Cherry Health Care Limited

Cherry Trees

Inspection report

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Good**
Is the service caring?	**Outstanding**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

This was an unannounced inspection carried out on 2 and 5 February 2015. We last inspected the service in July 2013 and found they had breaches in Regulations 9 (Care and welfare of people who use services), Regulations 13 (Management of medicines) and Regulation 10 (Assessing and monitoring the quality of service provision). The provider sent us several action plans which told us how they were addressing the issues in the last report. At this inspection we found the provider had made the required improvements to address the breaches in Regulations 9, 10 and 13.

Cherry Trees Care Home is situated in the Kimberworth Park area to the north west of Rotherham. The home is purpose built and facilities are provided on the ground and first floor level; access to the first floor is by a lift. Cherry Trees is registered to provide accommodation for 66 people who require personal care. Some people living at the service had a diagnosis of dementia. At the time of this inspection there were 23 people using the service.

The manager had submitted an application to be the registered manager of the service and attended a 'fit person interview' on the second day of this inspection. We have not been notified that this process has been

Summary of findings

completed at the time of writing this report. 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.

People told us they felt safe living in Cherry Trees. One person said, "Staff are here for you, they make you feel safe. It's nice living here." There were procedures to follow if staff had any concerns about the safety of people they supported. The requirements of the Mental Capacity Act 2005 were in place to protect people who may not have the capacity to make decisions for themselves. The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment.

People's physical health was monitored as required. This included the monitoring of people's health conditions and symptoms so appropriate referrals to health professionals could be made. For example we spoke with the palliative care advisor who told us, "Cherry Trees staff are very good at making timely referrals to ensure the appropriate care is given to people who are approaching their end of life." We also spoke to a visiting GP who said, "The staff act in a timely manner to seek medical advice."

There were sufficient staff with the right skills and competencies to meet the assessed needs of people living in the home. Staff were aware of people's nutritional needs and made sure they supported people to have a healthy diet, with choices of a good variety of food and drink. People we spoke with told us they enjoyed the meals and there was always something on the menu they liked.

People were able to access activities. Plans to utilise the summer house were on the way to make best use of the gardens when the weather becomes warmer. People could also access religious services which were held periodically at the home.

We found the home had a friendly relaxed atmosphere which felt homely. Staff approached people in a kind and caring way which encouraged people to express how and when they needed support. One person said, "It feels like home living here." Another person said, "Staff are always there when you need help."

Staff told us they felt supported and they could raise any concerns with the registered manager and felt that they were listened to. People told us they were aware of the complaints procedure and said staff would assist them if they needed to use it. We noted from the records that no formal complaints had been received in the last 12 months.

There were effective systems in place to monitor and improve the quality of the service provided. We saw copies of reports produced by the registered manager and the provider. The reports included any actions required and these were checked each month to determine progress.

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?

Good

The service was safe.

Staff knew how to recognise and respond to abuse correctly. They had a clear understanding of the homes procedures in place to safeguard vulnerable people from abuse.

People's health was monitored and reviewed as required. This included appropriate referrals to health professionals. Individual risks had also been assessed and identified as part of the support and care planning process.

There were enough qualified, skilled and experienced staff to meet people's needs. We saw when people needed support or assistance from staff there was always a member of staff available to give this support.

Medicines were stored and administered safely. Staff and people that used the service were aware of what medicines to be taken and when.

Is the service effective?

Good

The service was effective.

Each member of staff had a programme of training and were trained to care and support people who used the service safely and to a good standard.

The staff we spoke with during our inspection understood the importance of the Mental Capacity Act in protecting people and the importance of involving people in making decisions. We also found the service to be meeting the requirements of the Deprivation of Liberty Safeguards.

People's nutritional needs were met. The food we saw, provided variety and choice and ensured a well-balanced diet for people living in the home. We observed people being given choices of what to eat and what time to eat.

Is the service caring?

Outstanding

The service was caring.

People told us they were happy with the care they received. We saw staff had a warm rapport with the people they cared for. Relatives told us they were more than satisfied with the care at the home. They found the manager approachable and available to answer questions they may have had.

People had been involved in deciding how they wanted their care to be given and they told us they discussed this before they moved in.

The manager had a good understanding of how to support people at the end of their life. We saw preferred preferences were recorded in people's care plan.

Summary of findings

Is the service responsive?

Good

The service was responsive.

