Care First Class (UK) Limited

Cherry Lodge

Inspection report

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22 August 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 15, 17 and 22 August 2017 and was unannounced on the first and second days but the manager knew we would be returning on the 22 August. At the last inspection on 30 and 31 August 2016, we found that the provider required improvement in four of the five domains we looked at, but was meeting the legal requirements of the Regulations we inspected.

Cherry Lodge is a residential care home providing accommodation and residential care for up to 46 people, some of which were living with dementia. The home also provides short stay interim beds (EAB) for people discharged from hospital, who may require further assessment of their care and support needs before returning to their own home. At the time of our inspection 45 people were living at the home.

It is a legal requirement that the home has a registered manager in post. There was no registered manager in post. 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 started at the home in July 2017 and gave us their assurances; they would submit an application to become the registered manager. At the time of writing this report, no application has yet been received from the new manager, should an application not be received, we will consider our regulatory response.

At our previous inspection in August 2016, we found that for the questions is the service safe, effective, responsive and well-led, improvement was required. At this recent inspection, although we found there had been some improvement, overall the service still required improvement.

Systems in place to monitor and improve the quality of the service were ineffective in ensuring people received a good and continually improving quality of service. The audits had not identified the issues we found and had not always been consistently applied to ensure where shortfalls had been identified, they were investigated thoroughly and appropriate action plans put into place to reduce risk of reoccurrences.

The provider's recruitment processes were not consistently robust and did not always ensure the necessary security checks were completed to make sure persons employed by the provider were safe and appropriate to provide care and support to people living at the home.

Where people lacked the mental capacity to make informed decisions about their care, relatives, friends and relevant professionals were involved in best interest's decision making. However, mental capacity assessments and best interest decisions were not always applied consistently to clearly show what decisions people were being supported or asked to make in relation to their care. Applications had been submitted to deprive people of their liberty, in their best interests; therefore, the provider had acted in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People and relatives had not received satisfaction questionnaires to comment on the quality of the service being delivered. However, the management team had started to put in place systems to gain feedback from people living at the home, relatives and visitors. People, their relatives and staff told us the management of the home had improved, was organised and 'well-led.'

Staff were trained to identify signs of abuse and supported by the provider's processes to keep people safe. However, staff did not always follow the provider's own safeguarding procedures when unexplained bruising or marks were noted on people's bodies. Potential risks to people had been identified and appropriate measures had been put in place to reduce the risk of harm, although the information contained within some risk assessments was not always effectively communicated to staff. People were supported by sufficient numbers of staff. People were supported to receive their medicines as prescribed. Although protocols to support staff on when to administer medicine that was required on an 'as and when' basis were not in place.

Most people spoke positively about the choice of food available, although there was some inconsistency with staff not always ensuring people were given a choice of food available. People who were on food supplements could not always be sure they regularly received them, although people were supported to eat and drink enough to maintain their health and wellbeing. People were supported to access health care professionals , however, instructions left by health care professionals were not always effectively communicated to care staff. People's health care needs were assessed and regularly reviewed. Relatives told us the management team were good at keeping them informed about their family member's care.

People and relatives told us that staff were kind, caring and friendly and treated people with respect, although there were occasions when people's dignity were not maintained. The atmosphere around the home was warm and welcoming. People were relaxed and were supported by staff and the management team to maintain relationships that were important to people. There had been an improvement in the provision of activities that provided opportunities to optimise people's social and stimulation requirements. People and their relatives told us they were confident that if they had any concerns or complaints they would be listened to and matters addressed quickly.

People felt they received care and support from care staff that had effective skills to meet people's needs. Staff received supervision and appraisals, providing them with the appropriate support to carry out their roles.

We saw staff treated people as individuals, offering them choices whenever they engaged with people. Where people had the capacity to make their own decisions, staff sought people's consent for care and treatment and ensured people were supported to make as many decisions as possible.

We found three breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were not always safeguarded from the risk of harm because staff had not reported possible safeguarding issues to the manager and had not always followed the appropriate safeguarding procedures.

The provider's recruitment processes were not robust and did not always ensure people were supported by appropriate staff.

Risks to people were assessed and managed appropriately but information provided by health care professionals was not always recorded on the risk assessments and care plans to keep care staff informed.

Although there were sufficient numbers of care staff to provide care and support to people, there were times of the day when calls bells were not always responded to in a timely way.

People received support to take their medicines safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People received care and support from staff that were trained and knew people's needs.

Mental capacity assessments did not consistently identify what decisions people were being asked to make, or supported to make, in relation to their care.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible.

People were supported to receive food and drink that met their needs although people on fortified supplements did not always consistently receive these.

