R G Care Ltd

Cherry Tree

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Cherry Tree is a residential care home providing accommodation personal care for up to seven people living with diagnosis including mental, physical health and learning disability needs. At the time of this inspection seven people were living at the service. People living in the home have their own bedrooms and there are shared communal spaces, including lounges, a kitchen and a garden area. The building is one floor.

People's experience of using this service and what we found
The systems in place to audit the quality of the service were not robust or sufficient to alert the provider of the concerns and issues within the service. Audits had not picked up areas which were identified during the inspection. People were at risk because the provider had not acted to ensure they had sufficient oversight of the service. Records were an area of concern across the service; records were not complete and accurate.

Risks associated with people accessing transportation, walking around the home with their bare feet and allergic reaction of eating had not been robustly assessed and action had not been taken to reduce risks to keep people safe.

Medicines were not managed safely. Policies and processes for managing medicines were not always followed. Controlled drugs (CD) prescribed for people were not being recorded in the medicines administration records (MARs). People did not always get their medicines as prescribed. We did not see any evidence that people who administers medicines had undergone appropriate training and competency assessment were not routinely carried out.

People's care plans contained conflicting and confusing information about their mental capacity. It was not always clear when a person lacked capacity and when a best interest's decision had been made, who had been involved in the decision making process.

Maintenance tasks had not always taken place in a timely manner, which could put people at risk of harm. We observed the garden was not being maintained as there was overgrown stinging nettles and weeds which could potentially be a hazard for people. After the inspection, the provider sent a photo of the garden being maintained.

There was a lack of provider and managerial oversight of the service. There was a failure by the provider to ensure robust governance arrangements were in place to monitor the safety and quality of the service.

Shortfalls across the service such as poor risk management, lack of oversight of medicines and limited oversight of people mental capacity had not been identified prior to our inspection.

Confidentiality of people's personal information was maintained. Staff were aware of their roles and responsibilities and felt supported by the management team. Staff followed infection control procedures and people were protected from the risk of infections such as COVID-19. Staff were safely recruited. People and relatives told us staff were caring and they were treated with respect.

Right Support
The service did not always support people to have the maximum possible choice, control and independence over their own lives. Due to lack of staffing and more recently, a lack of experienced staff, the person's choices, control and independence were not maximised. They were regularly unable to take part in activities. Staff shortages had impacted on the ability of people to access activities of their choice. One staff told us, "We can't take them [people] out as we don't have enough staff." Records confirmed people did not always receive support from staff to pursue their interests due to availability of staff.

Right Care
Staff failed to protect and respect people's privacy and dignity. During our inspection we saw people were not always treated in a dignified manner by staff. Staff had training on choking, however, we could not be assured this was effective. People were at risk of not receiving their medicines when needed and recording systems were not always in place or guidance for as required medicines. Staff did not always have the relevant skills or experience to ensure they received the appropriate care.

People who had individual ways of communicating, using body language, sounds, Makaton (a form of sign language), PECS (The Picture Exchange Communication System) pictures and symbols could not interact comfortably with staff and others involved in their care and support because not all staff had the necessary skills to understand them. One staff told us, "We need training in Makaton and PECs so we could communicate with them [people]."

Right culture
People failed to receive good quality care, support and treatment because staff could not always meet their needs and wishes. Staffing levels were reported to be consistently below the number required to meet people's needs and to keep people safe. The provider had not established, or implemented, appropriate staffing levels that either ensured people were safe, or that they received the care they needed. The providers monitoring and oversight processes was not effective and had not identified the substantial shortfalls being identified

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
This service was registered with us on 05 March 2021 and this is the first inspection. The last rating for this service under the previous provider, Care Management Group Limited was Good.

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support right care right culture.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the

service can respond to COVID-19 and other infection outbreaks effectively.

This service had not previously been inspected and we wanted to check that people were receiving safe care and support.