We found that peoples' needs were thoroughly assessed prior to them moving in to this service. Visitors told us they had been consulted about the care of their relative before and during their admission to Cherry Trees.

Communication with relatives was good and visitors we spoke with told us that staff notified them about any changes to their relatives care.

Visitors told us the manager was approachable and would respond to any questions they had about their relatives care and treatment.

People were encouraged to retain as much of their independence as possible and those we spoke to appreciate this. People could access activities that were planned both in the home and in the community.

The service had a complaints procedure that was accessible to people who used the service and their relatives. People told us they had no reason to complain as the service was very good.

Is the service well-led?

Good

The service was well led.

The manager listened to suggestions made by people who used the service and their relatives. The systems that were in place for monitoring quality were effective. Where improvements were needed, these were addressed and followed up to ensure continuous improvement.

Accidents and incidents were monitored monthly by the manager to ensure any triggers or trends were identified.

Cherry Trees

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 2 and 5 February 2015 and was unannounced on the first day.

The inspection team consisted of an adult social care inspector and an expert by experience with expertise in the care of older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection visit we gathered information from a number of sources. We looked at the information received about the service from notifications sent to the Care Quality Commission by the manager. We also contacted Healthwatch Rotherham and looked on the NHS Choices web site to gather further information about the service. We spoke with a visiting GP and Palliative care advisor. We also spoke with and received information from the local authority commissioners who also monitor the standards within the home.

The service was not asked to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

At the time of our inspection there were 23 people using the service. We spoke with the manager, a senior, four care staff, the activity coordinator and the cook. We also spoke with eight people who used the service and three visiting relatives. This helped us evaluate the quality of interactions that took place between people living in the home and the staff who supported them.

We spent time observing care throughout the service. We also used the 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 looked at documentation relating to people who used the service, staff and the management of the service. We looked at three people's written records, including the plans of their care. We also looked at the systems used to manage people's medication, including the storage and records kept. We also looked at the quality assurance systems to check if they were robust and identified areas for improvement.

Good

Is the service safe?

Our findings

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. People we spoke with told us they felt safe. One person said, "It's my home, I feel safe and staff look after us all."

A safeguarding vulnerable adult's policy was available and staff were required to read it as part of their induction. We looked at information we hold on the provider and found there were no ongoing safeguarding investigations.

We spoke with staff about their understanding of protecting vulnerable adults from abuse. They told us they had undertaken safeguarding training and would know what to do if they witnessed bad practice or other incidents that they felt should be reported. They were aware of the local authorities safeguarding policies and procedures and would refer to them for guidance. They said they would report anything straight away to the senior or the registered manager.

Staff had a good understanding about the whistle blowing procedures and felt that their identity would be kept safe when using the procedures. We saw staff had received training in this subject.

The manager told us that they had policies and procedures to manage risks. There were emergency plans in place to ensure people's safety in the event of a fire or other emergency at the home. We saw there was an up to date fire risk assessment which had been agreed with the fire safety officer. Risks associated with personal care were well managed. We saw care records included risk assessments to manage a person at risk of falling. The risk was managed by obtaining equipment to alert staff if the person got up out of bed, which may result in the person falling. Staff were also vigilant when observing people moving around the home. For example we saw staff responding quickly to assist people who were unsteady when getting up out of the lounge chair.

The manager told us that all accidents and incidents were reported to the provider's clinical team to analyse the information and report back to the operations manager to discuss how to reduce the number of accidents incidents reported. The operations manager gives the home manager an action plan and this was regularly reviewed to ensure lessons were learned from previous events.

We found the provider had structures in place which enabled them to have an overview of risk and safety within the service. As well as the clinical team there was a health and safety team who completes a yearly inspection of the premises and sets an actions for the manager to address. The operations manager also visits regularly to monitor the quality of the service and provide support to the manager.

We looked at eight staff recruitment files including care staff, cook, domestic staff, and activity co-ordinator. We found that the recruitment of staff was robust and thorough. Application forms had been completed, two written references had been obtained and formal interviews arranged. All new staff completed a full induction programme that, when completed, was signed off by their line manager. Staff we spoke with confirmed the arrangements to ensure they were competent and confident to work unsupervised.

The administrator told us that staff at the service did not commence employment until a Disclosure and Barring Service (DBS) check had been received. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps to ensure only suitable people were employed by this service. The manager was fully aware of their accountability if a member of staff was not performing appropriately.