Staff supported people to receive medical attention when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The provider had not ensured that the service was always caring. They had not ensured that people were consistently kept safe and that staff were effectively deployed to meet people's needs.

Peoples' dignity was not always maintained.

People' independence was promoted where possible.

People made decisions about their care with support and guidance from staff and were supported to maintain contact with relatives and significant people in their lives.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People and their relatives were not consistently involved in planning and agreeing their care and received care that met their individual needs.

People spent time completing social activities they enjoyed but the activities were not always person centred and suited those people living with dementia.

People were confident that their concerns would be listened to and acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were systems in place to monitor and improve the service but they did not always ensure identified shortfalls were investigated thoroughly and appropriate action plans put in place to reduce risk of reoccurrences.

There was no registered manager.

People were happy with the service they received.

Cherry Lodge

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 15 and 17 August 2017 with a further announced visit on the 22 August 2017. The inspection team consisted of two inspectors, an expert by experience and a specialist advisor on the first day and one inspector on the 17 and 22 August. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The specialist advisor was a qualified nurse who had experience of working with older people living with dementia and/or mental health needs.

As part of the inspection process we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences that put people at risk of harm. We refer to these as notifications. We reviewed the notifications that the provider had sent us, to plan the areas we wanted to focus on during our inspection. We reviewed regular quality reports sent to us by the local authority to see what information they held about the service. These are reports that tell us if the local authority has concerns about the service they purchase on behalf of people. We had received a number of concerns from partner agencies that related to keeping people safe and from risk of avoidable harm. We looked into these concerns as part of our inspection.

We spoke with 17 people, three relatives, the manager, the deputy manager, the provider and seven staff members that included care and domestic staff. Because a number of people were unable to tell us about their experiences of care, we spent time observing interactions between staff and the people that lived there. We used a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also looked at records in relation to seven people's care and medication records to see how their care and treatment was planned and delivered. Other records looked at included nine staff recruitment files to

check staff were recruited safely. The provider's training records were looked at to check staff were suitably trained and supported to deliver care to meet people's individual needs. We also looked at records relating to the management of the service along with a selection of the provider's policies and procedures, to ensure people received a good quality service.

Requires Improvement

Is the service safe?

Our findings

The provider's recruitment processes required improvement. We looked at nine staff records and found the provider had not followed their own recruitment process for six of them. For example, one staff member had not had a Disclosure and Barring Service (DBS) check completed prior to their employment. The DBS check can help employers to make safer recruitment decisions and reduce the risk of employing unsuitable staff. While we were on site, the manager took action to address this. We found the provider had not always requested two references or had accepted generic references that were a number of years out of date. Records did not evidence that gaps in employment had been followed up at the interview stage with the prospective applicant. Five of the staff members had since left the home and although they posed no risk of harm to people living at the home, the provider had not ensured their recruitment procedures were robust and had operated effectively. This was a breach of Regulation 19(2) HSCA 2008 (Regulated Activities) Regulation 2014.

At the last inspection in August 2016 we rated the provider as 'requires improvement' under the key question of 'Is the service safe?' We found areas of the home were not sufficiently clean and risks to people had not always been consistently managed to ensure people remained safe from risk of harm. For example, upholstered furniture in the main reception area was stained and the smell of urine in that area was strong. Risk assessments for two people had identified they were at high risk of falls but risk assessments at the time had not been updated to reflect these falls. When people had fallen and sustained injuries to the head, the response from staff was inconsistent. The records we looked at at the time showed medical intervention had not been consistently requested and the people had not consistently been kept under close observation following the head injuries.

At this inspection we found there had been a significant improvement with the cleanliness of the home. The upholstered chairs in the reception area had been cleaned and there was no unpleasant smell in the reception area. However, there remained an unpleasant odour from the first floor bathroom and one bedroom. We brought this to the attention of the manager. The bathroom had been used to store plastic bags that contained soiled items for laundry that were promptly removed. Whilst the odour in the bedroom was found to have been caused by a cleaning product used by domestic staff. The manager spoke with the domestic staff and agreed the product had created an unpleasant vinegary odour. The staff were instructed by the manager not to use this product.

At this inspection, we saw there had been some improvement in the management of risks but further improvement was required. We saw that individual risk assessments were completed to assess people's risk of falls, developing sore skin, nutritional risk and moving and transferring. The assessments were, overall, updated each month and there was a brief record of the actions to be taken to reduce the risk of harm to people. We saw people being moved safely using a hoist and staff used appropriate moving and handling techniques that ensured people were transferred safely. However, one care plan, we looked at indicated the person may become distressed and exhibit behaviours others may find challenging and could cause harm to others. Although there was some information for supporting the person there was very little information for staff on how to support the person in these circumstance. It was not clear what actions they should take

to try to minimise any risk of harm, other than offering the person reassurance. We saw that staff had recorded what occurred leading up to, during and after an incident but there was no clear behaviour management plan in place to ensure staff had information to consistently support the person. We spoke with the manager and they agreed the processes currently in place to support, manage and record any behaviour, deemed to be challenging, required improvement.