Enforcement
We have identified breaches in relations to safe care and treatment, good governance, staffing, need for consent, person-centred care, privacy and dignity, meeting nutritional and hydration needs, and, premises and maintenance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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 effective. Details are in our effective findings below.	**Inadequate**
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 not 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

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by one inspector, a medicines inspector, a specialist advisor in learning disabilities and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Cherry Tree 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.

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there the service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced

Inspection activity started on 05 May 2022 and ended on 09 May 2022. We visited the location's service on 05 and 06 May 2022.

What we did before inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We sought feedback from the local authority who work with the service. We reviewed the information we already held about the service. This included their registration report and notifications. A notification is information about important events, which the provider is required to tell us about by law. We used all of this information to plan our inspection.

During the inspection
We reviewed a range of records. This included four people's care records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed. We reviewed multiple medicine administration records. We spoke with seven members of staff including area manager, company director, deputy manager, two agency staff and two support workers. We also spoke with one relative.

We used the Short Observational Framework for Inspection (SOFI) to spend time observing people. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at care records, minutes of meetings, staff training records and quality assurance records. We spoke with a professional who regularly visits the service.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• Robust risk assessments were not in place to ensure people received safe care.
• People were not being appropriately protected against risks and action had not been taken to prevent the potential for harm. Risks to people had been identified and a risk assessment put in place however, we saw there was not always sufficient guidance in place to manage risks.
• For example, we saw two people walking around the house with no footwear. We asked the provider to show us risk assessment for these two people. There was no risk assessment or guidance in place. This lack of staff guidance put people at high risk of harm from poor quality care. During our observation in the kitchen, staff came in with the resident with no footwear telling another staff to look after the resident while they were helping another resident. This meant this person was at risk of a potential for a very serious incident.
• Another resident care plan mentioned a person likes to touch plug sockets and switches every morning and likes to go to the garden and touch plants and fences. Again, there was no risk assessment or guidance in place. This lack of staff guidance put people at high risk of harm from poor quality care.
• Another person care plan mentioned the resident was allergic to strawberry. There was no risk assessment or guidance in place. This lack of staff guidance put people at high risk of harm from poor quality care.
• Most of the resident care plans mentioned to do activities outside from the home they would need staff to drive them by using the company vehicle. However, there was no risk assessment or guidance in place.
• Some people in the home could display behaviour that could challenge. This included verbal, non-verbal or physical behaviour towards staff or other people. However, risk assessments did not guide staff on how to deescalate the behaviour or situation and encourage more positive behaviour. One person's risk assessment only stated, "Staff should always try to calm [person] down when they are agitated and not willing to listen to any staff." There was no further guidance on how they would do this. Another person's risk assessment did not contain any information on actions staff should take. The management team told us Positive Behaviour Support (PBS) were in place to observe people's behaviour but these were not in the care plans we viewed. This could put staff and other people at risk of harm as staff did not have sufficient information on how to support people whose behaviour could challenge.
• During the inspection, we noted two people at times behaved in a way that could challenge staff and the service. There was basic information on risk assessments that included potential behaviour triggers, the risk assessments lacked detail on de-escalation techniques staff may use to support the person.
• The provider did not always manage the safety of the living environment and equipment. Staff told us people enjoyed spending time in the garden. Environment checks had failed to identify the need to remove waste from the garden. The garden was also overgrowing with stinging nettle, and drainage was covered with overgrown weed which means people were at risk of trips and falls. We spoke to the deputy manager who arranged for this to be removed immediately.

• We saw lesson learnt log for the past incident. The provider had systems to ensure lessons were learnt from any incidents. Where incidents and accidents occurred, they were recorded with appropriate actions taken to reduce the risk of re-occurrence. However, we did not see any evidence if this was shared with staff, or, what actions taken to mitigate future risks. For example, there was no clear guidance for staff about immediate actions they should take in response to distressed reactions from people. This meant there was no learning from incidents, or analysis to identify themes and trends and actions taken to prevent reoccurrence.
• These failures evidence a lack of learning from events or action taken to improve safety, placing people at risk of harm.

