Care Management Group Limited

Cherry Tree

Inspection report

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Date of inspection visit: 22 January 2015
Date of publication: 28/05/2015

Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Inadequate**
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**

Overall summary

The inspection was unannounced and took place on 22 January 2015. The home had no previous inspections since it registered with the Care Quality Commission in November 2013.

Cherry Tree is a care home registered to provide care, support and accommodation for five people with learning disabilities. The service offers support to people with behaviours that challenge. On the day of our visit there were four young men using the service all assessed as requiring one-to-one support.

At the time of our inspection there was no registered manager in place. 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. There were interviews taking place. After the inspection we received information that the newly appointed manager would start the process to register as soon as they start working for the home.

Summary of findings

We found that the provider was not meeting legal requirements. People's needs were assessed on admission but were not always reviewed or updated. People's records were not always accurate, complete and did not always reflect the individual's current condition.

There were a number of health and safety concerns identified on the day of our visit. We also observed that care was not always delivered in a way that promoted the safety of people using the service. Some staff had a very limited understanding of risk and how to manage it. Two out of four staff we spoke with did not know how to record behaviours that challenged.

Staffing levels at night was one waking staff and a floating member of staff between the sister homes within the same location. This was not enough to safeguard the safety and wellbeing of the people who used the service considering that one of them was usually up at night, another had a medical condition that could take the member of staff away for some time. The people were all assessed as needing one-to-one support during the day due to their assessed needs.

We noted gaps in the training and knowledge of staff particularly in relation to the care of people with behaviour that challenged. Although some staff were caring, two staff members we observed were not always caring. People who use services were not always enabled to participate in making decisions relating to their care or support.

The service was not always responsive. People were not always engaged in meaningful activity for the duration of the visit. For one person the activity offered was not age appropriate.

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

Where people lacked the mental capacity to make decisions, the manager made best interests decisions in line with legislation. This included making applications where necessary to deprive people of their liberty. Staff were aware of the Mental Capacity Act 2005 and understood that a person could have capacity to make some decisions but could lack capacity to make more complex decisions, such as those relating to their finances.

There were procedures to monitor the quality of care delivered but some of these were yet to be fully implemented as part of an improvement plan initiated by the interim manager. We identified shortfalls in the quality of staff employed. For example, two staff on duty were unsure of how to engage effectively with people they were supporting.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was unsafe. There were inadequate procedures in place to ensure that people were protected from abuse or harm. Staff had varying knowledge about how to recognise and manage risk related to challenging behaviour.

We identified several health and safety hazards such as the broken trampoline, the state of one bathroom and the misleading note on the fire panel which prioritised switching off the alarm without checking where the fire was.

Is the service effective?

Requires improvement

The service was ineffective. Although staff had annual appraisals, and regular supervision, there was insufficient training relating to managing specific challenging behaviour and a lack of one-to-one observations.

People were supported to eat and drink a balanced diet.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements. This included ensuring that best interests decisions were sought when applying for deprivation of liberty safeguards (DoLS).

Is the service caring?

Requires improvement

The service was not always caring. People who use services were not always enabled to make, or participate in making, decisions relating to their care and support. Whilst some staff were knowledgeable, other staff were not engaged and did not display positive behaviours towards people they looked after.

Is the service responsive?

Requires improvement

The service was not always responsive. People were not always engaged in meaningful activity. For one person the activity was not age appropriate.

Care plans were not always person centred or available in a format that people using the service could understand.

There was a complaints procedure in place, however we did not see it available in a format that people who used the service could understand.

Is the service well-led?

Requires improvement

The home was not always well-led. There was an improvement plan in place and an interim manager in place until the newly appointed manager took over. However, work still needed to be done to ensure that skilled and experienced staff were employed and supported to effectively care for people who presented with behaviour that challenged.

Records were not always accurate and did not always reflect the current needs of people who used the service.