We had received information of concern regarding two separate incidents. One concern was that staff had not responded appropriately and failed to follow guidance provided to them when people had sustained a serious injury after a fall. Staff we spoke with told us they had received guidance on what to do in the event of such an emergency. We saw a copy of a 'falls protocol' was signed by the staff members and placed in their individual staff files. Copies of the protocol was displayed on the staff room notice board and in the main office. We spoke with seven staff members and they all explained the steps they should follow when dealing with this type of emergency. One staff member said "First thing we do is hit the emergency alarm for help, reassure the person to help keep them calm and look for visible signs of injury." Another staff member told us, "If the person says they are in pain we don't move them we would call 999." The second concern is on-going and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk. This inspection examined those risks.

People and relatives we spoke with told us they felt the home was a safe environment for people to live in. One person said, "I feel safe in my room." Another person told us, "It is very safe, the front door is locked so strangers can't get in." A third person explained, "Yes, I feel safe, I'm not worried." A relative we spoke with told us, "I have no concerns about the safety of [person's name], I've never seen anything that would give me any cause to be concerned." Staff we spoke with explained how they would report any suspicion of abuse and the signs they would look for that could indicate a person was being abused. One staff member said, "I'd look for people's body language, they might wince if in pain or point to where they are hurting." Another staff member told us, "You get to know people and how they are so if someone who is usually quite chatty and bubbly suddenly became withdrawn and quiet then that should tell you that something is wrong."

Staff we spoke with all told us they would report any changes in peoples' behaviours, suspicious or unexplained bruising, but we found this was not routinely happening. This meant that although people we spoke with told us they felt safe, we found that staff had not always recognised that certain injuries should have been reported under the provider's safeguarding procedures. For example, two care plans we looked at included body maps that detailed unexplained skin tears and bruising to people but we found the incidents had not been notified to the manager. We discussed with the manager, deputy manager and provider the need for all changes in people's behaviours, unexplained bruising and skins tears to be reported so that the incidents could be investigated, referred to the safeguarding authority if appropriate and monitored to ensure people's safety. The staff files we reviewed showed staff had completed safeguarding training. We noted the provider had arranged for staff to complete further safeguarding training in September 2017.

People, relatives and staff we spoke with all told us they thought there were sufficient members of staff on duty to support people. One person told us "There is always someone around," another person said, "There's always plenty of staff." A third person explained, "Staff come around all the time." The provider had introduced an additional staff member between the hours of 4pm to 10pm to support the night staff when helping people to bed. This was in response to concerns raised that there was insufficient staff members on duty during these times. People we spoke with told us they did not 'usually' have to wait long for assistance. One person said, "Sometimes I have to wait when they're [staff] busy but on the whole, they are pretty good." We noted that there had been delays in answering some call bells. For example, on the

first day of our visit an alarm was activated at 12.35pm and at 12.55pm we went to check on the room. The person was up and walking about in their bedroom. We informed staff and they went to check on the person, who, it was found, had not required any assistance. Overall, we found there were sufficient staff on duty to attend to people's care and support needs.

People received their medicines safely and as prescribed. One person told us, "I can ask for medicine if I need it." Another person said, "Yes, I have my tablets when I'm supposed to." During our visit we saw medicines were locked away in a secure facility. The temperature of the room was not consistently recorded during July and August 2017. However, the dates that had been recorded showed the temperature was within acceptable limits. Processes were in place for ordering and supply of medicines and we found that people's medicines were available. We observed the administration of medicines during the morning. We saw staff checked against the medicines administration record (MAR) for each person and stayed with people until they had taken their medicine. However, we noted for one person who had their pain relief dispensed in a drink, the staff member gave them a tall glass of orange squash and then left the person to drink it in their own time. The person did not drink all of the squash, therefore did not take all of their pain relief, although the MAR sheet was completed as administered. We discussed this with the manager and explained the need for staff to remain with the person until they could be sure all medicines had been taken and to consider using a smaller glass containing less fluid.