The failure to assess, record and mitigate risks to people's health and safety was a breach of regulation. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment)

• Checks were carried on the premises. These included checks related to fire safety, gas and electrical installations. Please refer to the Effective section of this report for more details.
• Staff had completed Personal Emergency Evacuation Plans (PEEPs) for people which included consideration of specific risks. The deputy manager spoke of their plans should they need to evacuate people in the event of an emergency. People's records included clear instruction on how to use evacuation equipment. This provided assurance risks to people from fire were being assessed and managed effectively.

Staffing and recruitment
• The service did not have enough staff to meet peoples assessed needs. Five people had been assessed for one to one support during the day, two people required two staff members to provide personal care and support during the day.
• We observed one person who the provider had assessed as requiring two staff members to support during the day. However, only one staff was at present supporting the person for the whole day. We also observed this staff was being rushed and hurried in order to support this resident. This meant this person was at risk of a potential for a very serious incident.
• Staff consistently told us there was not enough staff, one said, "Yes, we do need more staff and some of the residents do require two people to support them [people]." Another staff told us, "It can be challenging to support them [people] in the morning." One relative also shared their concerns, "Every time I come here, I always see new staff."
• The deputy manager told us how shortages in staffing and recruitment challenges had impacted on their ability to ensure people had opportunities to take part in activities. "We have a shortage of staff and has impacted on our ability to provide new activities to them [people]."
• We also looked at four-week staff rota. The staff rota confirmed on average each day there were six agency staff being deployed at Cherry Tree. Agency staff also confirmed they work at least three days a week. This resulted in people not being supported or able to take part in activities and visits how and when they wanted. This meant people were not receiving the support they required to ensure they remained safe and well cared for.

The provider had not ensured that sufficient numbers of suitable, experienced staff were deployed to meet people's assessed needs. There was not a systematic approach to determine the number of staff needed and to meet the needs of people using the service and keep them safe at all times. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Recruitment practices were robust. The provider completed checks on prospective employees to ensure

they were safe to work with people. These checks included seeking references, checking staff criminal record and checking their identity.

Using medicines safely
• Medicines were not managed safely. We reviewed medicine administration records (MARs) and saw a number of gaps with no explanations why. Staff told us that sometimes fluctuation of internet signals prevented syncing of records. However, the home had a process that needed to be followed when this occurred, but this was not being followed.
• We saw that PRN protocols were in place, to support staff to administer when required medicines. However, we noted that communication tools were not readily available to assist staff in communicating and understanding residents. We were told that one of the residents is fluent in Makaton but none of the staff had any training as yet.
• Controlled Drugs (CD) storage facilities were available, however, CDs were not managed safely. In the most recent CD book, we found schedule two CD drugs missing one tablet of Medikinet (methylphenidate hydrochloride) 20mg and 1 capsule of Medikinet 40mg. Two tablets of Schedule four CD Lorazepam 1mg.
• We went on to check the previous book and also found a number of discrepancies. Whole pages of CD were used up and records made as administered to residents without documentation of the medicines name, strength and form entered in the CDs record book.
• When topical medicines were administered, we did not see evidence that body maps were used to show where they needed to be applied.
• Medicines were stored a clinical room. We did not see any recording of how unwanted medicines were disposed of in appropriate waste medicine bins.
• Care plans did not have appropriate medicines risks information. We saw that hospital passports (A hospital passport is a document about you and your health needs. It also has other useful information, such as your interests, likes, dislikes, how you communicate and any reasonable adjustments that you might need.) were not readily available and when we asked, staff could not find them. We were then told that they were being reviewed and in the computer system, therefore if any of these residents were to go into hospital in an emergency, staff would not have been able to take their hospital passport with them.
• We did not see evidence that staff ensured accurate, up-to-date information about people's medicines was available when people moved between care settings. Staff told us that they were in the process of updating residents grab bags (to be used in an emergency), this would include hospital passports which they were also updating.

