London And Manchester Healthcare (Romiley) Ltd

Cherry Tree House

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 14, 15 and 16 December 2015. Our visit on the 14 December was unannounced.

Our inspection was brought forward because we had received concerns relating to staffing levels and the high number of safeguarding alerts raised with the local authority, by health and social care professionals.

When we previously inspected this location on 30 March 2015, the provider was not meeting the Health and Social Care Act Regulated activities 2008 (Regulated Activities) Regulations 2014. We found that, care plans were not reviewed regularly and did not identify how risks would be managed, repositioning charts to prevent people from developing pressure ulcers were not in place and skin creams were not always applied as directed. During this inspection we found some improvements had been made in these areas, however we found further issues of concern and further improvements were still needed.

When we visited the service there was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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.

Cherry Tree House is a purpose built three storey care home owned by London and Manchester Healthcare (Romiley) Ltd. It provides nursing care for up to 81 people. Accommodation is provided across three units, one on each of the three storeys. Bramhall Unit, situated on the ground floor, and Romiley Unit, on the third floor, catered for people who needed nursing care. Marple unit, which predominantly supported people living with dementia, was situated on the first floor. All bedrooms are single occupancy with en-suite toilet and shower facilities. The home has a secure garden and off road parking is provided. There were 75 people living in Cherry Tree House at the time of our visit.

We identified nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

There were insufficient numbers of suitably qualified staff to meet the needs of the people who used the service. During the inspection we saw staff were unable to meet the requests for support from people who used the service, and people had to wait for assistance.

The staff recruitment and selection procedure in place was not followed to make sure new staff were recruited safely. For example some pre-employment checks such as obtaining references before people started working at the home were not carried out.

The systems in place for monitoring the performance of individual staff members were inconsistent.

At our last inspection in March 2015, we found that some skin creams had not been written up on a medication administration record (MAR) and there was a risk of the wrong skin cream being applied. At this inspection we found that there was no consistent system used across the home to show how or if creams had been applied, each of the three units were working to different processes. This meant that there were insufficient safeguards to ensure the safe management of topical creams.

Care plans were not always informative. We looked at a communication care plan for a person who was extremely hard of hearing, yet this was not mentioned in their care plan when considering how best to communicate with the person.

The service employed three activities co-ordinators who actively engaged with people individually or in groups. There were activities on offer throughout the day to suit peoples tastes, including visiting performers. However on the Bramhall Unit people told us, and we saw that people who used the service were left in their rooms for long periods of time.

We found discrepancies in risk assessments, where the risk of pressure sores developing had been identified there was no evidence of appropriate care planning, treatment and support to make sure people's skin integrity needs were met. Turning charts to indicate when a person at risk of developing pressure sores were not completed.

People who used the service told us that they felt safe because staff were kind and available when they needed them.

Care plans were completed and records included short and well written biographies to give care workers a good understanding of the individual. Care plans were person centred and focussed on people's abilities and aimed to maximise people's independence.

The premises were kept secure, with keypad entry to each unit.

Where people who used the service lacked capacity to consent to care and treatment the appropriate steps were taken to protect their rights.

On the Marple Unit we found that people did not always have the opportunity to make choices for themselves.

The communal areas and the bedrooms we looked at were clean. Policies and procedures to minimise the risk of infection were followed.

People told us the food was of an acceptable standard and we saw meals were fresh and looked and smelled appetising. Dietary needs were taken into account, and people were given choices of foods to eat.

We saw good interaction and communication between staff and people who used the service.

Summary of findings

Care was taken to ensure that individual's privacy and dignity was respected.

Where the home received complaints, we saw evidence of an acknowledgement, investigation and follow up report.

We found that audits completed had not highlighted the concerns we raised during this inspection and detailed in this report, nor had the provider's quality assurance and governance systems resolved some of the concerns raised at our last inspection in March 2015.

The staff we spoke to were confident that the registered manager was helping to improve the service. We saw that she has begun to implement systems for improving the quality of care, but

systems were not yet robust enough to ensure that practices were consistent across the whole of the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe

There were insufficient staff to meet people's needs safely and people were at risk of harm because the staffing levels and skill mix were not reviewed continuously and adapted to respond to the changing needs and circumstances of people using the service.

The staff recruitment and selection procedure in place was not all ways followed to make sure new staff were recruited safely.

Skin Creams were not always being applied safely

There were appropriate procedures in place to ensure people were safeguarded against potential harm from others.

Where a risk of pressure sores developing had been identified there was no evidence appropriate care planning, treatment and support was in place to make sure people's skin integrity needs were met

Is the service effective?

Requires improvement

The service was not always effective

Staff members received appropriate training to carry out their role, however some staff were still unclear about particular topics and would benefit from refresher training in those areas.

