Barchester Healthcare Homes Limited

Cherry Blossom Manor

Inspection report

German Road
Bramley
Tadley
Hampshire
RG26 5GF

Tel: 01256886436
Website: www.barchester.com

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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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 25 and 26 February 2016 and was unannounced. Cherry Blossom Manor provides nursing and personal care for up to 77 people, including those living with dementia. At the time of our inspection 63 people were living in the home. Cherry Blossom Manor is a two storey building built around a secure inner courtyard.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People, their relatives and staff told us staffing levels were not sufficient to meet people's needs. Although rosters indicated that sufficient staff were on duty, it was not clear that they were always deployed appropriately to meet people's needs and wishes promptly.

Staff training had been affected by the lack of a trainer to deliver and drive training in the home. The registered manager was aware of the training that required updating, and had planned for this to be completed. Staff were supported to develop their skills and knowledge to effectively support people through their old age and end of life needs.

People were protected from the risk of abuse. Staff understood indicators that may indicate abuse, and how to raise their concerns. The provider and registered manager investigated safeguarding concerns robustly. They had shared learning with staff and implemented actions to protect people when an issue was identified.

People were protected from health and environmental risks. Risks associated with people's health or wellbeing were reviewed regularly to ensure these risks were managed safely. Environmental checks and servicing protected people and others from potential risks in the home.

People were protected from risks associated with their medicines, because nurses followed safe practices to administer their medicines safely.

The registered manager had completed all required pre-employment checks to be assured people were supported by staff suitable for their roles.

People's consent was sought for the care they received. Where they lacked the mental capacity to make informed decisions about their care, these were legally made on their behalf by those who could represent their needs and wishes. Conditions on authorisations to deprive people of their liberty in order to keep them safe from harm were lawfully met.

People were supported to maintain a healthy and nutritious diet. Their preferences were known and used to encourage people to eat and drink sufficiently.

People's health needs were known and monitored to ensure they were attended by health professionals when necessary. Staff followed guidance to ensure people's health needs were managed effectively.

People and their relatives described staff as caring and friendly. People were involved in decisions about their care, and were reassured when they became anxious. Visitors were welcomed to visit at times suitable for them. People's dignity and privacy were respected and promoted by the staff who supported them.

People's care was reviewed regularly to ensure staff were responsive to their changing needs. Activities and communal areas including a café provided opportunities for people to socialise and interact with others.

People and their relatives were encouraged to provide feedback, and were aware of the process to resolve any concerns and complaints. Feedback was used to inform changes to improve the quality of care people experienced.

Staff were held accountable to deliver their roles effectively. Staff who excelled in their roles were celebrated and rewarded. The registered manager spoke of the support she experienced from the provider, and valued the hard work her staff team invested in the home. Staff told us team work and organisational support had improved since our last inspection.

Audits were used to identify improvements required in the care and support provided. A central action plan was reviewed by senior managers. This held the registered manager accountable for implementing identified improvements to ensure people experienced quality in their care.

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 always safe.

Although staffing levels met the provider's assessed requirement to care for people safely, people, their relatives and staff raised concerns regarding staff availability.

People were protected from the risk of abuse, because staff understood and followed the correct procedures to identify, report, investigate and address safeguarding concerns.

People were protected from risks affecting their health and safety, because monitoring and checks were in place to identify and manage risks safely.

People were supported by staff of suitable character to meet their needs safely.

People were protected against the risks associated with medicines, because staff administered their prescribed medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training was planned and in the process of completion to ensure staff maintained the skills required to meet people's needs. Staff were supported to deliver their roles effectively.

Staff understood and implemented the principles of the Mental Capacity Act 2005 to ensure people were supported to make informed decisions about their care.

People's dietary preferences and needs were effectively met. Staff had identified people at risk of malnutrition, and supported them to maintain sufficient dietary intake.

People were supported to attend health appointments. Effective liaison with health professionals promoted people's health and wellbeing.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were caring and friendly.

People's wishes informed their care, and visitors were welcomed to visit at times suitable for them.