We found no evidence that people had been harmed. However, medicines were not always managed in a safe way. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• We were not assured that the provider was preventing visitors from catching and spreading infections. The provider's policy for visitors, such as relatives and professionals, included a check of their temperature but inspectors' temperatures were not checked upon entry to the building. One relative visited a person who lived in Cherry Tree also said no temperature was recorded, or, staff did not provide hand sanitizer upon entry to the building. We discussed this with the management team who told us they would ensure the policy was followed correctly in future.
• Staff used personal protective equipment (PPE) such as disposable gloves, masks and aprons when providing personal care to people. Staff told us they washed their hands thoroughly before and after providing personal care to help contain the spread of infection.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was using PPE effectively and safely.
• We were assured that the provider was accessing testing for people using the service and staff.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured that the provider's infection prevention and control policy was up to date.
• We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
Systems and processes to safeguard people from the risk of abuse;

• We received concerns from the local authority prior to our inspection that systems and processes for safeguarding people from the risk of abuse were not in place. Records showed safeguarding concerns were raised with the local authority, but they were not always sent promptly. After one incident, a safeguarding alert was not sent until two days later.
• The provider had since addressed these concerns and had reviewed their procedures to ensure reports were sent immediately and without delay. There was an available safeguarding policy. Staff had also received recent safeguarding training, which including identifying and reporting if people were at risk of abuse.
• One member of staff told us, "I will report any abuse to the manager." Another member of staff told us of the actions they would take if they felt somebody was being abused. Staff were also aware of the whistleblowing procedures. A whistle blower is a person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organisation.

Visiting in care homes
• The provider was facilitating visits for people living in the home in accordance with the latest government guidance.

Inadequate

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were not always assessed in line with guidance.
• CQC would expect providers of services for people with a learning disability and on the autistic people to demonstrate how they are complying with the principles of right support, right care, right culture guidance.
• People did not receive care and support which complied with recognised models of care. The British Institute of Learning Disabilities (BILD) described how the positive behaviour support (PBS) approach promotes people's quality of life. PBS is about working in partnership with people. Treating them with dignity and respect and enabling them to have a better life. All behaviours have a meaning… Positive behavioural support is an approach that puts the person at the centre to make systems work for the person. (Bild definition of PBS). Observations of staff evidenced significant shortfalls in the quality of support people received.
• We reviewed one person's care plan, during mealtime this person needed encouraging after every bite, otherwise this person will not swallow and could be at risk of choking. During our lunch observation we noticed staff was not engaging with this person, as staff was busy looking at their mobile phone. Staff failed to provide support in line with their assessed needs.
• Records did not provide relevant information for staff. For example, risk assessments had not offered guidance to support a person when they experienced distress. Staff were observed offering support in a respectful manner. However, the lack of guidance increased the risk of people not receiving consistent support when they were experiencing distress. Staff told us they did not have any formal method to record what led up to episodes of distress, what was happening for the person or what supported them to manage this. One staff told us, "We don't have this information in front of us". Another staff described how they managed when a person displayed self-injurious behaviours, "Not sure why [person] does it I try to stop it by interacting with them". The provider failed to ensure they had an effective system to support people to manage emotional distress. Consideration had not been given to the function behaviours that may challenge others or self-injury may have for people and not sought or carried out functional behavioural assessments.
• There were sections to record if people were subject to a Deprivation of Liberty Safeguard (DoLS) or had a legally authorised representative, but people's capacity to make decisions was not detailed in their assessments.
• People's hospital passports were incomplete and did not have relevant information in place in case of emergency. This meant people were at risk of receiving care from staff who did not fully understand their health conditions or preferences in how care was delivered.

