribed.

Systems and processes to safeguard people from the risk of abuse
•People were protected from the risks of ill-treatment and abuse as staff members had received training and knew how to recognise and respond to concerns.
•Information was available to people, staff, relatives and visitors on how to report any concerns that people might be at risk of harm or abuse.
•Staff told us when they reported safeguarding concerns, the interim manager listened and took action straight away to ensure people were not at risk of harm or abuse.
•A relative told us, "I know [Name's] safe here."

Preventing and controlling infection

•The provider had effective infection prevention and control systems and practices in place which included regular checks to minimise the risks of infections spreading which followed recognised best practice. However, we did see continence pads were sometimes stored on the floor which did not follow good practice.

•Staff were provided with training in infection control and good hygiene and had access to personal protective equipment to assist in the prevention of communicable illnesses. One person told us, "They do my personal care in the morning and night. They always wear gloves. It is the first thing they do. I have noticed that the hygiene is good here."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
•Improvements were required in supporting people to access healthcare services. A senior member of staff had not been given sufficient training, support, guidance or the tools they needed to identify when they should refer people to healthcare professionals. They did not know the criteria for making a referral to the dietician.
•Whilst there was evidence to show staff had sought the advice of other professionals in response to fluctuations in a resident's health, the healthcare professionals we spoke with felt this was not always done in a timely way or the information in the referrals was always accurate. One healthcare professional told us they had received a referral for one person indicating they had poor mobility. However, when they visited the person they found they were immobile and had been immobile for over a month. The other healthcare professional confirmed their advice was not always sought in a proactive and timely manner, particularly in relation to skin damage.
•We found these concerns had not been addressed on the second day of our visit. Another person had sustained skin damage but it had not been referred to community healthcare professionals until it was very severe. Healthcare professionals told us staff must have been aware of the damage because they had provided personal care and put a dressing on it.
•We received mixed comments from people and relatives about their health needs being met. Most people were happy with the healthcare support they received. One person told us, "The optician came here, it didn't cost me a penny. A dentist came and gave me a filling. My family do my nails and I've seen the doctor two or three times." Another said, "Chiropodists, nurses and the dentist come regularly."
•However, a relative said they had asked for a hearing test for their relation, but had been told they would have to wait until the hearing test service was 'available' to visit. Two other people told us they had problems with their hearing aids that had not been resolved. One said, "I have hearing aids but one's packed up. I first asked to get it fixed a month ago. I've asked three times since but nothing has happened." A relative told us their family had a similar experience. We shared this with the management team who said they would look into it.

The above concerns demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care.

Staff support: induction, training, skills and experience
•Staff had access to a range of training essential to support them in their role. Some training was delivered though e-learning on the computer and other training was face to face.

•Most staff told us they had the training they needed to be competent in their role. A visitor told us, "The staff that have got to know [Name] well are extremely good. I've seen some excellent practice."
•However, a healthcare professional told us they had concerns regarding staff's knowledge and understanding in relation to the prevention of skin damage, catheter care and frailty in general. They told us they were working with the management team to arrange training in these areas to ensure staff had the skills to meet the needs of people in the home.
•Our observations on the day of our inspection was that although staff had completed training, they were not always putting their learning into practice. For example, improvements were required in some staff's awareness of what it was like to live with dementia and how to support people effectively. At lunch time a member of care staff put music on, but did not turn the television off, which was confusing for people living with dementia. A member of the provider's management team, who was on site that day, noticed and checked each person agreed, before turning the television off. The member of the provider's management team had to intervene on several occasions during lunch, to remind staff about the best way to support people living with dementia, such as sitting beside people when assisting them to eat and offering people choices by showing them the meal options.
•We found the provider had not ensured senior staff had the training to effectively carry out their duties and responsibilities. For example, one senior staff member who was responsible for assessing risks and care planning told us they had not received any training in these areas from the provider. They told us they relied on training they had previously received. Risk assessments and care plans we looked at showed senior staff did not have the understanding or knowledge to complete these documents effectively.
•New staff received induction training and supervision from more experienced staff to support them in their roles. However, we could not be sure how effective the induction was. When we asked a member of staff who had completed their induction whether any care plans were in paper format, they were unable to tell us. The deputy manager later confirmed only 60% of care plans had been transferred onto the electronic system which indicated this staff member would not know where to go to find out about people's needs.