People's dignity and privacy were respected and promoted by the staff who supported them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People enjoyed chatting with staff, but staff did not always have sufficient time to meet this need.

People's changing needs were identified, assessed and managed responsively.

People and their relatives understood the process to raise concerns, and these were resolved appropriately.

Is the service well-led?

Good

The service was well-led.

People's and their relatives' views were used to help improve the care people experienced.

Staff were held accountable to deliver their roles effectively. They spoke of improving team work and organisational support.

Audits were used to identify and drive improvements to the quality of care people experienced.

Cherry Blossom Manor

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 checked 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.

The inspection took place on 25 and 26 February 2016 and was unannounced. The inspection team consisted of three inspectors.

Before the inspection we looked at previous inspection reports and notifications that we had received. A notification is information about important events which the provider is required to tell us about by law. We reviewed information shared with the Care Quality Commission (CQC) by commissioners of care. A Provider Information Review (PIR) was being prepared at the time of our inspection, as the deadline for submission was the following month. A PIR 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. We discussed the contents of the PIR during our inspection to review the quality of care people experienced.

During our inspection some people were unable to tell us in detail about their experience of the care they received. We observed the care and support people received during our inspection to inform us about people's experiences of the home. We spoke with 12 people and five people's relatives to gain their views of people's care. We spoke with the regional director, registered manager, two nurses and four care workers. We also spoke with ancillary staff in catering, maintenance and domestic roles. We use the term 'staff' in this report to refer to a mix of staff roles, including management, care and nursing.

We reviewed five people's care plans, including their daily care records, and medicines administration records (MARs). We looked at four staff recruitment and supervision files, and the staff roster from 18 January to 21 February 2016. We reviewed policies, procedures and records relating to the management of the service. We considered how people's, relatives' and staff's comments and quality assurance audits were used to drive improvements in the service.

We last inspected this service on 5 and 10 March 2015. We did not identify any breaches of the Regulations at

that inspection, and rated the home as Requires Improvement.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they were not always assured that sufficient staff were available. One person commented "I don't think there is enough staff as when they are busy I have to wait for a long time for them to answer my bell". A relative said "Staff do their best, but there is just not enough staff to meet every resident's needs. Staff are fantastic, they are so short staffed". People's and relatives' comments indicated that there were not sufficient staff to spend quality time with people, although their needs were usually met promptly. During our inspection call bells were answered promptly. Staff were patient and responsive to people's needs, but did not appear to have time to sit and chat with people to provide the social connections and reassurance people valued.

Staff told us they were always busy, especially when rosters were affected by unexpected short notice absence. They said they sometimes struggled to respond to call bells promptly. Staff comments included "Staff are always rushed", and "Staff do not have sufficient time to interact with residents, they only have time to complete the required tasks". They told us the skills and knowledge mix of staff was not always considered to ensure people were supported by staff they recognised, or who knew their needs well.

The registered manager explained that they struggled to recruit permanent nurses of the required calibre because of the home's geographical area. They told us staffing had been strengthened by recruitment of care workers, and the reliance on agency nurses was mitigated because of the consistency and quality of the agency nurses used. The registered manager described the employment of care workers as "Just enough", but confirmed that short notice unexpected absence could occasionally affect planned rosters. The deputy manager and registered manager were trained nurses, and were available should nurse staffing be reduced due to unexpected absence.

The provider's dependency tool was used to identify the number and skills of staff required to meet people's needs. This took into consideration changes that affected people's needs. The registered manager told us this tool "Worked well, but there is no slack". The tool had not been altered recently to account for a reduction in the number of people living in the home, which meant the home was slightly over-staffed according to the dependency tool used. The registered manager reviewed rosters daily to ensure sufficient staff were planned for the next day's shifts. They took steps to source replacement staff where a need was identified, for example in response to late notice absence. Some maintenance and activities staff had been trained as care workers, and their working day was flexible to cover this role when required. The maintenance person confirmed this did not affect safety in the home, and care workers were aware of activities they could run for people in the activity staff member's absence.