We found where necessary, in people's best interests, discussions had taken place with the family members and GP relating to medicines being added to people's food and drinks without their knowledge. Staff spoken with told us they also sought guidance and advice from a pharmacist how medicine should be disguised, so as not to impact on the effectiveness of the medicine. However, we could not find evidence in people's files that the discussions with the pharmacist had taken place. Protocols were not in place to provide additional information about medicines which were prescribed to be given only when required. Although staff we spoke with were aware of the signals and behaviours of people that could indicate they were in pain or required their as and when medicine, this guidance would help support new and agency staff. The manager immediately started to put protocols in place.

We found people who required pain relief to be administered through a skin patch had received their medicine as prescribed and records of the application of skin patches had been accurately recorded in line with good practice.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in August 2016, we rated the provider as 'requires improvement' under the key question of 'Is the service effective?' We found although there were arrangements in place to ensure that decisions were made in people's best interests; the process for assessing a person's capacity to make a decision required improvement. At this inspection we found there had been some improvement but further improvement was required.

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 people lack mental capacity to make particular decisions, any made on the person's behalf must be in their best interests and as least restrictive as possible. We checked the provider was working within the principles of the MCA and found that improvement was required.

We saw where people were unable to make some decisions for themselves mental capacity assessments were not consistently completed. Best interests decisions did not always clearly record what the decision related to and why it was in the person's best interests. For example, we saw a hospital appointment had been cancelled for one person. We asked staff if the appointment had been rearranged. We were told the appointment had been cancelled at the request of relatives and that the relatives had Lasting Power of Attorney (LPA). However, there was no evidence that the LPA was for health and welfare and that it was in the best interests of the person not to attend the appointment. Although the manager told us they would follow this matter up with the family because the provider had not seen the LPA and cannot confirm if it is in place for such a decision this is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that a large number of people had sensor mats in their bedrooms but without a rationale for their use. Staff told us that the sensor mats were in place to alert the staff that the person was moving around in their bedroom. However, there was no documented rationale and best interest's decision making for the use of the sensor mats such as if the person was at risk of falling so the mat was for their safety. We found one person had a signed consent document to the use of a sensor mat. We checked the records for another person unable to consent to the use of a sensor mat. We found there was no evidence of a mental capacity assessment or evidence that a best interest's process had been followed in relation to this decision.

We found on the mental capacity assessments we reviewed, the decisions to be made were almost identical and therefore not always individualised to the person's circumstances. The best interests decisions we saw did not always state the benefit to the person and why it was in their best interests. We discussed with the manager the need to be sure family members had an Lasting Power of Attorney (LPA) for health and welfare when they were making decisions on their relative's care. We also discussed the need to improve the completion of mental capacity assessments and the best interest process to ensure assessments were decision based and time specific. The manager told us they had identified this as an area for improvement. We were shown evidence that the manager had already started to take steps to improve the assessment

process with the introduction of new best interest forms and mental capacity assessments.

People we spoke with told us staff asked for permission before carrying out any care or support. One person said, "Staff do ask me first before they do anything and check I am happy with what they are doing." One member of staff said, "I always ask people what they want and make sure I give them a choice, for example what food they like or clothes they want to wear." Staff we spoke with gave us examples of how they would obtain people's consent before supporting them. One staff member said, "It depends on the person, I could just ask some and they'll understand but others you might have to show them things or write it down and explain it more slowly so they can understand."

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the last inspection we found that staff were not always aware of the restrictions in place in respect of people who were subject to a DoLS. At this inspection, staff we spoke with were able to explain why DoLS applied to people although not all staff were aware who the DoLS applied to. However, they did tell us there were only a few people who could leave Cherry Lodge on their own whilst the remaining people would not be safe if they did try to leave the building. One staff member explained, "Say if someone wanted to out outside they might be open to abuse so a DoLS would be put in place because they are at a high risk of harm and we need to keep them secure." Another staff member told us, "DoLS are in place for people's best interests, it's to safeguard them from risk of injury, we have quite a lot here [living at Cherry Lodge]." We saw applications had been made to authorise restrictions on people's liberty in their best interests in order to keep them safe.

People spoken with told us they were happy with the staff and felt staff had the skills and knowledge to support them. One person said, "They [staff] are always there to help you, they are very good, when I ask for help I get it." A relative we spoke with said, "I think the staff have the skills to help mum." Staff we spoke with told us they had received training to support them in their role. One staff member said, "We have quite a lot of training, I've recently completed training in moving and handling, fire safety, dementia and diabetes." Another staff member told us, "The training is good." New staff to the home had completed an induction that included working alongside more experienced staff before being 'signed off' by the provider. Staff also received training to support them to complete their NVQ Level 2 and Level 3. Staff did not complete the Care Certificate but had completed training that reflected the Care Certificate standards. The Care Certificate is an identified set of induction standards to equip staff with the knowledge they need to provide safe and effective care. Staff we spoke with confirmed they had recently received supervision from the new manager. Staff continued to tell us they had not received consistent supervision because the home had been without a permanent registered manager but this had improved. Staff we spoke with told us they felt supported by the new manager and deputy manager and that they would speak with both managers if they were concerned about anything.