The provider did not always carry out appropriate assessments to ensure the service could meet people's

needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• The service did not have an effective system to check staff's competency to ensure they understood and applied training and best practice. We observed examples of poor staff practice, some staff could not always provide assurance they could effectively communicate with people. This increased the potential risks of not understanding their roles and responsibilities effectively.
• Not all staff had received training for people's communication needs. For example, several people's support plans included reference to Makaton, a communication aid used by some people in the service. Care plans did not include information about signs and gestures people used to express themselves or any guidance for staff in how to support people with this.
• At the time of this inspection the service did not have enough levels of trained and competent staff to meet people's needs.
• We looked at two people's care plans who were at risk of choking. We asked two agency staff the procedure for preventing someone from choking. One agency staff was not able tell or demonstrate the prevention of choking, another agency staff confirmed they did not receive any training around choking.
• The skills of staff did not always match the needs of people using the service. Observations of staff did not provide assurance of their knowledge and skills supporting people with their communication needs. Records relating to communication identified some people using Makaton, a form of communication which, 'Uses symbols, signs and speech to enable people to communicate.' We observed people communicating with Makaton, however, we did not see staff responding. One staff member said, "We never had training on how to communicate in Makaton".
• Staff did not receive support from the provider. The provider had a supervision policy, however, the provider told us they had no formal guidance on timeframes for when staff should receive supervision and appraisal of their work.
• Records showed four staff only completed one supervision within a year. Records showed two staff working for more than 12 months did not have appraisals to support their development and they did not receive regular supervision to enable them to carry out their duties. There were no formal competency checks in place to ensure staff were competent in all aspects of their role.
• Support workers told us that they were subject to spot checks but were not able to recall when they had their last individual supervision meetings.
• The above issues meant that we could not be assured that staff received the appropriate support and supervision from the provider to enable them to carry out the duties they were employed to perform

The provider did not ensure that staff received the appropriate training, support, supervision and appraisal as necessary to enable them to carry out their duties. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff told us they felt supported by the provider and management team. One member of staff told us, "I can go to anyone [in management team] and ask for support." Another member of staff stated, "I feel supported by [provider and deputy manager]."
• Following the inspection, the provider told us a new training provider will be onsite for the next six months to provide face to face and practical training for all staff. This includes Makaton, PECs, epilepsy and choking training.
• Training records for new staff showed that they received induction training when they first started with the service. New staff were able to complete online training, these included, basic life support, moving and handling, safeguarding, health and safety, falls prevention, and, food hygiene.

Adapting service, design, decoration to meet people's needs
• Some doors around the service had signs but weren't very clear as the image is too small to see. Food menu and activities timetable were displayed in a small written text, despite some people living there who can't read.
• People room doors were not personalised. During our inspection we did not know which room do residents resided in as there were plain white doors. We also found one resident's cupboard was left outside the communal area and was not locked.
• The garden was not well maintained. The garden was overgrowing with stinging nettles, and drainage was covered with overgrown weeds which means people were at risk of trips and falls. We spoke to the deputy manager who arranged for this to be removed immediately.

The failure to ensure the premises is suitable for the purpose it is being used is a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• People knew their way around the service and were seen actively finding their way to lounges, dining rooms and their bedrooms as well as outside of the building. Corridors and rooms were spacious.
• After the inspection, the provider sent a photo of the garden being maintained.

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 when this is in their best interests and legally authorised under the MCA. 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• The provider were not working to the principles of the MCA 2005. People's care plans contained conflicting and confusing information about their mental capacity. Where it was deemed that action should be taken in their best interest, there was no evidence to support that the decision had been made in line with MCA 2005 Code of Practice and that the persons' rights had been properly considered.
• One of the resident care plans said they had capacity around bowel movements and management of continence. The care plan detailed all the support they needed in this area and that they have PICA (PICA is a feeding disorder in which someone eats non-food substances that have no nutritional value, such as paper, soap, paint, chalk, or ice) and is at risk of eating their incontinence pads and faeces. This would throw some doubt onto their capacity. The provider did not completed an MCA assessment, and, a best interest decision made around the type of care they require was also not completed. This meant people were at risk of receiving care from staff who did not fully understand their health conditions.
• Where people had a DoLS authorisation, this was not clear in their care plans. This meant staff may not have the information they needed to understand people's legal status and make sure their rights were upheld.
• Where decisions were made in their best interest by professionals or the person's representatives, such as relatives, there were no records of this for all the care plans we looked at. There was no evidence the care

plans had been agreed and signed by either the person or their representatives.
• We also asked the provider to show record of DoLs authorisations and applications. Unfortunately, there was no record of DOLs applications, we only saw a spreadsheet of when the application was submitted.