A maximum of three nurses were required for each shift. The roster demonstrated that although sufficient nurses were available to cover the roster, a total of 25 agency nurses had been used over a five week period. The nurses' role included daily management of care workers on each unit to ensure people's needs were attended to promptly. Care shifts were fully, and on occasion over staffed for all shifts bar two in the same period. The roster indicated that sufficient staff were available to safely meet people's needs, but comments and our observations indicated that they may not always be managed efficiently.

The regional director and registered manager were aware of the consistent concerns raised regarding staffing levels, but were confident that the dependency tool they used accurately indicated the required staffing level. During our inspection they had agreed a plan that would enable them to identify the cause of the discrepancy between their identified staffing requirements and the feedback they received from people, their relatives and staff. The findings from this plan would be evaluated to ensure staff were deployed appropriately to meet people's needs and wishes.

All the people we spoke with said they felt safe with staff. Staff we spoke with understood indicators of abuse and the process to report any concerns. They were aware of the whistle blowing procedure if they were not satisfied that issues were dealt with appropriately in the home.

Senior staff in the home had completed additional safeguarding and investigation training to ensure they were able to respond appropriately to safeguarding concerns. A safeguarding concern raised since our previous inspection had been robustly investigated by the registered manager and provider. They had implemented actions following their investigation to ensure people were protected from potential harm or abuse. The learning from this investigation had been shared with care and nursing staff to ensure the issues identified were understood and would not be repeated. People were protected from the risk of abuse, because staff understood how to identify indicators of abuse, and took actions to protect people from harm.

Staff were trained to assess and manage risks associated with people's health and wellbeing. Specific training ensured they were able to identify and address issues such as managing people's pressure care and falls risks. For example, people at risk of developing pressure ulcers were regularly repositioned as required, and their nutritional intake was monitored as this could affect their skin condition. Nurses understood factors that affected people's risk of falling, including their footwear, medicines and health. Measures were put in place to support those at risk or with a history of falling, such as supporting them to exercise safely, or reminding them to use walking aids. Risk factors were identified and safely managed.

Guidance on people's care plans ensured that care workers were informed of safe methods to support people's needs. For example, it noted the type of hoist and the number of care workers required to assist when people transferred between their bed and chair. Risks were reviewed at least monthly to ensure they addressed people's changing needs. Where people's risk rating had altered, for example in response to further falls, actions had been taken to protect the person from harm. For example, sensor mats were used to alert care workers when people at risk left their beds at night. A falls diary alerted nurses to changes and trends related to people's identified falls risk. The diaries were reviewed by the registered manager and community nurse to ensure all appropriate actions were in place to support people's needs and promote their safety.

The maintenance person carried out regular checks, and ensured required servicing by external contractors was completed to protect people and others from potential harm in the home. For example, fire extinguishers had been serviced in November 2015, and the gas safety certificate was renewed in October 2015. Staff were trained to support people in an emergency, such as a fire in the home. Agency staff confirmed that they were shown fire exits and the fire procedure was explained to them as part of their induction before they began work. Permanent staff were required to attend regular fire drills and complete and refresh training to ensure they understood how to keep people safe in the event of a fire.

In addition to daily reviews of the environment and responding to issues highlighted by staff, the maintenance staff completed routine checks, including water temperature checks, flushing water outlets, and ensuring window restrictors were secure. This meant people were protected from environmental hazards such as scalding, Legionella disease and falling from height. Legionella disease is an illness caused

by a water borne bacteria that can be found in stagnant water. People and others were protected from potential risks in the home, because required checks were completed.

Records demonstrated a robust recruitment process that met legal requirements. All required checks had been completed, including identity, reference of good conduct in previous employment and full employment history. Disclosure and Barring Service (DBS) checks had been completed to assure the provider that staff were suitable for their appointed role. DBS checks disclose criminal records that may mean an applicant is unsuitable to support people. Nurses' registration was checked to ensure that nurses were on the active register of the Nursing and Midwifery Council. The provider took all appropriate actions to assure themselves that staff employed were of suitable character to support people safely.