The above concerns demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

Assessing people's needs and choices
•Before people moved to Cherry Tree Lodge, a comprehensive assessment of their needs was completed. People's assessed needs were documented in their care plans. Care plans were not always updated when there was a change in people's health to ensure staff had the information they needed to manage risks safely.

Supporting people to eat and drink enough to maintain a balanced diet
•People's dietary needs, preferences, likes and any allergies, were assessed and recorded when they moved into the home. This information was shared with the cook, to make sure they provided suitable meals and snacks. However, the information in the cook's folder was not always changed when people's needs changed. One person's dietary information said 'fork mashable', but they currently required pureed meals. The cook was confident they and care staff knew people well and would only offer them suitable food, but as agency staff were also on duty, there was a risk people would be offered unsuitable meals.
•At lunch time most people were offered a choice of meals, but for one person on a puree diet, staff did not offer them a choice. The cook told us one of the main options was also suitable as a soft meal, but staff had not understood or offered this to the person.
•We found there was a risk that some people may not have enough to drink because staff only asked if they wanted a cup of tea and did not offer them a choice of drinks. Some people had lost significant amounts of weight. We did not see people were offered fortified or high calorie snacks with their morning or afternoon drinks to increase their calorie intake.

•A visitor told us staff understood their friend's preference for 'finger foods' and were observant to the person's mood and energy, which affected their ability to drink safely. They told us, "Staff note their mood and thicken the drink if needed".

Ensuring consent to care and treatment in line with law and guidance.
• The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority.
• In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. The provider had made appropriate applications and had systems in place to renew and meet any recommendations of authorised applications.
•People's care plans included a mental capacity assessment. The manager had applied for the authority to deprive people of their liberty, when they lacked the capacity to consent to living at the home. Where people lacked the capacity to make other decisions, their care plans recorded which decisions staff should make in people's best interests.
•Overall staff worked within the principles of the MCA in their interactions with people. However, we saw occasions when staff did not offer people choices to support their decision making. For example, they did not always provide people with a choice of hot drinks or use visual aids to prompt people's memories to enable them to make their own decisions.

Adapting service, design, decoration to meet people's needs
•The premises were purpose built to support people's physical and emotional needs. the corridors were wide enough to use equipment safely and there were directional signs for each unit. There were large communal areas to offer people a choice of where to spend their day. A relative told us, "[Name]'s bedroom is nice. We brought in photos and things from home."

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Requires Improvement: People were not always well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; equality and diversity
•Overall people were happy with the caring nature of staff and felt they had positive interactions with them. One person told us, "The staff are very kind and caring, very respectful." Another person said, "All the staff are nice, they never shout." Relatives felt equally confident with one relative telling us, "From what I have seen they are very nice and kind." However, one person told us, "The other night two carers came to me because I wanted to go to the toilet. They didn't say a word to me."
•We saw occasions when staff were caring in their approach, but the main interaction with people was focussed on when they offered support or completed a care task.
•A visitor told us most of the staff were very caring, "Which is reflected in an air of contentment" and "[Name]'s face lights up when staff walk in with a smile, address her by name, touch her hand." However, they also told us, "Staff awareness of dementia is inconsistent. For some of the staff it would not occur to them to sit and chat, hold a hand or stroke a hand, or apply hand cream. It needs more awareness training, so it's not just about pads and tea, but to make their day better."
•Our observations indicated that staff did not always have time to take an interest in people's emotional well-being. By mid-morning in one unit, eight people were sat in the lounge, five with their eyes closed, with the television on, but the volume was too low to hear it effectively. Care staff offered people a 'cup of tea', instead of a choice of hot drinks, and we did not see those care staff engage with anyone on a personal or individual level, apart from knowing their names and whether they took sugar.
•The provider had not demonstrated a caring attitude to people. They had not ensured people received care from staff with the skills, knowledge and experience to safely meet their individual needs and know their likes, dislikes and preferences for their daily lifestyle choices.