Cherry Tree

Detailed findings

Background to this inspection

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

This inspection took place on 22 January 2015 and was unannounced. The inspection team consisted of an inspector, a specialist advisor who was a nurse lecturer in learning disability, and an expert by experience – this is a person who has personal experience of using or caring for someone who uses this type of service. The expert had experience in caring for their own child with a learning disability as well as fostering children with learning disability including autism.

Prior to the inspection we asked for the information held by the local authority and the local Healthwatch. We also reviewed the services website.

During the inspection we spoke to four people using the service. We interviewed staff including the interim manager and care staff. We conducted a Short Observational Framework for Inspection (SOFI) for 30 minutes. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We observed care interactions between staff and people. We reviewed four care records, four medicine administration record charts and staff files.

After the inspection we contacted one relative, the clinical director and the Positive Behavioural Support (PBS) trainer.

Inadequate

Is the service safe?

Our findings

We observed that care was not always delivered in a way that promoted the safety of people using the service. Some staff clearly had a limited understanding of the needs of people they were working with. A person was assessed as needing one-to-one support from staff due to their risk of challenging behaviour which may result in other people being harmed. We saw that for several periods throughout the morning shift this person was left unattended, escalating the risk of them potentially harming other people. An incident occurred during the visit where this person was able to attack another person in our presence. It was clear that lack of staff vigilance had enabled the incident to occur. The incident was later reported as a safeguarding incident.

Some staff had a very limited understanding of risk and how to manage it. Two out of four staff we spoke with did not know how to record behaviours that challenged. From reading the incident forms and daily records it was apparent that most of these incidents where largely happening when observing staff had turned their attention to other duties. The number of preventable incidents indicated that people were not being effectively protected from the risk of harm. One person reported not always feeling safe at Cherry Tree as they were scared of another person who used the service.

There were no clear behaviour management plans which reflected the way the people with challenging behaviours were being supported. The support plans seen were generic with no specific guidance of how staff should support the people.

This was a breach of regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were a number of safeguarding incidents that occurred between December 2014 and the day of our inspection. Of particular concern was the incident recorded in two people's daily report as having occurred on 4 January 2015. A person had made a complaint that another person had entered their bedroom and repeatedly attempted to make inappropriate and unwanted sexual contact. Both people had been assessed as needing one-to-one support. This raised some concerns that if both these people were being offered one to one support where were the staff who should have been observing them. There was no incident form or safeguarding alert raised, which also showed that some staff could not distinguish the difference between daily records and a potential safeguarding concern.

This was a breach of Regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing at night consisted of one waking staff member and a floating member of staff between the sister homes within the same location. This was not enough to safeguard the safety and wellbeing of the people who used the service who were all assessed as needing one-to-one support during the day due to their challenging behaviour. This could be a challenge as the supports needs of the people using the service were high with some not always sleeping at night. For example, one person had epilepsy and if a seizure occurred during the night the waking staff member would not have capacity to look after the needs of other people. However, we were not able to establish a correlation between staffing numbers and incidents.

This was a breach of Regulation 22 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were a number of health and safety concerns identified on the day of our visit. A latex glove was placed over the fire alarm in the bathroom and supplementary fire instructions stuck by the fire alarm panel could be dangerous as they focused on silencing the alarm and did not say anything about the evacuation procedure. The note made no reference to identifying whether there was a fire before silencing the alarm thereby putting people at risk. We raised this with the interim manager and the glove and broken trampoline was removed during our visit. The garden trampoline was condemned as unsafe as up to six springs were broken in the same area creating the risk of a fall through and subsequent injury. Despite noting this early the trampoline was used by one person and the staff member providing one to one support appeared unaware of the risk. Subsequent to this the trampoline was removed from the garden and a new one ordered by the interim manager.

Inadequate

Is the service safe?

The second bathroom and adjacent toilet, used by all staff on duty, all visitors and those living there were unfit for purpose due to leaks and significant damp and mould. We saw a business plan to renovate this bathroom in the new financial year. However, on the day of our visit people using the service were still using this bathroom and were at risk of falls and other health hazards associated with using a damp and mouldy bathroom such as allergies. Whilst the maintenance team were on site there were times when tools and sealant were left without supervision. This could be a potential hazard to people who used the service, staff, visitors and others.