People's medicines were stored, administered and disposed of safely. Medicine trolleys were not always kept locked when the nurse stepped away to administer people's medicines. However, they were positioned to ensure the nurse kept the trolley in view, and others were unable to access the trolley's contents. Medicine containers were labelled when they were opened, and stock checks ensured that medicine records accurately reflected the medicines stored. The pharmacy had conducted a medicines audit in February 2016. Recommendations from this had been implemented at the time of our inspection.

People's medicine administration records (MARs) demonstrated that people received their prescribed medicines at the times required. Nurses were aware of people's time specific medicines, and ensured that people received these as directed to manage known health issues. People's allergies were clearly recorded, to ensure people were protected from possible harm. Some people's health needs meant they required regular checks, for example to monitor blood glucose levels to control diabetes. Records demonstrated that nurses completed these checks and used them to ensure people were administered their required medicines safely.

Requires Improvement

Is the service effective?

Our findings

An overview of current staff training completion indicated that training had been refreshed since our last inspection. However, for newer staff, and those whose training had been up to date at our last inspection, records showed that 23 of the current 43 care and nursing staff listed had not completed or refreshed all their required training in accordance with the provider's requirements. For example, 13 nurses and care workers had not refreshed their moving and handling training within the previous 12 months, and 14 nurses and care workers had not completed or refreshed training in the Mental Capacity Act (MCA) 2005. Staff spoke knowledgeably about applying the principles of the MCA 2005, indicating that they had the skills and understanding to meet people's needs effectively.

The registered manager explained that the provider's home trainer had been promoted to another role, and this had affected training arrangements. Training had already been arranged to refresh staff in moving and handling and infection control skills. Where mobilising equipment was used, this was usually managed by two care workers working together. Induction training for care and nursing staff included an introduction to safe moving and handling. All staff were required to complete their induction before they worked alone. This reduced the risk of people being supported by untrained staff. Two nurses had been trained to deliver moving and handling training in the home, and a new full time trainer had been appointed. The registered manager told us they had been overseeing training, and the overview provided for us demonstrated that she was aware of the training that required completion. The new trainer was expected to ensure all training was brought up to date within two months of our inspection.

Staff we spoke with confirmed that they completed and refreshed their required training. They told us of some of the training they had recently completed, including moving and handling and fire safety. Rosters demonstrated that staff were provided with protected time to complete required training. This meant that staff were not rostered for care delivery on these days so they could concentrate on their training. All staff, including long term agency nurses, were required to complete and refresh the provider's mandatory training. Care workers were supported to gain relevant health and social care qualifications. The registered manager explained that they planned to train all care and nursing staff in the 'Six steps' programme for end of life care, and staff rosters were planned to enable staff to attend training sessions. At the time of our inspection, 60% of the designated staff had completed this training.

Nurse training ensured they were able to maintain their professional status. They understood their professional role and responsibilities, for example to ensure records were updated and reviewed regularly to reflect people's current needs. Additional training had been arranged to support them to understand how to complete people's care plans to meet the provider's standards. They were able to attend external training days, such as diabetes study days, to maintain their professional status and equip them with the knowledge to deliver their nursing role effectively.

Records demonstrated that staff were supported with regular supervisory and staff meetings. These provided opportunities to discuss and resolve issues or concerns individually or as a group. Care workers were given lead duties and tasks, demonstrating that they were entrusted to make improvements in the

home. Where issues had been identified, for example in completing record keeping in a person-centred manner, care workers had been supported to learn through teaching sessions and group discussions. This demonstrated that staff were supported to develop the skills required to ensure people's needs were met effectively.

Care workers listened to people's wishes, and ensured they were given choices, for example in where they spent their day, the activities they attended, and their meals. One person was booked to see the hairdresser during our inspection. A care worker checked with them that they still wanted to attend. They explained that it was long walk to the home's salon, and asked the person if they would prefer to use their wheel chair or walk. A staff member told us "Residents can do pretty much whatever they want".