We looked at the number of staff that were on duty on the days of our visit and checked the staff rosters to confirm the number was correct with the staffing levels they had determined. The manager told us they had a flexible approach to ensure sufficient staff were on duty to meet people's needs. They told us they would listen to staff if they raised any concerns about not being able to meet people's needs. People who used the service and their relatives raised no concerns about staffing levels. One relative said, "There always seems to be sufficient staff working, but I sometimes worry when new staff are on duty because they may not know my relative's needs. However everything seems to be okay and I can always talk to the manager if not."

Good

Is the service safe?

At the last inspection of the service we found the management of medicines were unsafe. We issued a warning notice which told the provider they must take steps to achieve compliance.

At this inspection we found there were appropriate arrangements in place to ensure that people's medicines were safely managed, and our observations showed that these arrangements were being adhered to. Medication was securely stored with additional storage for controlled drugs, which the Misuse of Drugs Act 1971 states should be stored with additional security. We checked records of medicines administration and saw that these were appropriately kept. There were systems in place for checking medicines stocks, and for keeping records of medicines which had been destroyed or returned to the pharmacy.

We saw care plans included how each person preferred to take their medication and any allergies they may have had were also recorded. Staff had recorded if people had the capacity to consent to taking their medication and appropriate documentation was seen in relation to this.

During lunch we observed the senior care staff administering medication. We saw they did this in a professional, low key manner. They locked the medicine cabinet every time they left it even if only moving to a nearby person. We heard the senior care worker ask people if they required pain relief and acted upon their wishes.

We saw the senior care worker followed good practice guidance and recorded medicines correctly after they had been given. Some people were prescribed medicines to be taken only 'when required', for example painkillers. We saw plans were available that identified why these medicines were prescribed and when they should be given. The senior care staff we spoke with knew how to tell when people needed these medicines and gave them correctly.

The manager showed us training records to confirm staff had the necessary skills to administer medication safely. An annual competency check was also undertaken. Monthly audits were undertaken to ensure medication was administered as prescribed. We were given a copy of the Pharmacist advice visit record completed in January 2015. Any errors were picked up and dealt with by the manager. The manager explained how they addressed this. For example, it may involve further training and assessment to ensure staff were deemed competent to continue to administer medication to people who used the service.

Good

Is the service effective?

Our findings

People were supported to have their assessed needs, preferences and choices met by staff that had the right skills and competencies. People and relatives we spoke with told us that the care provided was very good. However one relative told us that sometimes communication between staff could be better. We discussed this with the manager who told us they were looking at ways to improve communication between staff working different shifts. The unit manager on Thorpe Hesley unit showed us a communication book which is used at handovers between shifts.

We looked at the care records belonging to three people who used the service and there was clear evidence that people were consulted about how they wanted to receive their care. Consent was gained for things related to their care. For example we saw people had consented to the use of photographs on care plans and medical records. People were also consulted about their continuing involvement in care plan reviews and these had been signed by the individual or their relative.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and to report on what we find. This legislation is used to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in their best interests and protect their rights. The Deprivation of Liberty Safeguards (DoLS) is aimed at making sure people are looked after in a way that does not inappropriately restrict their freedom.

We found the service to be meeting the requirements of the DoLS. The manager was aware of the latest guidance and was reviewing people who used the service to ensure this was being followed. We were informed that five DoLS applications had been sent to the local authority for their consideration. They told us that most staff had received some training in the subject but they wanted to undertake further training which they were hoping to source in the near future. The staff we spoke with had a good understanding of the principles of the MCA that ensured they would be able to put them into practice if needed.

We looked at completed mental capacity assessments and documents completed for best interest decisions. The manager told us they intended to add further details to the best interest decision documents. This would enable then to demonstrate who had been involved in making decisions on behalf of people who lacked capacity, for example family, GP and social worker.

All new staff completed a full induction programme that, when completed, was signed off by their line manager. We spoke with a member of staff who had not worked at the home for very long. They confirmed the arrangements to ensure they were competent and confident to work unsupervised. The staff member said, “I worked alongside a senior for a while and had the opportunity to read care plans before assisting people with their personal care.”

