Mr & Mrs MF Joomun

Cherry Leas Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Cherry Leas is a residential care home providing accommodation and personal care to up to 16 people in one adapted building. The service provides support to older people and people living with dementia. At the time of our inspection there were 15 people living at the service.

People's experience of using this service and what we found
The provider did not have sufficient oversight of the quality of the service or the risks to people's safety. Risks were not always effectively monitored to ensure appropriate action was taken to keep people safe. Risks were not consistently identified, and risk assessments did not always contain up to date information. There was a lack of oversight of incidents and accidents which meant the provider was not able to demonstrate action taken to mitigate the risk.

The provider did not have effective systems and practices to safeguard people from the risk of abuse. There was not clear oversight to identify trends and prevent the risk of reoccurrence. Statutory notifications were not routinely made to CQC regarding safeguarding referrals and serious injury to people who used the service.

The provider did not have a clear system to learn from events and take appropriate action to improve safety. Not all staff members felt able to raise concerns.
The fire risk assessment did not appropriately identify all the risks to people who lived at the service.

The provider did not ensure support for staff was consistent and effective. Staff members told us they did not always feel able to be open when things went wrong, and they did not always feel they were treated equally.

People were supported by staff who knew them well and people's relatives spoke positively about the care they received. However, there were not enough staff to support people to stay safe and meet their needs.

People received their medication as prescribed. The provider had assessed staff competency to help ensure they understood how to support people appropriately with their medicines. However, not all records were maintained in line with national guidelines.

The provider did not follow or meet national guidance in relation to infection control. The premises at Cherry Leas Care Home were not clean and hygienic, which put people at risk of infection.

The provider did not have embedded systems for good quality assurance. The service was not proactively using systems to identify areas for improvement. Where concerns had been identified appropriate action had not been taken to address the issues raised.

The provider did not always ensure collaboration with external stakeholders. There was little evidence of working in partnership to make improvements to the service.

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

Rating at last inspection
The last rating for this service was good (published 10 January 2018).

Why we inspected
We received concerns in relation to the management of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from Good to Inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

Enforcement
We have identified breaches in relation to safe care and treatment, governance, staffing and failure to notify CQC of other incidents at this inspection.
Please see the action we have told the provider to take at the end of this report.

The provider responded promptly to the concerns raised during the inspection, sending a comprehensive action plan detailing the action to be taken to reduce the level of risk.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Cherry Leas Care Home on our website at www.cqc.org.uk.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Cherry Leas Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

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

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Cherry Leas is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Cherry Leas is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
Many of the people living at Cherry Leas Care Home were not able to talk to us about their experiences of the care being provided. We 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 also spoke with two people and four relatives, about their experience of the care provided. We spoke with nine members of staff including the provider, the registered manager, senior care workers, care workers, the cook and the domestic. We reviewed a range of records which included people's care records, monitoring charts, risk assessments and medicines charts. We looked at three staff files in relation to recruitment and records relating to the safety of the environment and governance systems at the service.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● Risks to people's safety were not always effectively monitored to help ensure appropriate action was taken to mitigate future risk. For example, the provider's accident and incident log evidenced a person who lived at the service had fallen four times since September 2021. On each occasion the person was checked over and it was recorded that no injuries were found. No analysis had taken place to identify whether any of the falls were preventable and there was no clear information regarding action to be taken to mitigate the risk of the person falling again.

● One person's care plan demonstrated they had consistently lost weight since January 2022. However, the care plan did not give any other information regarding this weight loss. There was no investigation into why the person was losing weight, and no action plan to ensure this was addressed. This placed the person at risk of continued weight loss and potential poor health outcomes.

● Individual risk assessments had not always been updated to reflect changes in the support requirements of people who lived at the service. For example, one person had an unwitnessed fall on 5 February 2022 resulting in serious injury and hospitalisation. The falls risk assessment for the person was last updated on 19 December 2021 and no analysis had taken place since the fall to identify whether it was preventable. There was no update to the care plan in relation to this fall or information regarding adjustments that may have been required to prevent further occurrences.