The MCA 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interest and as least restrictive as possible. Nurses had been trained to assess people's mental capacity should they be concerned that people were unable to make an informed decision about their care or support. The provider's MCA 2005 toolkit guided them to assess and record their findings, and any subsequent decision made in the person's best interest. People's care plans evidenced that these assessments had been completed appropriately. Their relatives or others, such as health professionals and staff who knew them well, were included in discussions to ensure the person's needs and wishes were used to inform their plan of care. People's consent was sought for the care they received. Where they lacked the mental capacity to make informed decisions about their care, these were legally made on their behalf by those who could represent their needs and wishes.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where DoLS had been applied for and/ or granted, records showed that mental capacity assessments and a best interest decision had informed the application, for example regarding the use of bed rails to keep people safe at night. DoLS applications were reviewed in accordance with people's changing and increased needs.

People spoke positively about the choice and quality of food provided. Comments included "The chef will make whatever food I ask" and "The food is delicious, we must have the best chef ever". The chef told us "Meals are a social occasion, they are massively important for people". The chef told us they enjoyed serving meals, as this gave them the opportunity to assess people's enjoyment. They chatted with people about their mealtime experience and preferences, and used their feedback to inform menu changes.

The chef was told of people's specific dietary needs before their arrival, but always spoke with them when they arrived to discuss their preferences. People's dietary intake was monitored for the first few days after their arrival until staff were assured they were eating and drinking well. The chef told us staff informed them when people's weights decreased, so that they could fortify meals as necessary. They told us catering staff were "Always in the know" because communication between staff worked effectively.

People were supported to choose drink and menu options. Menus were placed on dining tables, but care workers also showed plated meal options to support people to select their choice. People were provided with aids to help them eat or drink independently, such as lipped bowls and glasses with double handles. When appropriate, people were assisted to eat their meals. Care workers were prompt to identify when people were not eating well, and offered to cut food up or otherwise help people to encourage them to eat.

Meals were not rushed. A care worker sat quietly supporting a person unable to eat independently in their room. The care worker waited for the person to finish each mouthful before offering the next, and offered sips of drink regularly. They ensured the person's mouth was wiped to maintain their dignity. The meal offered was thickened and pureed, in accordance with guidance from the speech and language therapist (SALT). This ensured that the person's dietary needs were met.

Monitoring charts were used effectively to record people's daily food and fluid intake when these were associated with dietary or health risk. One person required their fluid intake to be restricted to manage a known health condition. Staff were considerate of this person's thirst, but encouraged them to keep their liquid intake within the preferred limits as far as possible. Monthly nutritional meetings and reports provided opportunities for staff to discuss and review people's nutritional care needs. They considered weight gain or loss over a weekly and six month period, and the impact of health conditions such as dementia or dietary restrictions. They ensured people were reviewed by the GP, SALT or dietician as necessary to manage their nutritional needs effectively.

Indicators of poor health related to known health conditions were documented in people's care plans. This ensured that care workers were aware of signs of poor health, and understood the requirement to alert nurses to these changes.

People were supported to attend or be visited by health professionals as their needs required. Liaison and guidance from health professionals was discussed during clinical meetings, and documented in people's care plans. Staff were informed of the actions required to manage people's known health issues. For example, referral to the SALT and falls clinic, and guidance from a tissue viability nurse, were discussed in a clinical meeting during our inspection. Urine and blood samples were taken when people's health indicated concerns. The nurses liaised effectively with the GP to ensure the results of tests were used to inform the treatment people received to manage their health needs. Clinical meetings demonstrated that nurses were well informed of people's changing needs, and guidance from health professionals to address these was effectively implemented.

Good

Is the service caring?

Our findings

People and their relatives spoke positively of the caring nature of the staff who supported them. Comments included "Staff are very nice" and "Staff are very friendly and helpful". One person told us the care workers were "Lovely girls, nothing is too much trouble", and another told us "I can't praise the home enough, it was the best move that I made [choosing to live here]". One relative told us they were very pleased with their loved one's care, stating "I think that mum is well taken care of. It is an amazing facility. It is generally a good home". Thank you letters and cards from people's relatives praised the care and support staff had provided for their loved ones.