This was a breach of Regulation 15 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 15 (1) (b) (c) (d) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were arrangements were in place in relation to obtaining, recording, handling and disposal of medicine. Medicines were kept safely in a locked main cupboard as well as within locked cupboards in three people's rooms. We saw staff carry out checks before safely administering medicine. We saw in the medicine administration records and training records that only trained care staff were allowed to administer medicines including emergency medicine to be given in the event of a seizure. However, we were not certain that medicines were prescribed and given to people appropriately. We observed that one particular person was constantly drowsy and dozing off throughout our visit. When we reviewed their medicine administration record we found them to be on a lot of sedatives regularly. Staff told us that these medicines would be reviewed and we saw evidence of this in previous medicine charts.

Requires improvement

Is the service effective?

Our findings

We looked at staff files and saw that annual appraisals were completed and regular supervision was taking place. However, we noted gaps in the training and knowledge of staff particularly in relation to people's specific needs. Although the service provided training it was not specific enough to the needs of the people living at the service. One member of staff told us that they "didn't want to be at the home". This member of staff said they had not been trained for the current needs and found the level of care challenging. It was evident from their facial expression, without a smile, that this person did not want to work at this service. The same staff stood passively and did not offer any reassurance after an incident of provocation between people. Another staff member, who was supposed to be providing one-to-one, missed an incident of provocation between two people as they had walked ahead and not been aware or noted the seriousness of the incident. They had to be convinced by another member of staff to write an incident form. Both staff member's files did not contain evidence of relevant training on managing challenging behaviour. The above behaviours did not encourage or support people using the service.

We saw mixed abilities in the staff that were on duty. We observed that two staff communicated effectively with people and had a good understanding of indicators that suggest changes in the person's wellbeing. However, more effort could be made to engage people with limited communication as the other two staff had received no specific training relating to challenging behaviour related to the people they were supporting. These two staff did not demonstrate an understanding of how to manage behaviours that challenge. More training and support could be offered to staff on working with people with Autistic Spectrum Disorders, supporting people who present with challenging behaviour and principles of one-to-one observation.

This was a breach of Regulation 23 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Laminated placemats in the dining room indicated where each person sat at the table. These placemats had a guide to the support plan on the reverse, however some did not relate to the person's current needs. For example, a person was noted as having no risk of swallowing yet in the support plan there was a speech and language therapy risk assessment. Our attention was not drawn to the place mats at the start of the visit and some staff seemed unaware of this reference point. In addition two people who had a lot of incidents between them sat at the same dining table. This could potentially increase the risk of subsequent incidents occurring. **We recommend that systems is in place to ensure that the placemats are updated the same time swallowing risk assessments are updated in order to avoid the risk of inappropriate support being given at meal times.**

Where people lacked the mental capacity to make decisions, the manager made best interests decisions in line with legislation. This included making applications where necessary to deprive people of their liberty for their own safety. Staff were aware of the Mental Capacity Act 2005 and understood that a person could have capacity to make some decisions but could lack capacity to make more complex decisions.

People were happy with the food choices they had. There was no menu board on display setting out what people would be eating for the week or day, with the exception of one person's healthy eating menu with pictures that was displayed on the fridge door and in use as on the correct day. This menu according to staff had been prepared by the person's parent. However, people told us they were satisfied with the quality of the food offered. They said that they were given choices of food. There were no concerns around fluid and nutrition. We saw people ate at a time they chose and were supported to choose what they wanted to eat in the kitchen. Hot and cold drinks were available at people's request. Staff were aware of special diets and we saw a note in the kitchen with a guide for a person who was being encouraged to eat a healthy diet.

Requires improvement

Is the service caring?