Most of the people we spoke with told us they were satisfied with the food they received. One person said, "It's all nice food." Another person told us, "It's [food] very good but no choice." We saw there was a white board in the dining room that displayed a handwritten menu that was difficult to read. Not all the people we spoke with could recall being given a menu to choose their meal. One person said "Yes we get a menu every so often but not every day." Another person told us, "If you don't like it [food] you go without." However, this was not evidenced at the time of our visit. We saw one person pushed their meal away and staff brought the person a different choice, which the person ate. However, people were not told of the choice of meals available. We could hear some people asking what their dinner was. We saw there was a lack of consistency from staff when it came to reminding people what it was they had requested for lunch. Condiments were not available on all tables and we saw one person trying to alert staff that they required

salt whilst another person got up and fetched the salt from another table. At the time of our inspection visit, the manager had purchased additional condiments for all the dining tables.

One person we spoke with, who chose to remain in their room, told us they had not received any morning drinks on the first day we arrived. Although the person did have soft drinks available to them, they told us, "No such thing as a mid morning cup of tea, I'd have one if they brought one." We saw that no drinks had been brought up to the first floor in the morning. We discussed this with the manager and deputy manager who assured us people on the first and second floors were offered drinks and told us they would look into why no drinks were made available. We saw that when people asked for drinks, staff would fetch drinks for them.

People's nutritional needs were assessed and there was information in people's care plans about their nutritional preferences. We saw from one person's weight charts their weight had fluctuated since 06 February 2017 with a gradual loss of almost 6kg since 06 February 2017. We found the provider had made an appropriate referral to the GP in respect of the weight loss. We saw that additional support was sought from speech and language therapists (SALT) where people had difficulty swallowing their food. We found the provider had also sought advice from dieticians and staff would add additional calories to people's food. For example, the use of cream instead of milk. However, when kitchen staff were asked who required a fortified diet; we were told cream and butter was added to everyone's meal, irrespective of whether or not they required the additional calories to maintain their weights. We discussed this matter with the manager. On the second day of our visit, the kitchen staff had received a list of names of people living at the home that required the additional calorie intake.

People we spoke with told us they were regularly seen by health care professionals, for example, the GP, tissue viability nurses, optician, podiatrist or dentist. Relatives we spoke with had no concerns about their family member's health needs. One person said, "They [staff] are very quick to get the doctor if I'm ill." We saw that healthcare professionals completed visiting records with instructions for staff. This supported people to maintain their health and wellbeing. However, instructions left by professionals were not always transferred into the daily care plans that were accessed by care staff. For example, when people were at a high risk of developing sore skin, the actions recommended by health care professionals were not always reflected in people's care plans. We saw the health care professional had left instructions for staff to encourage one person to use a pillow to help alleviate pressure. When we spoke with the senior staff, they were aware of this guidance, however, care staff spoken with were not aware of this guidance nor had the information been written up in the care plan. We spoke with the manager and the senior staff member who explained the healthcare professional had requested additional pressure support for the person and this was due to be delivered to the home shortly, therefore taking away the need for a pillow.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in August 2016, we rated the provider as 'good' under the key question of 'Is the service caring?' At this inspection we found the service required improvement.

People living at the home were not consistently supported to receive personalised care. For example, we heard one person calling for assistance on two occasions on the third day of our visit. We asked the manager to intervene on both occasions because the person was clearly distressed and needed to use the bathroom. On checking the person's records, we saw they were on hourly checks and discussions with staff confirmed this, however, the person clearly required assistance between the hourly checks. We spoke with the manager about the person. We were told the hourly checks were sufficient to meet the person's needs and that the person 'always called out' and when staff tried to accommodate the person, they would regularly change their mind. This demonstrated a more task led approach was taken towards the person as opposed to a person centred approach. It was not dignified for the person to be heard pleading to use the toilet when they needed to. Although, we did see the person later during the day and they appeared to be more content and relaxed in the lounge area.

Care plans we looked at included information about people's previous lives, their likes and dislikes and their individual preferences. However, this information varied from care plan to care plan with some care plans containing more personalised information than others. We could not see any evidence of how this information was being used to personalise support for some people. This meant that some of the care and support being offered to people was more task based and not always person centred on people's individualised needs.