Although staff were busy, when they were able to speak with people it was enjoyed by all. Conversations between people and staff were personal and knowledgeable. We observed staff in all roles showed interest in people's activities and wellbeing, and administrative staff chatted with people about their families and weekend plans. This helped people to feel valued and included in other's lives. Staff listened and responded to people's requests.

A care worker supporting a person to the hairdresser checked that they had everything they needed before they left their room, and gently reassured them when they became anxious. The care worker was thoughtful and cheerful, and supported the person with compassion. All staff, including agency workers, knew and addressed people by name. This helped people to know they had the staff's attention, and provided reassurance that the staff member knew them and their needs.

One care worker was supporting a person to prepare their breakfast. The care worker offered a variety of toppings for the person's toast to ensure they provided the topping wanted. They showed them the options, and checked that they had selected the person's choice before they assisted them to top their toast. Staff were patient and caring with people.

People's care plans detailed information that promoted their wishes and things that were important to them. For example, one person's care plan noted their preference for the skin care products used. It noted the times people wished to get up or go to bed, and their preferences, such as the number of pillows they wanted, and whether bedroom lights should be left on or turned off. This ensured that people were supported and cared for in accordance with their wishes.

Visitors were welcomed into the home throughout the day and evening. One person confirmed their relatives and friends could visit "Anytime they want". A café near the reception area provided an inviting communal area for people to mix, or to meet with their visitors. Drinks were available for people and their visitors to help themselves. A range of communal rooms in the home provided a choice of meeting venues for people and their visitors to mix or spend quiet time out of their rooms.

People and those important to them were invited to attend care plan reviews. This gave them the opportunity to discuss any changes to their care or support they would like. One relative told us "We are fully involved with mum's care plan".

People's care plans reminded care workers to be discreet when assisting people to the toilet, and promote their dignity and privacy at all times. We observed staff were respectful of people's dignity and privacy.

Actions to support people requiring end of life care were understood and implemented by nurses and care workers. A directory ensured they had key contact numbers available to request support when necessary, for example from the specialist palliative care team or bereavement support groups. Staff were completing training to understand and deliver best practice in end of life care. A lead nurse reviewed care and nursing practice as well as paperwork to ensure people were supported with care and compassion when they needed end of life care.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us staffing levels were not sufficient to provide the level of social stimulation people wanted and valued. A relative said "A few more staff would make this home good ". One staff member commented "If we had more staff then we could spend more time with the residents". Staff appeared to be too busy to spend quality time with people.

People's social needs were discussed at clinical meetings. Where people chose not to socialise, or their care needs meant they spent a lot of time in bed, nurses noted on the allocation sheet that care workers should visit them regularly to chat with them. Monitoring charts noted that people's health needs were met regularly, but daily records did not clearly demonstrate that their social needs were also supported regularly. Staff told us they did not always have sufficient time to meet people's social needs.

Relatives did not always feel that activities were available or suitable for everyone, and one relative told us "Some residents do not have enough stimulation". Some people spoke positively of the activities available in the home. One person told us "The activity staff do activities in my room [with me] which I like", and another said "I join in with some activities if they are of any interest to me".

People's care records documented the activities they participated in or enjoyed, including reminiscing and socialising in the home's café. Nurses knew people who enjoyed visits from a staff member's dog, and encouraged this to lift people's spirits. Some people's records had not been regularly updated or reviewed to evaluate their inclusion or enjoyment of the activities provided. People's known interests, hobbies or employment were not always used to inform the activities provided.

There were games, books and films available in communal lounges for people's use. Lounges were decorated in a homely fashion, and clothes were left on hangers in one lounge for people to fold if they wished. This provided the opportunity for people to engage in an activity related to their life experience. An internal courtyard included raised flower beds, which enabled people to join in with gardening activities in good weather if they wished. Posters on noticeboards informed people of planned activities in the home and local community, including dance classes, walks, and church services. People told us the home was well presented, and they enjoyed the companionship of living with others. One person told us "My family think it is a five star hotel".