Our findings

The service was not always caring. People who use services were not always enabled to participate in making decisions relating to their care. For example there was a lack of effective communication between a person and the staff member supporting them. This resulted in the person not being able to communicate their needs effectively to the staff member. Some staff were not very responsive to people's needs. For example, following an incident where one person snatched a biscuit and thumped another person in the chest, we saw no one checking on this person who just stood in the corridor for several minutes after the incident happened.

Upon entering the home staff told us that a person would approach us on entry and touch our shoes after which they would ask to shake hands. We were told they would then move on. Whilst grateful for the notification it became clear that the person's behaviour was often anticipated as a negative rather than an opportunity to understand them better. This resulted in some staff fearing the response and not understanding the behaviour. We were warned, "Don't put your cup on the table until you have finished your drink because he will watch then take it before you finish." Towards the end of the visit it became a manageable behaviour as the person waited for us to finish the drink before taking the cup. This person's behaviour did not seem to be understood and there was a lack of developing his behaviour in a positive way. For example, he could be supported to place used crockery on a table or shelf by the locked kitchen door rather than getting down to the floor on his knees and leaving crockery on the floor by the kitchen door.

From our observations and staff feedback we received suggested that more could be done to engage with people with limited communication. There could be more effective ways of communicating with people such as picture boards which would reduce people's anxiety as they would know exactly what to expect during the course of the day. For example, there was a person who seemed to understand Makaton, a sign language developed specifically for people with learning disabilities, however none of the staff on duty could communicate using this method. All that was available was four Makaton signs on a notice board. This resulted in the person being frustrated as staff did not understand when the person tried to communicate using Makaton. One of the inspection team who had experience of communicating using Makaton observed this person trying to communicate using Makaton throughout our visit.

Some staff we observed appeared to be caring and compassionate except for two staff members who appeared to have very limited understanding of people's needs. The interactions of these staff members with the people lacked any warmth or compassion; they used inappropriate language such as "good boy" and displayed negative body language such as folding arms or keeping a very long distance from the person they were supporting. The same two staff members did not make any attempt to positively engage with people they looked after and were not always within sight of the people they were supposed to be offering one-to-one support.

These were breaches of regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us that some staff were caring. One person said they were "happy living at Cherry Tree for over a year" and still have the same keyworker. Another person said they were "looking forward to going to the shop on the bus". For others who could not communicate verbally we saw them smile or react positively when they saw certain members of staff on duty. Some interactions we observed between staff and residents demonstrated that the staff really enjoyed working with the residents. There was evidence that people were treated with dignity and respect by some of the staff.

People's independence was promoted in areas of personal hygiene and making drinks and snacks.

Staff told us that people's wishes and preferences were respected. However, this was not always evidenced in the care records we reviewed. A support plan highlighted a person's religious needs and suggested arranging two-weekly visits to a local place of worship. However, there was no evidence that this has ever happened. Staff we spoke with could not recall this person ever going to a religious service.

Requires improvement

Is the service responsive?

Our findings

On the day of the visit, people were not always engaged in meaningful activity. We saw that an activities plan had been produced but it was not dated and was not always followed. The activity chart set out plans for the day but was not always a true reflection of what was actually happing on the day. For example, on the day of our visit, nobody went out although one person had been scheduled to go out shopping. Staff told us and we saw that another person did not go out at all because staff feared they would run out. We saw one person sometimes engage in colouring however the content of the colouring book was not always suited for this person as it was a children's colouring book. For example, upon reading this person's support plan, we found they liked cars however staff had not considered that a car themed colouring book would have been more age appropriate and stimulating for this person.

This was a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw limited evidence of person centred care in the care records we reviewed. With the closure of the day centre for the holiday period people had limited activities during the day; this had resulted in one person being very unsettled by having no structure until the day centre reopened at the end of the month. We reviewed behaviour charts which were being collected, however staff were unclear about how these were used to change practice. We noted in particular for two people within the service, who were both receiving one-to-one, support that although these behavioural charts had been collected they were not being used effectively to put measures in place to manage the behaviours presented.