A number of staff explained to us how they supported people who became upset or anxious but referred to people as "kicking off." People living with dementia can become disorientated, confused and frightened and may not be able to express their anxieties and fears with words and may exhibit these feelings in other ways. We found this language used by some staff was not respectful. We noted the provider had arranged for staff to attend training for dignity and respect as well as dementia awareness training.

Everyone we spoke with said staff were kind and caring. One person said, "They [staff[are very kind you know." Another person told us, "They [staff] help me and find out how I am." Another person explained, "We're very lucky you can always ask staff if you need anything." A relative told us, "We are very happy with the staff, they are lovely." We saw people were relaxed in the company of all the staff and staff were visible and engaged in friendly conversation. We saw that staff treated people with kindness and empathy; they spoke to people in a sensitive, respectful and caring manner. Staff understood people's communication needs and gave people time to express their views, listening to what people said.

People we spoke with told us they felt involved in decisions about their care and support needs. One person said, "They [staff] do say do you want this or that." Another person said, "If I don't want something, I tell them [staff]." Staff were able to explain to us how they encouraged people's independence and supported people who could not always express their wishes. For example, staff said once they got to know people,

they could tell by facial expressions and body language, whether the person was comfortable with the level of care being provided. If the person was showing any signs of distress or anxiety when care was being provided, staff told us they would find alternative ways to deliver the care and provide lots of reassurances until the person was more relaxed. For example, one person could become upset when personal care was being given. Staff explained they would leave the person for a period of time and return later. If the person was still upset, a different staff member would attend to the person.

People we spoke with told us staff respected their privacy and dignity. One person told us, "The staff are very respectful." A relative told us, "I think the staff respect mum's privacy, she's never complained and if there was anything she'd let us know." Staff addressed people by their preferred names and knocked on people's bedroom doors before entering. Some people chose to have their bedroom door open or closed and their privacy was respected. People were supported to make sure they were appropriately dressed and that their clothing was arranged to maintain their dignity. Although we did see one person being transferred from their wheelchair to a lounge chair and the blanket was not effectively placed to maintain the person's dignity and the person's skirt had dropped and exposed their under garments. However, our observations overall demonstrated that staff were friendly and they laughed with people and supported people to move around the home safely. This was carried out with care ensuring people moved at the pace suitable to them.

Everyone we spoke with told us there were no restrictions when visiting. A relative told us "Although we tend to visit at the same time, I'm sure we could just turn up and it wouldn't be a problem." There were separate rooms and areas for people to meet with their relatives in private. We found people living at the home were supported to maintain contact with family and friends close to them.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in August 2016, we rated the provider as 'requires improvement' under the key question of 'Is the service responsive?' We found although there were arrangements in place to ensure complaints were addressed, there were no outcomes recorded to help the provider identify trends that would enable them to learn and further develop the service. We had also found that improvement was required in developing interests and hobbies for people. At this inspection we found there had been some improvement but further improvement was required.

We found an initial admission assessment of people's care and support needs was undertaken and located in the front of care plans. However, we noted they did not always reflect the person's current needs which meant the information might be misleading to a new member of staff who may not have the time to read the whole of the care plan. For example, one person's initial assessment stated they had a urinary catheter and this was not the case at the time of our inspection visit. We found that changes to a person's health was identified and recorded in the care plans and showed the involvement of health care professionals when needed. However, staff did not always continue to follow the guidance set out by health care professionals to maintain a person's health. For example, two people, at risk of developing sore skin, had received input from health care professionals. We found instructions left by health care professionals were followed by the care staff and the peoples' skin healed quickly. However, on both people's records, we saw the health care professionals returned in a short period of time because the condition of their skin had deteriorated again. Although the staff were quick to respond to the sore skin and involve the health care professionals, we found there was no evidence to demonstrate staff continued to follow the health care professional's instructions after the skin had healed to prevent reoccurrences. We discussed these examples with the manager who had agreed to ensure staff applied protective barrier creams and instructions from health care professionals were followed as more effective processes were required. At the time of our inspection visit, the manager talked us through and showed us the processes he had introduced to rectify this.

At the last inspection in August 2016, the provider's complaints process required some improvement. People and relatives we spoke with told us they knew how and who to complain to. One person told us, "I've got no complaints at all." A relative said, "We've raised a couple of minor things and they have always been addressed quickly." Another relative told us, "I wouldn't hesitate in going to the manager, his door is always open." We reviewed the complaints file and saw there had been a small number of complaints made since our last inspection. Because there had not been a consistent manager at the home since January 2017, and a number of issues had been raised directly with CQC that were not recorded, we could not be sure this was a true reflection of the number of complaints raised. The new manager told us complaints and concerns were taken seriously and would be used as an opportunity to learn and improve the service. We saw the complaints the new manager had dealt with had been investigated and resolved to the satisfaction of the parties concerned. We found the new manager had a process in place that could identify trends to ensure the service could be improved upon and reduce the risk of any reoccurrences.