We found that staff received supervision (one to one meetings with their manager) and they told us they felt supported by the manager and also their peers. The manager had commenced annual appraisals, and staff had been given appraisals for them to complete. They had been told who would complete their appraisal and to make an appointment for it to be completed. Annual appraisals provide a framework to monitor performance, practice and to identify any areas for development and training to support staff to fulfil their roles and responsibilities. Staff we spoke with said they received formal and informal supervision, and attended staff meetings to discuss work practice.

Staff had attended training to ensure they had the skills and competencies to meet the needs of people who used the service. The records we looked at confirmed staff had attended regular training. Most of the staff who worked at the home had also completed a nationally recognised qualification in care to levels two, and three. We saw that staff had received training in dementia care and end of life care level 3. The manager told us that they planned to further develop lead roles for some staff which will include dignity, moving and handling, dementia, and end of life champions. Staff identified as the dementia champions were booked to commence attending peer support meetings in February. This will enable them to network with champions from other care services.

We found the service worked well with other health care agencies to ensure they followed best practice guidance. For example end of life care and living well with dementia. The manager used web sites like the Alzheimer’s society to

Good

Is the service effective?

develop their model of care for people living on Wentworth unit; however this was still in its early stages. The palliative care nurse also had links with the home for advice on medication and support to relative.

The provider had suitable arrangements in place that ensured people received good nutrition and hydration. We looked at four people's care plans and found that they contained detailed information on their dietary needs and the level of support they needed to ensure that they received a balanced diet. Risk assessments such as the Malnutrition Universal Screening Tool (MUST) had been used to identify specific risks associated with people's nutrition. These assessments were being reviewed on a regular basis. Where people were identified as at risk of malnutrition, referrals had been made to the dietician for specialist advice.

The cook told us they received training specific to their role including food safety, healthy eating and food processing. They had a good knowledge of specialist diets. For example they showed us and information folder produced by the provider in conjunction with guidance from the 'Food standards agency.' This was in relation to the 14 allergens. **The Food Information Regulation, which came into force in December 2014, introduces a requirement that food businesses must provide information about the allergenic ingredients used in any food they provide.**

The cook informed us that mealtimes were flexible to meet people's needs. They told us the main meal of the day had been moved to teatime. They said this had been beneficial to people who used the service. We observed that snacks and drinks were available at any time. Snack boxes, jugs of squash and bowls of fruit were placed about the service for people to consume when they wanted. Menus were displayed in the dining areas with the main choices; individual requests and dietary needs were catered for in addition to these.

We joined a group of people eating their meals. We carried out a SOFI during lunch on the second day of this inspection. We saw that people had several choices of hot and cold drinks, including squash and water. The majority of the people were able to eat their meals independently, where people needed support, this was done discreetly by staff. One person told us they were waiting for their onion bhajis to cook as that was what they liked. Others said the like the lighter meal at lunch time and looked forward to their main meal which was served at tea time. Tea coffee, juice and water were served throughout the day and water and juice were available in the lounges for people to help themselves. People were also asked if they would like a glass of sherry which seemed very popular.

People's care records showed that their day to day health needs were being met. People had access to a designated GP who held a regularly for routine consultations and medicine reviews. On the first day of this inspection we spoke with a GP who was visiting to review a person's end of life medication. The GP told us that the home responded to people's need in a caring and professional manner. They said, "Staff are prompt to seek medical attention if needed." Additionally, the district nurses visited the service on a regular basis for routine treatments, such as changing dressings and undertaking blood tests. Records showed that people were supported to attend other specialist services such as the diabetic clinic, audiology and dental services.

Cherry Trees provides care to people living with dementia and had started to create an environment that helped people to orientate themselves around the unit. Bright coloured bedrooms doors were clearly named and memory boxes had been placed at the side of the doors to help people find their bedrooms. Corridors had colourful pictures of old London buses and red telephone boxes.

Outstanding ☆

Is the service caring?

Our findings

People told us they were happy with the care they received. We saw staff had a warm rapport with the people they cared for. Our observations found staff were kind, compassionate and caring towards the people in their care. People were treated with respect and their dignity was maintained throughout. People who used the service and visitors were positive when describing interactions with the staff. One person said, "I am comfortable here; I like to have a lie in until lunch time and then I get up. The staff help me into my wheelchair." Another said, "I can wash myself but staff help me, I am very comfortable here; its cosy." Relatives told us they were more than satisfied with the care at the home. They found the manager approachable and available to answer questions they may have had.