The failure to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005 is a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
• There was a lack of information in a person's care plans about their nutritional needs, preferences and support needed to maintain a balanced diet. Care plans did not record people's preferences on food and drink.
• We saw food menus being displayed around the house. However, this was not being followed. During our inspection the menu showed chicken wrap for people, instead they were served with tuna pasta. We asked staff if people were consulted on the change of menu. Staff confirmed they did not consult with anyone at Cherry Tree. Staff told us they did not have a dedicated staff member to work in the kitchen and prepare meals, so this responsibility was shared amongst the staff, including the team leader.
• We observed the lunchtime service. We noted staff used different plates and cutlery for each resident at Cherry Tree. The lunchtime services staff paid little attention to people to check if they were satisfied with their meal and if they wanted anything else. Condiments such as salt and pepper were not on the tables. After the meal, staff did not provide any wipes or tissue for resident to clean their hands or mouth.
• Staff were aware of people's specific dietary needs to manage their medical conditions, allergies, cultural and religious needs and if people required a soft or pureed diet. However, important information about people's dietary needs, allergies and tolerances were not available for view in the kitchen. This could be a risk should a person be served the wrong type of food by a new member of staff or an agency staff.

We found no evidence that people had been harmed. However, records showed that people might not have been provided with suitable food and drink. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support
• Interaction with health care professionals was recorded in care plans to assist staff to support people appropriately. Healthcare professionals, such as GPs, neurology and dieticians were all engaged in supporting people to have their health needs met by the service.
• People attended appointments to receive treatment or check-ups. Relatives told us they were contacted by staff if people were not well or there were changes to their health.

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.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

• People were not always treated with dignity. We saw a staff member asking a resident to sit on the floor which apparently the person likes to do anyway, but in this context, it did not appear appropriate and was being used as a way off managing risk.
• Some staff did not engage or smile at people whilst serving meals. A person who was sat alone in their bedroom was provided with assistance to eat their lunch. However, the staff member supporting them failed to engage in conversation with them.
• Another staff member took a person's unfinished meal and tray away without encouraging them to finish their meal or acknowledge them. After the meal we did not see staff offering tissue to wipe their hands or mouth.
• A staff member in passing saw a resident banging on the radiator. We observed the staff speaking very sternly to a person telling them off because they were banging on a radiator. The way the staff communicated with the person was not respectful.
• We also observed an instance of no engagement or interaction between staff and people. For example, we saw two staff sitting around the dining table, another two staff sitting in the corner of the lounge and chatting away. One person was watching TV and two people were sitting on a sofa and looking out the window. These practices did not ensure people were cared for and supported.
• Care plans did not always contain information relevant to the person and were not individualised to reflect people's needs. A positive person-centred culture was not promoted which took account of people' views and preferences and promoted good outcomes for them. Staff told us they understood people. A staff member said, "We take our time to understand residents and their needs. We observe what they like to do and eat."
• Care plans did not always show involvement from people and their families. There was limited information to show people were involved in making decisions about their care.
• The provider failed to seek and act on feedback from all people and their families for the purposes of improving care. During our inspection, the provider confirmed they did not ask families or relatives for their feedback.
• Support and risk plans did not include details of the extent of how people might communicate in ways that staff could find challenging and tended to underplay the significance of it. The provider recorded strategies to support people with their needs. However, it was not recorded on the electronic care plan system. This

meant staff may not have had access to the information and therefore may not have been able to respond appropriately.

The provider failed to ensure people were treated with dignity and respect. Staff failed to ensure people's privacy was maintained. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We discussed these observation with the area manager who told us they would remind staff of their responsibilities to ensure they treated people with respect and promoted their dignity.