At the last inspection in August 2016, improvement was required in the development of interests and activities for people living at the home. At this inspection we found there had been an improvement,

although some further improvement was still required. We saw that some people were supported to participate in social activities of interest to them. We found the provider had an 'activities co-ordinator' that developed hobbies and activities for people living at the home. The activities co-ordinator also had other duties they were responsible for and we were told it was the responsibility of all care staff to ensure people received some social interaction and stimulation. We saw there were pictures on the walls of days out where people were seen to be smiling and happy. More events had been planned and family members were also encouraged to attend.

People who chose to remain in their rooms told us they were happy to read their books, watch television, one person we saw, regularly went out to the local shops. We were told by people and relatives we spoke with people had enough to keep them stimulated and prevent social isolation. One person told us, "There is always something going on." A relative said, "I think I need to make an appointment to see mum, she's always doing something." We saw staff encouraged people to participate in singing to musical dvds whilst other people were engaged in reading magazines, newspapers and books. The provider explained they had purchased raised flower beds that were kept at another of their homes and it was their intention to bring them across to Cherry Lodge for those people interested in gardening.

During the three days we were on site, we noted there were different activities for people but found the same people were involved. We could not see evidence of any person centred hobbies or activities suitable for people living with dementia taking place. The staff explained they tried to make some interests more person centred, for example one staff member told us how they ensured people interested in football regularly received updates and final scores about their favourite football teams. The home had a large, accessible garden to the rear of the property that people could access. However, we saw only one person had the door code to freely access the garden for fresh air. Families used the garden to take their relatives out when they visited and if the weather was fine. We did not see care staff ask people if they wanted to access the garden for fresh air.

We asked staff how people's cultural and spiritual needs were being met. We were told how some families brought in their relatives' own food because the provider did not offer a culturally diverse selection of meals. The manager explained this was an area that required improvement and they were currently putting measures in place to address this shortfall. For people whose religion was important to them, the provider had arrangements in place for visitors to attend from local places of worship.

People we spoke with and their relatives told us they were satisfied with how people's needs were being met. One person explained when asked if they were involved in the planning of their care, "The staff do ask me if I am happy with how things are done but I don't recall going through any care plan." A relative told us, "We are involved in mum's care needs, they [staff] always phone us if anything happens so on that front we are kept informed, but I can't recall completing any reviews as such." Care plans we looked at, although we could see they had been reviewed regularly, there was no evidence to show how people or their family members had been involved in the review process. All the care plans we reviewed contained 'This is me' booklets but only one was completed. There was a small amount of personal life history information at the front of each care plan. However, staff we spoke with were knowledgeable about people's needs and risks associated with their care and were able to give examples of personalised care and how they managed difficult situations. For example, when people became upset and angry. All the staff we spoke with told us that they received updates in changes in people's needs in handovers between staff at shift changes and would also read peoples' care plans. One staff member explained, "I like reading the care plans, it gives you the background on people and helps us to get to know people quickly."

Requires Improvement

Is the service well-led?

Our findings

At our previous inspections in September 2015 and August 2016, we rated the provider as 'requires improvement' under the key question of 'Is the service well-led?' We found that improvement was required in the quality assurance systems that monitored the quality and delivery of the service. At this inspection we found the service still required improvement.

Systems to monitor recruitment processes were ineffective because the provider had not ensured all the appropriate employment checks had been followed up and completed. The provider's systems to monitor the quality and safety of the service had failed to ensure that accidents and incidents had been consistently reviewed, for themes and trends so that action could be taken to mitigate the risk of a reoccurrence of the incident or injury. The systems in place to monitor the effectiveness of the MCA training to ensure staff were aware of how to ensure that people's legal rights were been promoted, required improvement. Systems in place for recording when additional fluid and food supplements were given to people, required improvement. Systems to ensure soiled laundry was removed promptly and not left for periods of time in a communal bathroom, required improvement. The providers systems did not audit the response times to people's call bells, so that they could analyse the themes and trends for delays so that action could be taken to address.