Supporting people to express their views and be involved in making decisions about their care
•A visitor told us they attended care plan reviews for their friend, because staff respected their long-standing friendship and their knowledge of the person. However, another relative told us, "We have never been invited to care plan reviews."
•Relatives did feel informed about their family member's health and wellbeing. One commented, "I've never come and found anything I didn't know about."
•However, we found more could be done to support people to express their views on a day to day basis. For example, care staff did not always involve the person in how they were supported. We saw a member of care staff put a clothes protector on one person, without speaking or explaining what they were doing.

Respecting and promoting people's privacy, dignity and independence
•We found inconsistency in the promotion of people's dignity and personal sense of wellbeing. We saw one

person being supported to have their lunch in bed by a member of staff. The staff member sat next to the person but there was minimal interaction. They did not describe the food being offered, enquire as to the temperature of the food or ask whether the person liked what they were being given. When we returned to this person at 3.30pm, their clothing was badly stained with their main meal and pudding and there was a cold cup of tea out of their reach. Their sheets were badly stained by a previously spilt drink and as the sheet was damp and cold, it suggested the spillage had occurred earlier in the day.

• We saw a member of staff standing over a person when assisting them to eat, until a senior member of staff told them to sit in a chair beside the person.

•At lunch time we saw staff offered people hand wipes and helped some people to wipe their hands before they ate. However, a visitor told us, "I have seen the dignity charter and champion, and staff should always check people's hands are clean. A minority of staff don't do that." A relative told us they manicured their relation's hands, because care staff did not seem to notice when their nails needed cleaning or cutting.

•Some people had bedrooms with very large windows which looked out onto the street or public areas such as the car park. People could only maintain their dignity and privacy if they were in bed during the day by closing their curtains which meant they had no natural light at such times.

People's continence products were stored on the floor in people's bedrooms in full view of any visitors to the room. This did not promote people's dignity.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

Inadequate: Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
•There was little evidence of person centred activities which related to interests that were important to people in the past or that were important to them now. We found there were long periods of inactivity in the lounge areas when people were sleeping because there was little to interest them or provide activity and occupation that was meaningful to them. There were missed opportunities to engage people with daily tasks or interests and to maintain life skills. The provider's director of dementia services told us, "We really do expect staff to be doing activities in the lounges."
•Whilst the décor was appropriate, there were limited items on individual units to provide sensory stimulation and to promote engagement of people with dementia care needs. There were no objects of different shapes and textures to provide sensory stimulation. There were no items to stimulate people's interests or senses or promote spontaneous conversations. There was nothing within the environment on the individual units to link into people's past lives to avoid boredom and lethargy.
•The service had an activities co-ordinator, but they were absent on the day of our inspection visit. There was a weekly activities planner displayed in the home and in people's bedrooms. However, none of the activities on the planner took place on the day of our inspection. This meant people who were looking forward to the activities on the planner were disappointed. When one person said, "There was a film on the plan for this afternoon", a staff member replied, "It's changed now." No explanation was given as to why.
•A visitor told us, "When we were first here, they wrote down [Name's] life story, now finding out about people is less formal." A member of agency staff told us people's care plans on the hand-held devices did not give them information about people's previous lives, for example where they had worked or their family relationships. This was a lost opportunity to guide staff about how to engage people in topics of conversation that might interest them.
•Each person had a care plan that informed staff how to meet people's needs. However, we could not be assured the care people received was reflective of their own individual needs and frailties. For example, we looked at re-positioning records which indicated one person had been repositioned in three minutes. When we discussed this person's needs with a senior member of staff they told us due to the person's understanding, frailty and pain levels, it would take 10 minutes to do it properly. They added, "To position safely and correctly you have to take your time with vulnerable residents and it does take time to position correctly."

The above concerns demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

Improving care quality in response to complaints or concerns
•The provider's complaints policy and process was available in the entrance to the home.