● The fire risk assessment did not appropriately identify all the risks to people who lived at the service. Personal emergency evacuation plans (PEEPs) did not clearly outline the support needs of each person. A report of non-compliance from the fire authority had been issued to the provider regarding aspects of the environment that required action to make them safe. We found the provider had not taken action to meet all the identified risks.

● Environmental risks were identified during the first inspection site visit on 21 April 2022, including wardrobes at risk of falling as they were not affixed to bedroom walls; a gate at the top of fire escape stairs was easy to open posing a risk of falls; a gate to the kitchen area was easy to open posing a risk of access to kitchen appliances and utensils. On the second site visit on 27 April 2022 we found that the provider had addressed most of these risks, although some wardrobes still required fixing to the wall.

The provider had not effectively assessed and managed risks to people's safety. This was a breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider responded promptly to our feedback, providing an action plan detailing how action would be taken to address these concerns. We observed some action had been taken to address environmental and infection control risk at the second site visit on 27 April 2022.

Staffing and recruitment

● There were not enough staff available to support people to stay safe and meet their needs. The registered manager told us there should be three members of staff for both the morning and afternoon shifts, we reviewed the rotas for the service across a two-week period and found just four shifts where three staff were on duty. For the rest of the dates reviewed, there were consistently two members of staff on duty for the morning and afternoon shift.

● The provider completed a dependency tool to calculate staffing levels in the service. However, this did not take account of the time taken for one staff member doing a medicines round, or the time taken to support people with certain aspects of their personal care, such as bathing. The provider had not considered the additional time taken to clean the home, as the domestic worked only three mornings per week. One member of staff told us the home could do with more staff, as when there were two carers on a shift and one was doing the medication round, there was just one person left to oversee the people.

● One person who required the assistance of two carers to mobilise was observed walking to the bathroom and moving from the dining room to the lounge, was assisted by only one staff member. Their care plan had not been updated to reflect the recent change to their level of need regarding mobility and assistance required.

● Limited interaction was observed between the staff team and people living in the service. We observed people waiting for support and interactions were tasks based with limited interaction or socialising. One person was supported into the lounge in a wheelchair and waited for approximately ten minutes to be moved to an armchair. The transfer by the care staff was observed to be respectful and the staff member spoke to the person about what was happening during the transfer. A second person was also supported into the lounge in a wheelchair and was still waiting to be transferred to an armchair after approximately ten minutes.

● One staff member told us they felt residents lacked stimulation, another stated that they did not have time to do anything with the residents, a third said that more staff were needed. Of eight staff spoken with, six stated they were stretched, short staffed, and there was no time to do anything with people who lived there. Staff told us, "We could do with more staff. (Not having enough staff) can impact on people due to the nature of care needed as people have higher needs (e.g. mental health). There are often only two (members of staff) on a shift. If (one) is doing meds (the medication round) this leaves the other staff member alone. Residents lack stimulation. The carers role is huge, we need an activities co-ordinator" and we "..try to do some activities if (we) have the time" and "It's all a bit stretched, there are a handful of us that do over our hours and go the extra mile".

● People spoken with during the inspection said the carers were lovely and, they were lucky to have them but also said there could be more of them.

● The registered manager had completed recruitment checks for new staff to ensure they were safe to work in the service. However, not all checks were completed appropriately and not all relevant documentation was kept in the recruitment files. For example, one staff member we reviewed had just one reference, and it was not clear whether references had been verified, dates of employment and gaps in employment histories were not consistently recorded.

The provider had not ensured there were sufficient numbers of persons deployed to meet people's care and treatment needs. This was a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider responded promptly to our feedback, confirming agency staff were being brought into the service to ensure there were three people working throughout the day.