Some of the quality assurance processes have not been routinely followed due to there being no registered manager in post and interim managers from the provider's other homes had been providing cover. However, the registered provider has a responsibility to ensure that there were effective systems in place to provide adequate cover to make sure the service people received remained consistently effective and safe. This was not always the case, we found audits had not been consistently completed and processes did not recognise the shortfalls we identified during our inspection visits. We have taken into account the new manager had already introduced new monitoring systems and had been conducting their own audits to determine where the shortfalls were and what processes needed to be put in place to make the necessary improvements. However, the existing systems that were in place had not been effectice in driving the improvements required. This is a repeat 'requires improvement' for the service under 'Well Led' for the third time and is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It is a legal requirement that organisations registered with the Care Quality Commission (CQC) notify us about certain events. We had been notified about significant events by the provider.
It is also a legal requirement for a registered manager to be in place. At the time of this inspection visit, there was no manager in place therefore, the conditions of registration were not met. However, a new manager had started and only been in post for four weeks and gave us their assurance they would be applying to become the registered manager at the home. At the time of writing this report, no application has yet been received from the new manager, should an application not be received, we will consider our regulatory response.

The provider's processes in place to monitor Deprivation of Liberty Safeguards Emergency applications for

the three expired DoLS were submitted to the supervisory body. Before we left, the manager showed us their new system for monitoring new and existing DoLS applications. This was to make sure fresh applications were submitted in good time and where appropriate followed up by the manager.

People and relatives we spoke with were complimentary about the quality of the service. We found the atmosphere of the home to be calm and relaxed. Everyone knew who the manager was and told us that they could speak with him whenever they wished and that he was visible around the home and approachable. One person told us, "I see him [the manager] on a daily basis." Another person said, "He's a lovely man [the manager] and very interested in what is going on." A relative told us, "We are very happy with the care and support [person's name] receives here, the manager is always around and is very approachable." All the staff we spoke with told us there had been an improvement in the running of the home since the new manager's arrival, although some said they would 'reserve judgement' because they felt they had been let down before with other managers. One staff member said, "I like [manager's name] he seems genuine enough and I hope he stays because this home needs a stable manager." Another staff member told us, "I think [manager's name] is great, he's 'hands on', he provides personal care, he takes the laundry down, he's always on the floor helping us and talking to people, it so refreshing from the last manager we had who stayed in the office all the time."

There were mixed responses from people and relatives we spoke with when we asked them if they were involved in 'resident meetings' or if they had completed any feedback questionnaires on the service provided by the home. The management team confirmed no surveys had been sent out to people or their relatives since the last inspection but it was being reviewed and it was hoped a survey would be issued soon. We saw there had been some resident/relative meetings but they had not been held regularly because there had not been a permanent manager in place. However, people and relatives we spoke with told us if they had any feedback or concerns to raise about the home, they felt confident to approach the management team. One person told us, "This is a well-led home."

Staff members we spoke with told us the management team were approachable and if they had concerns regarding the service, they would speak with them. The provider had a whistle-blowing policy that provided the contact details for the relevant external organisations for example, CQC. Staff told us they were aware of the provider's policy and would have no concerns about raising issues with the provider, manager and deputy manager and if it became necessary, external agencies. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about malpractice, risk (for example, to a person's safety), wrong-doing or some form of illegality.

It is a legal requirement that the overall rating from out last inspection is displayed within the home. We found the provider had displayed their rating as required. Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found the provider was working in accordance with this regulation within their practice. We also found the provider had been open in their approach to the inspection and co-operated throughout. At the end of our site visit we provided feedback on what we had found and where improvements could be made. The feedback we gave was received positively with clarification sought where necessary.

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 11 HSCA RA Regulations 2014 Need for consent The provider's processes were not consistently effective at identifying shortfalls when monitoring the quality of the service relating to the welfare of people.

The enforcement action we took:

We have imposed a condition that the registered provider sends to the Commission a monthly report. The report should provide a summary of the quality assurance activities undertaken, the findings and any required actions to be taken including associated timeframes for completeness in order to demonstrate the service is able to meet the care needs and promote the safety and comfort of everyone living at Cherry Lodge.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's processes were not consistently effective at identifying shortfalls when monitoring the quality of the service relating to the welfare of people.

The enforcement action we took:

We have imposed a condition that the registered provider sends to the Commission a monthly report. The report should provide a summary of the quality assurance activities undertaken, the findings and any required actions to be taken including associated timeframes for completeness in order to demonstrate the service is able to meet the care needs and promote the safety and comfort of everyone living at Cherry Lodge.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider recruitment processes were not robust and did not ensure that persons employed had the appropriate competence and skills necessary for the work to be performed by them.

The enforcement action we took:

We have imposed a condition that the registered provider sends to the Commission a monthly report. The

report should provide a summary of the quality assurance activities undertaken, the findings and any required actions to be taken including associated timeframes for completeness in order to demonstrate the service is able to meet the care needs and promote the safety and comfort of everyone living at Cherry Lodge.