•Most people told us they would feel happy to raise any concerns. One visitor told us, "I can approach a senior if I am unhappy with anything" and "I can make a note in the book in reception of any problems. It's a valuable line of communication. The management team are always approachable and give feedback." However, we found some relatives had escalated their concerns to external organisations because they were not confident action would be taken by the provider.
•The provider's records showed complaints they had received had been investigated and the complainant responded to in writing with any areas for improvement identified.

End of life care and support
•There were no end of life care plans in the records we looked at although people were very frail. Whilst the appropriate healthcare professionals would be involved in people's care, holistically, it might mean that people might not spend their final days as they wished to.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Inadequate: There were widespread and significant shortfalls in service leadership. The provider and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
•The provider's ineffective leadership and systems to monitor the quality and safety of the service and to act on those findings, meant people did not receive a consistently good standard of service.
•Good governance of the service had not been maintained because too often there had been inconsistency in the management team which meant there was a lack of responsibility to identify the shortfalls we found, including risks to people's safety and welfare.
•At the last inspection in January 2018 there was no registered manager in post. Part of the provider's registration is that they have a registered manager. At this inspection, there continued to be no registered manager in post. A manager had registered with us in June 2018, but had then left the service in January 2019. A new manager had been appointed, but they were not due to take up their position until mid-March 2019. The provider had appointed an interim manager to support the home, but they were new to the provider group and were on annual leave on the day of our inspection visit.
•There was a new deputy manager in post. They had previously worked as a care team manager in the home and been promoted to their new role at the beginning of January 2019. The provider had not provided the new deputy manager with the knowledge, skills and support to carry out their responsibilities effectively. For example, they did not know the threshold for referring a person to a dietician or understand how to complete an effective accident and incident analysis. After our visit, the deputy manager decided their competencies and preferences were better suited to being a care team manager and planned to step back down to that role once a new deputy manager had been recruited.
•Two care team managers (CTMs) had resigned in the weeks prior to our inspection visit and one was due to go on maternity leave. A new CTM had been appointed, but there remained two CTM vacancies which meant there was a lack of consistent leadership on every shift.
•Staff told us the constant changes in managers impacted on the quality of care people received at Cherry Tree Lodge. One staff member told us, "The problem in the home starts from the top, there is no consistency. Since I have been here there have been 12 or 13 managers. The management have never been consistent."
•There had been significant changes in senior managers within the provider group which also impacted on effective leadership. The provider's operations manager who supported our visit had only been in role since 18 February 2019 and was new to the provider group.
•Some staff expressed lack of confidence in the provider to support the home and demonstrate good leadership. One staff member said, "This is what Runwood do. A day like today, all hands are on deck. We see people that we haven't seen for months and then they go again. There was no support for [name of previous registered manager] and it will continue." Another staff member told us, "The trust in the