Relatives and visitors to the home told us that there were no restrictions to the times when they visited the home. One relative said, "I come every day at different times and there has never been a problem. Staff always greets me in a friendly manner and offers me refreshments."

We saw there were designated dignity champions. The champion's role included ensuring staff respected people and looked at different ways to promote dignity within the home. We observed that people were treated with respect and dignity was maintained. Staff ensured toilet and bathroom doors were closed when in use. Staff were also able to explain how they supported people with personal care in their own rooms with door and curtains closed to maintain privacy. One relative we spoke with said, "They (the staff) are very good staff make sure they bob in and out of the room to make sure my relative is alright and her needs are met."

We looked at four care and support plans in detail. People's needs were assessed and care and support was planned and delivered in line with their individual needs. People living at the home had their own detailed and descriptive plan of care. The care plans were written in an individual way, which included family information, how people liked to communicate, nutritional needs, likes, dislikes and what was important to them. The information covered all aspects of people's needs, included a profile of the person and clear guidance for staff on how to meet people's needs.

We saw some files we looked at contained a 'This is me' document. This is a tool for relatives of people living with dementia to complete that lets health and social care professionals know about their needs, interests, preferences, likes and dislikes. The manager told us the tool had only recently been introduced and was given to relatives to complete. The information helped staff to better understand a person's needs, if they could not fully respond to the questions staff asked when getting to know them.

The SOFI observation we carried out showed us there were positive interactions between the three people we observed and the staff supporting them. We saw people were discretely assisted to their rooms for personal care when required; staff acknowledged when people required assistance and responded appropriately. For example, One person said, "They are never far away when we're in the lounge." Another person said, "I like to do my own thing, I go outside for a cigarette and can go to the shops if I want to."

We observed staff using mobility equipment such as a hoist in the lounge areas. The staff spoke to the person during the process and managed to assist the person in a very discrete manner, despite the dimensions and layout of the room not being naturally conducive to this. Other people carried on with what they were doing and did not appear to have their attention drawn to the process.

The service had a strong commitment to supporting people and their relatives, before and after bereavement. People had end of life care plans in place, we saw that relatives and significant others had been involved as appropriate. These plans clearly stated how they wanted to be supported during the end stages of their life. 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions were included and where people lacked capacity to make this decision, a mental capacity assessment best interest decision had been made by the appropriate people.

End of life champions had been identified taking a lead on promoting positive care for people nearing the end of their life. The service also had good links with the palliative care nurse, who provided support, when required. We spoke with the palliative care nurse who told us staff were very good at caring for people during this period. We also spoke with a relative of a person receiving this care and they told us, "Staff are excellent; my relative is never left on their own when relatives were unable to visit." We also received correspondence from a relative the letter said, "A calm,

Outstanding ☆

Is the service caring?

compassionate approach was adopted by staff when explaining a progressive condition to family members which proved extremely comforting. My relative was cared for in a professional, loving manner, in clean, comfortable surroundings. In particular, two members of the care team by far exceed our expectations in terms of their professionalism and commitment. In our opinion they provided the highest standard of end-of-life care possible for my relative."

People had chosen what they wanted to bring into the home to furnish their bedrooms. They had brought their ornaments and photographs of family and friends or other pictures for their walls. This personalised their space and supported people to orientate themselves.

The manager told us they would assist people to visit the local churches if they wished. This ensured the spiritual and religious needs of those who considered them of importance were met on a regular basis. We were told that the local church visited periodically and those people who wished to attend were given the information of where and when the service would take place.

Good

Is the service responsive?

Our findings

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. The people we spoke with told us the standard of care they received was good. We looked at copies of four people's assessments and care plans. They gave a clear picture of people's needs. They were person-centred in the way that they were written. For example, they included such information as people's preferences about their likes and dislikes in relation to food and leisure activities, and the times they usually liked to go to bed and to get up.

People we spoke with told us the staff were very caring, and nothing was too much trouble. One person said, "I like to stay in bed until lunch time then the staff get me up, for lunch."

We found that people's care and treatment was regularly reviewed to ensure the care and treatment was up to date. Relatives we spoke with told us they were able to discuss any concerns with the manager. One relative said, "I did raise a concern about how my relative was dressed to go hospital. The senior sorted it out quickly."