Systems and processes to safeguard people from the risk of abuse

● Systems, processes and practices did not sufficiently safeguard people from the risk of abuse.
● We found there was an inconsistent approach to the management of raising safeguarding referrals to the local authority. For example, one person had three unwitnessed falls, one in July 2021, one in November 2021 and one in March 2022. Records seen demonstrated the fall in July 2021 had been raised as a safeguarding referral with the local authority, but the following two unwitnessed falls had not been.
● The registered manager understood their responsibility to alert the local authority of safeguarding concerns but told us they were not aware of the requirement to notify CQC of safeguarding referrals made or of any serious injury to a person who lived at the service. We saw six safeguarding referrals were recorded as having made to the local authority since July 2021. None of these had been raised as a statutory notification to CQC.
● At the time of the inspection, there was no recorded oversight of safeguarding referrals made to the local authority to help identify themes and trends. A simple oversight log was completed and sent to CQC after the inspection, however, this was incomplete and did not contain information about all the referrals that had been made.

The provider had not ensured the required statutory notifications relating to serious injury and safeguarding were made to CQC. This was a breach of Regulation 18 (Notification of other incidents) of Registration Regulations 2009.

● Despite these concerns, relatives told us they felt people were safe living there.
● Following the inspection, the provider responded promptly to our feedback, confirming that the registered manager was being supported to make the required statutory notifications.
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. However, we saw up to date authorisations had only recently been applied for on people's behalf, and an outcome had not been received at the time of the inspection.

Using medicines safely
● People received their medicines as prescribed. The provider had assessed staff competency to ensure they understood how to support people appropriately with their medicines.
● Four medicine administration records (MAR) were reviewed and these were completed appropriately. A further three MAR charts were reviewed for people new to the service. We found a photo had not been completed for these people and their medicines information was handwritten. However, this had not been signed by the person who wrote it, or witness signed as a double check, to help prevent errors in medication and amounts being given to people. A member of staff told us they would make sure the handwritten MAR charts were signed after the medicine round.
● Staff members were observed giving medicine respectfully to people.

Preventing and controlling infection

●The service does not follow or meet national guidance in relation to infection control. People are at risk because there is poor prevention and control of infection

● The home was not clean. For example, toilets, commodes and toilet brushes were observed to be dirty which posed a risk of infection. Following our feedback, the provider purchased new toilet brushes for the service.

● The home was not hygienic. For example, there were open bins that were half full and dirty, there were unpainted radiator covers which meant they were porous and could not be properly cleaned. A bathroom was observed to have continence pads and a mattress in the bath. A shower room with a dirty toilet seat which was being used as a storage area for walking frames, a stand and a catheter bag on a stand. This posed a risk of infection to the people who lived at the service. Following our feedback, the provider removed stored items from the bathroom and shower-room. The action plan provided stated a full-time domestic was due to be appointed.

●The manager told us there was no risk assessment for clinically vulnerable groups of people regarding COVID-19. For example, black and minority ethnic people and those with physical and/or learning disabilities.

● At the last inspection the premises were in need of repair and renovation. At this inspection, the premises still required attention. Staff told us, "The home is a bit tatty. It needs some money spending on it to bring it up to date". Relatives told us, "The building could do with some money being spent" and "It's clean but could do with a lick of paint".

Visiting in care homes

● The provider had supported visits to the service across the pandemic and lockdown by constructing a visitors' pod in the garden. However, we were told t during a recent outbreak of COVID-19, the home had been closed to all visitors against government recommendations. No action was taken to address this. Relatives were seen visiting people during the site visits to the service.

Learning lessons when things go wrong

● The provider had some processes for reporting and investigating safeguarding incidents and accidents. However, there were not robust and did not include a system for making the required statutory notifications to CQC. Not all incidents were accurately documented and there was no clear approach to analyse or review these to mitigate the risk of reoccurrence.

● Staff members told us that they would not feel comfortable raising concerns with the manager or the provider.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider did not have effective processes in place to monitor the quality and safety of the service. For example, the fire risk assessment did not adequately identify the risks to people who use the service. There was not a system to identify concerns highlighted by the review and assessment of risk. Risks and incidents were not accurately recorded and there was a lack of oversight and learning from these. The tool for reviewing staffing levels was not sufficient and the provider had not ensured the required staffing levels were maintained.
- The provider had not ensured the relevant statutory notifications were submitted to CQC in line with their regulatory responsibilities.