People's needs were assessed, and this information was used to inform their plan of care. This was reviewed at least monthly to ensure their care plans remained current and met people's identified care needs. Some people stayed in the home regularly for respite care. Their needs were re-assessed at each visit to ensure their care plan remained responsive to their identified needs. Assessment tools were used appropriately to highlight changes to people's needs or risks associated with their care, for example to monitor weight loss. People, and their relatives when appropriate, were involved in care plan reviews, to ensure these reflected the care they wanted, as well as what they needed.

Daily records and charts demonstrated that people were supported in accordance with their plan of care.

For example half hourly or hourly observations were noted for people who were known to be unsettled, anxious or at risk of falling. Changes to these charts were discussed at clinical meetings, and this information was communicated to care workers promptly. One person's observation charts reflected a change agreed within a few hours of the clinical meeting, demonstrating that required changes to people's care were quickly implemented. Nurses reviewed people's care following accidents or incidents to ensure their care was responsive to their changing needs. For example, when a person had a fall resulting in a hospital admission, nurses identified that health issues had been affected by insufficient fluid intake. This person's fluid intake was now monitored regularly to promote their wellbeing. People's care was responsive to their changing needs.

People's likes, dislikes and preferences were documented in their care plans, along with their social, cultural and religious wishes. This meant that nurses and care workers were informed of people's preferences, and could engage people in conversations that were meaningful to them. Where people were unable to verbally inform staff of their needs or wishes, a communication log described how the person made these known. It was evident from their care plans that people's relatives had been asked to contribute to their care plans to inform staff of people's wishes where they were unable to do so for themselves. This meant that people preferences were known.

Some relatives had shared with us concerns they had raised with the registered manager. She explained the actions in hand to resolve the concerns shared. A relative told us "I know who to speak to if I had a concern, I find them very approachable". When people's relatives had raised concerns or requested particular staff actions to meet people's needs, these were shared at the clinical meeting to ensure they were implemented. For example, one person's care plan reflected a relative's concerns about continence care. This ensured that care workers were reminded of the actions required to remain responsive to the person's needs.

A leaflet available throughout the home invited people and their visitors to provide feedback. This explained how to provide comments, either in the home or electronically, and how this would be shared with others considering Cherry Blossom Manor as a home. Responses we saw were very positive about the care provided.

The provider's complaints policy was explained in a welcome booklet available in the home. The registered manager logged all complaints on to a central system that senior managers reviewed, and updated this as complaints were resolved. This demonstrated that the provider's complaints policy was followed to resolve complaints to the satisfaction of the complainant. At the time of our inspection there were no unresolved complaints.

Good

Is the service well-led?

Our findings

A relative told us "We are given the opportunity to attend relatives meetings and minutes are available if we want them". People were invited to attend monthly meetings to share their ideas and concerns. People had been encouraged to take on the position of chair for these meetings, so that they could set their own agenda and drive the meetings. Relatives supported people in resident and relatives meetings on the dementia unit. Feedback in staff meetings and actions to address concerns shared demonstrated that people's views informed their care and support. For example, comments raised regarding dirty crockery in a residents' meeting in January 2016 were discussed at the staff meeting in February 2016, with a plan to address the concerns agreed.

The provider's welcome booklet introduced people and their visitors to key staff in the home. It explained services available, such as the hairdresser and chiropractor, as well as key policies and procedures, such as the complaints policy and fire procedure. Leaflets in the home's café included a child friendly 'Visiting Gran's home', to help children understand people's needs and why they had moved into residential care. Liaison with a local hospice provided people and their families with reassurance that people's end of life care was managed compassionately.