We saw that there was a schedule of planned activities that takes place on a daily basis. We spoke with the activity co-ordinator about activities and events that were being planned. The co-ordinator told us that they planned to make more use of the summer house when the weather was better, turning it into a tea room. The co-ordinator told us that time was spent with people who were sometimes cared for in bed. This was to prevent social isolation. She said, "We often assist people who are in bed with their meals, this enables us to chat about current news and about their family and friends."

We saw activities taking place on both units during the two days of this inspection. On the first day activities included a sing-a-long and on the second day there were a lively quiz which resulted in laughter and chatter amongst participants. People said, "We have a great laugh trying to guess who the person was on the video."

The staff we spoke with had a very good understanding of people's needs and how to support them to continue to follow their interests. One person we spoke with told us they had a particular interest in tracing their family tree. They said, "I find the subject very interesting and staff took me to a place where I could continue to research my ancestry I can go back as far as 1700."

We saw that copies of Cherry Trees complaints policy were displayed throughout the home. People we spoke with mostly said they had no complaints but would speak to staff if they had any concerns. The manager told us that there had not been any formal complaints within the past year. Our review of the provider's complaints folder confirmed this. The manager told us that she operated an open door policy which encouraged visitors and relatives to raise any concerns they may have. We saw several visitors and relatives passed the office and acknowledged the manager. Relatives we spoke with complimented the manager's style of leadership and they said they had confidence in her ability to manage any concerns appropriately.

The manager told us that they had introduced relatives meeting although the first meeting was not well attended. It was hoped that the meeting would enable relatives to discuss any concerns and be part of developing the service further. The manager told us the next planned meeting was scheduled to take place on 18 February 2015.

Good

Is the service well-led?

Our findings

People we spoke with told us they knew who was the manager and said they were approachable and would deal with any concerns they might have. One person said, "If you want anything they sort it out for you." Another person said "I'd tell the manager or I could talk to the staff if I'm worried about anything." Relatives told us that the manager was always available. One relative said, "Things have settled down now and we all hope the manager will stay and establish herself. We have got confidence in her."

The service was well led by a manager who has been in post since October 2014 and was awaiting the outcome of a 'fit person interview' with the Care Quality Commission to become the registered manager.

The manager told us they worked well with the local community and had developed close links with schools and Churches. She told us people from the home went to a remembrance service held at the local school and there were plans to attend a fund raising event to support the Alzheimer's Society in the spring.

Staff we spoke with all said they felt supported by the manager and said, "Things are much better now." Staff told us that they understood the standards that were expected of them. Staff attended meeting and felt able to make suggestions about how to improve the service and they were listened to.

The manager had a clear vision of areas that they wanted to develop to make the service better. For example, developing lead roles for key staff which included dementia, dignity and end of life champions. They also wanted to develop dementia services using current best practice guidance.

The manager showed us certificates for staff that had been formally recognised at an awards ceremony in which all of the organisations services attended. Certificates were awarded in areas of dedication, inspiration, excellence, innovation and nurturing achievement. We spoke with some of the staff who said they felt, "Very proud to be nominated" as it meant they had been formally recognised by the organisation.

The provider had effective quality assurance systems in place to seek the views of people who used the service, and their relatives. Surveys were returned to the registered manager who collated the outcomes. Any areas for improvement were discussed with staff and people who used the service to agree any actions which may need to be addressed. We looked at outcomes from the last questionnaires sent to relatives and people who used the service in 2014. They had a 30% return on the surveys sent out. Comments were mainly positive and the manager told us that from the comments received she wanted to develop a 'Friends of Cherry Trees' support group.

The manager told us that they were introducing a comments box in the dining rooms so that people who used the service could give their views about the meals provided.

We looked at a number of documents which confirmed the provider managed risks to people who used the service. For example we looked at accidents and incidents which were analysed by the registered manager. She had responsibility for ensuring action was taken to reduce the risk of accidents/incidents re-occurring.

A number of audits or checks were completed on all aspects of the service provided. These included administration of medicines, health and safety, infection control, care plans and the environmental standards of the building. These audits and checks highlighted any improvements that needed to be made to improve the standard of care provided throughout the home. We saw evidence to show the improvements required were put into place immediately. For example, following a health and safety audit the home recognised that some staff were having allergic reactions to some of the gloves and certain soaps and liquids used to prevent the risk of cross infection. The manager introduced a skin questionnaire for staff to complete to assess which product they should or should not use. This was a positive approach to protect staff for developing skin allergies.