The provider did not have robust processes to monitor the quality and safety of the service. This demonstrated a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the provider responded promptly, providing an action plan detailing how action would be taken to address these concerns. For example, care plans and risk assessments were reviewed by the manager and were to be audited by the provider; action had already taken to address risks identified by the fire service and further action was planned; a new personalised and detailed personal evacuation plan had been introduced and was being completed for each person at the home; a full-time cleaner was due to be recruited and agency staff utilised to ensure three members of staff on the morning and afternoon shift. The provider was overseeing the notification process to ensure required notifications were made to CQC.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider did not ensure support for staff was consistent and effective. Staff members told us they did not always feel able to be open when things went wrong, and they did not always feel they were treated equally.
- Staff told us they did not always feel supported. They told us they did not feel able to raise concerns with the provider or registered manager and did not feel confidentiality would be upheld. For example, they told us they did not "….feel able to raise concerns about staff as the management were not very good or

confidential" and that they "would go to the owner with whistle-blowing concerns, but (did not) feel confident with this". They told us, "I would go to CQC or the local authority to do something about it if there was an issue". Staff told us, "The manager can be off. I don't think I'd be able to talk to her if there were staff problems, she would tell them" and, "The owner would probably just tell (the manager) what I had said".

● Staff told us morale was low in the home and there was not a good atmosphere. For example, they told us, "Morale is quite low at the moment ……You try to keep a smile on your face but it is hard" and "Staff morale is low, we can be short staffed at times" and, 'The staff talk about each other, there isn't always a good atmosphere".

● Staff gave mixed feedback regarding staff meetings with some people saying there were no staff meetings. One staff member told us last one was cancelled because of COVID-19, another said that there were no real team meetings, but the staff team work together and pass information to one another. This meant the staff team did always have the opportunity to meet to give feedback, discuss concerns or share learning.

● Although the training matrix showed training had been completed, staff members told us did not always feel they had enough training to support them in their role. For example, staff told us they had not had an induction or any training since starting at the service and training had been "on the back-burner." Comments included, they had "not done any (training) recently", they could "not remember the last training", they had "not really had any training" and had "not done any training at the home, but (had) completed it elsewhere".

● Relatives spoke positively about the care provided at the service. For example, they told us the staff were caring, and they trusted their relative being there; that the staff were good and were friendly and responsive to any requests.

● Relatives told us that they felt there was good communication and the manager was approachable. Comments included, "The manager is always about. … I feel able to raise complaints and concerns and "Spoken to the manager on a number of occasions. She's always well informed and knows about (my relatives) situation".

●Two staff members told us managers were approachable and they felt supported.

● Two relatives spoken with told us they were not aware of any relative surveys or relatives' meetings which means that relatives were not always asked for their feedback on the service.

Continuous learning and improving care

● The provider did not have embedded systems for good quality assurance and the service lacked drivers for improvement. Quality assurance audits were not consistently up to date; medicines audits were not up to date; recommendations by the fire safety team in January 2022 had not all been met by 21 April 2022 when we observed fire escape corridors were still cluttered.

●The provider did not always provide support and development for staff and did not always act on past risk or where actions were identified.

● Governance structures were not used to support learning. For example, there was confusion among the staff team about whether staff meetings were held. The staff meeting minutes we reviewed did not contain information about accidents, incidents or safeguarding so learning could be shared, and action taken to make changes and improvements.

Working in partnership with others

● One external partner informed CQC the management at the service was not always open to making the changes needed to make improvements. They told us there was a defensive attitude at the service.

● The provider had sought input from external professionals, such as the fire safety team. Essex County Council had conducted an infection control audit.

● The provider worked with healthcare professionals, such as GPs and district nurses to support the care and treatment needs of the people who lived at the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 The Care Quality Commission (Registration) Regulations 2009 (Part 4) Notification of other incidents The provider had not notified CQC of all incidents that affect the health, safety and welfare of people who use services. This demonstrated a breach of Regulation 18 (Notification of other incidents) of The Care Quality Commission (Registration) Regulations 2009 (Part 4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not effectively assessed and managed risks to people's safety. This demonstrated a breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good

governance
The provider did not have robust processes to monitor the safety and quality of the service. This demonstrated a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not have sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times. This demonstrated a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.