The support plans we reviewed had guidance which was not clear for staff about how they should meet people's assessed needs and their wishes. There were some generic risk assessments in place to assess potential risks to people's health and wellbeing. The support plans were only available in written format which meant that people had information about their care and support in a format they could not understand. The support plans and risk assessments had not been signed by the person and/or their next of kin. The support plans were not being reviewed at regular intervals and updated to reflect people's changing needs.

On the day of our visit, two out of the four staff were not very responsive to the needs of the people they were supporting. We witnessed an incident where one staff member who was supposed to be supporting a person was standing and watching a person whilst indoors whilst the person was walking about in the garden.

These were breaches of regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints procedure in place, however we did not see it available in a format that people who used the service could understand. We were not assured that people's complaints and experiences were listened to as we saw that concerns about on-going person to person incidents had not been addressed.

Requires improvement

Is the service well-led?

Our findings

We reviewed care plans, behavioural charts and incidents. We noted that records were stored securely in a locked cupboard. However, records were not always accurate, complete and did not always reflect the individual's current condition. For example, place mats that were in use that had people's communication passports in pictorial format were inaccurate. One of these said that a person had no swallowing difficulties whilst the communication care plan stated that this person had been referred to the speech and language therapist for swallowing difficulties. Support plans were sometimes undated and were not being evaluated regularly. Monthly support summaries were also incomplete.

This was a breach of Regulation 20 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our visit there was no registered manager in place. An interim manager from another service was on site at least three times a week to support staff. They were knowledgeable about caring for people with complex behaviours and had a positive attitude towards people and staff. They showed us plans in place to improve care plans. Medicine administration risk assessments had already been improved. We were notified that interviews had taken place and a manager had been appointed. However, It was evident that the changes in staffing and management had had significant impact on the service. Staff highlighted the lack of effective leadership in the past and high staff turnover had contributed to some of the concerns we found. These included a number of health and safety concerns and not ensuring that staff were skilled in caring for people with behaviours that challenged.

There were systems in place to monitor the quality of care delivered. Some of these were in an improvement plan and were still a work in progress. These included trying to improve handovers, ensuring that staff who administered medicines had completed competency assessments, and weekly auditing of incidents and behaviour charts.

Staff told us they could approach the interim manager and told us they could report any concerns relating to the care delivered. The interim manager was aware of the service's vision and values but these values were not always embedded in the attitudes and behaviours of two out of the four staff we observed during our visit.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not have suitable arrangements in place in order to ensure that Staff are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard. Staff did not always receive appropriate training. Regulation 18.(2) The registered person did not always take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services and others were not protected against the risks associated with inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each person which shall include appropriate information and documents in relation to the care and treatment provided to each person. Regulation 17.(2) (d)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not always encouraged to promote their autonomy, independence and community involvement. Regulation 10.1(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person did not have suitable arrangements to ensure that service users are safeguarded against the risk of abuse. Reasonable steps to identify the possibility of abuse and prevent it before it occurs were not always taken. They did not always respond appropriately to any allegation of abuse. Regulation 13(1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The registered person did not always take appropriate steps to ensure that, the premises and equipment used by the service was used and maintained properly. Regulation 15 (1) (b) (c) (d) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for service users.

This section is primarily information for the provider

Action we have told the provider to take

The registered provider did not always ensure that risks to the health and safety of service users of receiving the care or treatment were assessed mitigated.

Regulation 12 (1) (2) (a) (b)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The provider did not have suitable arrangements in place in order to ensure that staff were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard. Staff did not always receive appropriate training.

The enforcement action we took:
A Warning Notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Care and treatment was not always provided in a safe way for service users. People who use services and others were not protected against the risks associated of receiving care or treatment that is inappropriate. Care did not always meet people's needs especially for those using Makaton. People who use services and others were not protected against the risks associated of receiving care or treatment that is inappropriate. Care did not always meet people's needs especially for those using Makaton. People were not always enabled and supported to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible Regulation 9 (1) (a) (b) (3)(d)

The enforcement action we took:
A Warning Notice was Issued.