A survey held in August 2015 was completed by 22 people who were living in the home at that time. This demonstrated an improved satisfaction rating from the previous year. All respondents stated they were content with the care and support provided, and felt staff were skilled to meet their needs. Twice as many people stated they were satisfied with the availability of staff than in the year previously, with a satisfaction rating of 90%. The registered manager had reviewed responses, and made some changes in response to the views shared. For example, feedback on menu choice and food quality rated poorly in comparison with other factors of people's care. During our inspection, people told us they enjoyed the choice and quality of food available, and recent feedback to the provider confirmed this area of care had improved.

The provider's vision and values were displayed in the home. This stated that quality informed all that they did. Staff were expected to work together to improve the communities they served, acting respectfully, honestly, fairly and ethically, and should accept responsibility for their actions. The provider's role was to make people's lives meaningful and enjoyable, with a focus on people's abilities and aspirations. Actions implemented in the home demonstrated that people's views and feedback informed the care they experienced.

The registered manager described the workforce as "Enthusiastic and motivated", and told us staff "Worked well together". She valued her staff team, and felt valued and supported by the provider, describing the regional directors as "Fantastic" and "Motivating". Staff were held accountable for delivering their roles, and actions were allocated to named staff members to ensure responsibilities were owned and met. One staff member told us "I'm pretty happy with how things are going", and described the registered manager as "Supportive". Incentives, such as 'Employee of the month', rewarded staff for excelling in their roles.

Staff comments about the service were mostly positive. Some staff told us they worked well together, and

shifts ran smoothly. They told us they saw improvements in the running of the home, although there was "Still lots to be improved". One staff member described the work force as "Much better organised now".

The regional director explained the actions implemented following issues identified with record keeping. It was found that some people's monitoring charts had not always been fully completed. Daily notes and care plans had not always been updated or completed fully to clearly demonstrate that required care was provided to meet people's identified and changing needs. An independent consultant had provided support to the registered manager to analyse and identify trends. Learning was shared and actions implemented to address the issues identified.

The registered manager audited people's care plans to ensure record keeping issues had been addressed. Where issues remained, she had reassessed the care plans regularly to monitor progress until all required updates had been completed. The registered manager told us "Record keeping is 100% better" following concerns shared and investigated in September 2015.

In conjunction with clinical meetings, these actions ensured that changes to people's needs were promptly identified and documented. Nurses had been trained to complete paperwork thoroughly, and were held accountable for updating people's care plans. The registered manager was assured that required actions, such as referral to health professionals or close monitoring of health conditions, were implemented in accordance with the provider's and health professionals' guidance.

The registered manager completed clinical governance audits monthly. Areas of care including personalised care, management of complaints, documentation and medicine administration were reviewed to identify where any improvements were required. A review in January 2016 had identified some concerns regarding medicines storage. The pharmacy had completed an independent audit in February 2016 to ensure that the actions identified internally had been addressed. The pharmacy audit, and our own findings, did not identify issues with medicines administration, indicating that appropriate actions had been implemented.

Critical incident analysis was used to review and reflect on actions taken in response to accidents and incidents. Staff were encouraged to consider what they did well, and any improvements that could be implemented to manage a similar situation better. Learning was shared with staff to drive improvements to the care people experienced. The regional director described monthly regional meetings as an opportunity for registered managers to network, sharing information, best practice and learning.

The registered manager compiled a central action plan that recorded all required responses to identified issues, such as complaints, accidents and safeguarding concerns. It also logged any concerns identified from monthly quality of care audits the registered manager completed in the home. This action plan was held electronically to enable the provider's senior managers to monitor progress towards completion. The registered manager was held accountable for delivering the required actions to improve the quality of care people experienced.

The regional director carried out bi-monthly quality first audits at Cherry Blossom Manor. During these visits the registered manager's action plan was reviewed to ensure required actions were being progressed in a timely manner. These audits were sometimes themed to analyse information across the provider's services. This enabled them to identify trends and put actions in place across their services to make improvements to people's care. A quality first audit in December 2015 recognised areas of improvement since the previous audit, such as monitoring chart completion. This demonstrated that audits were used effectively to identify and review areas of improvement required. There were suitable systems in place to identify and resolve issues. Feedback, audits and reviews were used to drive improvements in the quality of care people

experienced.