management is not there. The position of trust has been broken." During our inspection we saw activities being supported by an activities co-ordinator from one of the provider's other homes. They confirmed they had not been due to work at Cherry Tree Lodge that day.
•Staff told us high levels of staff sickness and absence meant they often worked short staffed or had to work extra hours to make sure shifts were covered. Some staff told us they were working double their contracted hours which impacted on their personal wellbeing.
•The provider had not considered the risks of staff working overly long hours, such as, staff's energy to sustain good practice throughout long shifts and the requirements of the European Working Time Directive.
•Several staff worked in different roles on different days, which was not conducive to effective oversight of staff's practice.
•Improvements were required in the oversight and management of staff's practice to ensure people received a quality service. A senior member of the provider's management team, who happened to be on site that day, had to intervene on several occasions at lunch time, because care staff were not well-practised at supporting people with dementia.
•There was a 'blame' culture within the home. One staff member was being 'performance managed' after only four weeks in their role. The provider had failed to identify this staff member was not performing effectively because they had not received a proper induction or training plan. The provider's operations manager confirmed this staff member should have had a 'support plan' rather than a 'performance management plan' and assured us this would be immediately implemented.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility
•Governance and oversight systems had failed to ensure the provider was mitigating risks to people in relation to their care. The provider had not ensured there were appropriate systems in place to check the daily records made by staff to ensure people received the care and treatment they needed.
•Managers and senior staff had not taken responsibility to analyse information available to them, to ensure people received person-centred care that met their individual needs. For example, records we looked at indicated the care people received did not always take into account their individual frailty, pain levels and understanding of the task to be undertaken.
•Although the provider had a number of quality assurance processes in place at the service, these had not been effective in identifying the number of significant shortfalls in safety and quality. For example, we were given a copy of the document to be handed to the emergency services if the home needed to be evacuated in an emergency. This document contained the name of each person in the home, together with the unit they were on. However, it gave no information where each unit was in the home. The operations manager acknowledged the risks presented by not having this information and said they would address it immediately.
•The provider had not ensured staff had the necessary equipment to manage risk and carry out their role effectively. Care staff accessed some care records via hand held devices. On the first day of the inspection, six devices were broken which meant not all staff had access to a handheld device. We asked the area operations director what contingencies were in place should there be any disruption in the electronic system or access problems. They told us there was currently no system in place, but assured us they would be addressing this.
•There was no hard copy of each person's summary of care or risks should there be access issues to the electronic system or if a person needed to be transferred to acute care. This meant other healthcare professionals might not have the most up to date information to inform decision making.
•Not all residents were on the electronic system. There was no way of identifying who was and who was not on the system which made it difficult to access information in a timely manner.
•Senior staff responsible for producing care plans on the electronic system had not received appropriate training. The only member of staff who had received the training was the deputy manager. When we asked

the interim manager why the provider had implemented an electronic care planning system staff did not have the skills to use, they responded, "That is a very good question."
•There was a lack of communication in the home which had potential to impact on managing people's individual risks. The agency staff we spoke with believed everyone's care plans were on the electronic hand-held devices. This belief gave agency staff confidence in supporting people safely, without needing to ask permanent staff for guidance. An agency member of staff told us, "We can work independently with people because of the handheld. There is no need to ask staff." However, only 60% of people's care plans had been transferred to the electronic system and some were still in paper format in the care office. This gave agency staff a false sense of confidence in knowing how to support people safely.
•We could not be sure the provider's policies were reflective of changes in practice. For example, the dependency tool used to inform staffing levels should have been reviewed in January 2018.
•Improvements were required in promoting person-centred care. Care staff had not queried why there was no choice of main meals at lunchtime for those on a soft diet, which showed they accepted it was normal practice not to offer a choice of soft meals.

Continuous learning and improving care; Working in partnership with others
•Where quality assurance processes had identified shortfalls in safety and quality, action had not always been taken to address them. For example, the provider had employed an independent quality assessor to review the service in December 2018. The independent assessor had identified there were gaps in repositioning charts, there was no formal analysis of falls for any trends and patterns, topical cream records were inconsistent and the privacy of bedroom windows that overlooked public places needed to be reviewed. Action had not been taken in response to this report and we found the same concerns during our inspection visit.
•During a quality assurance visit by the local commissioners in September 2018 it had been identified that people on 'fork-mashable' and puree diets did not have a choice of menu and continence products were stored on the floor in people's bedrooms which was neither dignified or followed good infection control practice. We found the same concerns during this visit some five months later.
•Due to the level of concerns identified on the first day of our inspection visit, we returned on the 28 February 2019 to ensure appropriate action had been taken to improve risk management following our feedback to members of the provider's management team. We found it had not. They deputy manager told us they had only reviewed four people's risks assessments. We could therefore not be sure that the risks to the health and wellbeing of the other 48 people in the home were correctly assessed, identified and mitigated against.

The above concerns demonstrated a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Good governance.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•A visitor told us, "The (previous) manager was very good at engaging and listening to us and responding and taking action. Now we have another manager, another deputy. Change impacts the staff, people and relatives."
•Staff told us morale was low because they could not offer the level of care they wanted to. One staff member told us they had not had a supervision meeting with their manager for a while and said, "The stress is unbelievable."

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 The provider had not ensured each person received appropriate person-centred care that was based on an assessment of their individual needs and preferences.