• Staff ensured people's confidentiality was maintained. Personal information was stored securely and only accessed by authorised staff. Information was protected in line with General Data Protection Regulations (GDPR).
• We observed people being supported to bathrooms and ensuring doors were closed before people used them. Similarly, room doors were knocked upon before staff entered. One member of staff said, "I would always protect their dignity by making sure curtains were closed and door was closed. I encourage them to be independent and do as much as they could manage."
• Staff were trained in understanding equality, diversity and inclusion. Staff were aware of how to not discriminate people. Staff told us they respected people's beliefs and protected characteristics, such as their disabilities. A staff member said, "We have known them [people] for a long time. I treat everyone equally and do not discriminate because we are here to care for them."
• People's religious beliefs or practices were recorded in their care plans. Staff told us they supported people to practice their religion and fulfil their cultural needs.

Inadequate

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• Care plans were in place for people. However, we found they were not always personalised to include people's preferences in key areas such as communication, mental capacity, meal preferences and activities.
• Care records did not always capture all the needs people had or all the actions staff had to take to meet people's needs. This meant that staff reading the care records did not have the guidance or instructions to provide people with person-centred care. Furthermore, not all care staff were knowledgeable about the information contained in people's care plans.
• We noted where people had behaviours that could challenge the service, they did not have individualised care plans to reflect their individual needs and circumstances and the action to take to care and support them accordingly.
• The provider acknowledged the need to introduce more systems to assist people to have more choice and control of their life and to express their preferences.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• Staff did not ensure people had access to information in formats they could understand.
• Staff told us two people used Makaton, this is a form of sign language. Another person used PECS, this allows people with little or no communication abilities to communicate using pictures. Staff confirmed they did not received training in communications. This meant staff may not be able to communicate with the person effectively. The provider told us pictorial cards were used to assist with communication with this person.
• Agency staff had not been given sufficient opportunity to learn about the person's communication needs before supporting them. A staff member explained, "There are some fairly complex sounds that mean specific things. We have had new staff did not understand, you need experienced staff there to explain. If a staff member misinterpreted [the person], there is a lot of frustration for them. It is important that you understand them and what they are asking of you." The failure of staff to understand this person's communication sooner had resulted in an increased risk of self-injurious behaviour.
• People did not received information in a format they could understand. For example, activities timetable and food menu were being displayed in a written format, there was no posters or signage being displayed.

Door signage was not clear and visible for people to understand. This meant the systems were not in place to ensure everyone had the opportunity to have a say about their care preferences due to the lack of communication systems in place. Easy read care plans were not available for people.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People had limited opportunity to try new experiences or develop new skills to promote their independence. Care plans did not have information about their preferences of activities.
• There was little in the way of activities in the home at the time of our inspection. We observed people sitting down while the television was on for most of the day.
• The deputy manager told us they wanted to improve the programme of activities and was working on developing them. They told us they would be asking people the things they liked to do.
• There was a day centre next to the home, where people able to participate in a structured group activity. We saw residents of Cherry Tree participated in a swimming session.

We found no evidence that people had been harmed. However, we found arrangements were not in place to ensure that people received care that was person-centred. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
• Systems were in place to manage complaints in a timely manner. There was a complaints policy and relatives told us the staff and deputy manager had been responsive to any concerns they raised.
• At the time of inspection, no complaints had been received by the service. The deputy manager told us complaints would be dealt with appropriately by the management team and they would take action to investigate them should they arise.

End of life care and support
• At the time of the inspection no one was receiving end of life care. We did not see any evidence this had been discussed with people.

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.

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

• The systems in place to audit the quality of the service were not robust or sufficient to alert the provider of concerns and issues within the service. Audits had not picked up significant shortfalls in practices in relation to risk assessment, medicines management, staff deployment, meeting people's health needs, training, capacity and consent, dignity and respect, care planning, recording and people's feedback.
• People were at risk because the provider had not acted to ensure they had enough oversight of the service. There had been a lack of provider and management oversight at the service which had caused issues with safe staffing levels, monitoring of practice and day to day management. We discussed this with the provider. During the inspection the provider was interviewing a candidate for a new registered manager.
• We identified medicine administration auditing was not effective and records of what had been audited were not routinely kept by the service. We found missing signatures on MAR records. This showed the provider had not adequately assessed, monitored and improved the quality and safety of the service provided. Staff responsible for carrying out audits on care records and MAR records were not trained to do effective audits.
• The provider did not have oversight of audits, such as care plans and risk assessments. This meant robust processes were not in place to monitor the quality of the service, risks to people's safety and maintain complete and up to date records in respect of the decisions taken about each person's care and treatment.
• The provider was not clear on how to monitor or understand quality performance at the service. For example, they had not recognised concerns we identified in relation to poor care plans including risk assessments, there was a failure to ensure staff received a thorough supervision and an annual appraisal meeting.
• During our inspection, the provider confirmed they accepted that their quality assurance systems had not operated as well as they should. The local authority had visited the service shortly before our inspection and found areas of concern.
• Systems were not in place to engage with people and relevant others in the running of the service. The provider acknowledges there was no direct communication with peoples, but told us they were training their staff in Makaton and PECS.

The above evidence shows that the provider did not have effective systems to assess, monitor and improve the quality and safety of the service This was a breach of Regulation 17 (Good governance) of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Most staff we spoke with spoke positively about the provider. One member of staff said of their Area Manager, "They are amazing. They are working hard to improve this service." Another staff said, "There are challenges here, we want to work with them and make the service better."
• We also received feedback from some relatives that communication from Cherry Tree was relatively good. Relatives received information from Cherry Tree if the person was attending any health appointments and or if there were any changes to their health.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

• The provider was open and honest about when things went wrong. There were systems in place for dealing with complaints, and accidents and incidents were recorded and reviewed on an individual basis.
• The provider was aware of when the CQC should be made aware of events and the responsibilities of being a registered manager. They have reported events and accidents and incidents to CQC when these had occurred and as required by law.
• During our inspection we provided feedback to provider about issues of concern we found. The provider accepted that some things had gone wrong. Over the course of the inspection the provider took positive action to make improvements. For example, developing an action plan on how to improve Cherry Tree.

Working in partnership with others
• The management team had a good working relationship with other health and social care professionals. Records showed people had been referred to other health services such as GPs when needed. This helped to ensure people's changing needs were being met.
• The provider told us they signed up to other external support agencies to enable them to effectively manage the service. They now have a trainer at Cherry Tree who will provide face to face to staff for the next six months. Training includes Positive Behaviour Support (PBS), choking, care planning and risk assessment, and, communication.

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 Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure service users received person-centred care that met their needs and reflected their preferences. Regulation (1) (2) (3) (b) (c) (d)(e) (f) (g) (i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider was not ensuring service users' privacy and dignity was always being respected. Regulation 10 (1) (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure service users consented to the decisions made about their care and treatment.

Regulation 11(1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not ensure service users should be encouraged to eat and drink independently. They should receive appropriate support, which may include encouragement as well as physical support, when they need it. Regulation 14 (4) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider did not ensure service users' needs must be taken into account when premises are designed, built, maintained, renovated or adapted. Their views should also be taken into account when possible. Regulation 15 (1) (c)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed provide care and treatment in a safe way Regulation 12 (1) (2) (a) (b) (c) (f) (g)

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good Governance The provider had failed to operate effective systems and processes to make sure they assess and monitor their service. Regulation 17 (1) (2) (a) (b) (c) (e) (f)

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that sufficient numbers of suitable, experienced staff were deployed to meet people's assessed needs. There was not a systematic approach to determine the number of staff needed and to meet the needs of people using the service and keep them safe at all

times. This placed people at risk of harm. The provider failed to ensure staff received appropriate training and support to enable them to meet people's needs

Regulation 18 (1) (2) (a)

The enforcement action we took:

We issued a warning notice