Daily handover practices did not allow for sufficient information to be shared between staff at the start of their working day

Although care staff demonstrated a good understanding of people's needs we found the supervision they received needed to be improved to help make sure they were able to deliver more effective care.

Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) authorisations were in place for people, but consent was not always sought.

People who used the service and their relatives were confident in the support received to enable them to access health care.

Is the service caring?

Requires improvement

The service was not always caring

Staff were not always vigilant to the needs of the people who used the service.

People who used the service and their relatives spoke warmly about staff at the care home.

We saw some good interaction between staff and people who used the service and people's privacy and dignity were respected.

Summary of findings

People who use the service were given information in a way they could understand.

Is the service responsive?

Requires improvement

The service was not always responsive

People were left unattended for long periods and staff were not always attentive to people's needs.

Where complaints were received about the service these were followed up and investigated.

Is the service well-led?

Requires improvement

The service was not always well led

Accidents and incidents and care plans were not always audited effectively, and there was little follow up action recorded.

The service did not seek the views of people who used the service or their relatives.

Procedures to monitor safe care and treatment were inconsistent.

Staff were confident in the manager's ability to improve the service, and she was developing good systems of governance.

Cherry Tree House

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.

Before our inspection we were told that there had been a high number of safeguarding concerns raised and that there appeared to be insufficient staff to meet the needs of the people who used the service. For these reasons we brought our inspection forward. We reviewed the information we held about the service including notifications the provider had sent to us. We contacted the local authority safeguarding and commissioning teams. We also noted concerns relating to staffing levels raised directly to the CQC through our 'share your experience feedback.' This is a web based form which allows members of the public to inform us of any concerns or compliments they might have about a specific service.

As we had brought forward our inspection we had not requested the service to complete a provider information return (PIR); this is a document that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make

The inspection took place on 14, 15 and 16 December 2015 and involved three adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The first day was unannounced.

During the inspection we observed how staff interacted with people using the service and how care and support was being provided in communal areas. We spoke with nine people who used the service and eight visitors. We also spoke to the registered manager, the provider and ten people who worked in the home.

We looked at a range of records relating to how the service was managed; these included eight people's care records, and nineteen personnel files. We also reviewed training records for sixteen care staff and ten nursing staff.

Inadequate

Is the service safe?

Our findings

Prior to our inspection, we had received concerns from the local authority safeguarding team, health service personnel and anonymous concerns relating to unsafe care. The information we received covered a variety of issues, in particular not managing wounds, staffing levels and poor staff recruitment and retention.

The local authority and health staff had raised concerns with us about poor retention and recruitment of staff which had led to a reliance on agency workers.

We reviewed staff working rotas which showed that on each unit there were normally four carers, a registered nurse and an activities co-ordinator. In addition a receptionist, domestic, laundry and kitchen staff were employed across the service.

We saw that agency staff were utilised for night shifts on Bramhall Unit for eleven nights in the past three weeks. Agency staff can be requested by a service, often at short notice, to cover staff shortages. This means that they are not always familiar with the routines, likes and dislikes of the people who use the service. In an attempt to counter this the registered manager informed us that they were attempting to build up a register of bank workers who would be able to cover shifts on an 'as needed' basis, who would be given access to the same induction and training opportunities as regular staff to provide a greater consistency in delivering care

The registered manager informed us that the nurse on each of the 3 units takes responsibility for the day to day running of their unit, but recognised that this affects their ability to manage effectively. Consequently she was in the process of recruiting three unit managers who would be employed over and above the current staff levels, to allow for greater administration and smoother day to day running of each unit, and to allow nurses more time to deliver care safely.

Most visitors on Marple and Romiley Units thought there were enough staff to care for their relatives. One told us "[There is] always someone about. The staff are lovely and it seems there are plenty, they will come really quickly if I tell them my mum needs changing. I come in at any time; they don't know when we're coming." One member of staff on the Romiley unit told us that "staffing levels are always really good" and another on the Marple Unit said "there are enough of us about, and we all muck in together". Our observations on these units confirmed that there was a staff presence in the communal areas, and staff were able to spend time with people who used the service. None of the people we spoke to on these two units reported long waits for attention from staff when they requested help. One person told us: "I don't really wait long, no, and it's the same at night." Another said "I don't wait long; there's always somebody comes in", whilst a third person told us "Sometimes I have to wait for help, but they're always there for you." However this was not reflected on the ground floor, Bramhall unit. One member of staff who worked mainly on this unit told us that "we are always on the go". When we asked a visitor to the Bramhall unit if they believed that there were enough staff they replied: "They are always short-staffed. Prior to new management they had lots of agency staff, and sometimes not the required number of staff on, for example if someone went off sick."

The unit manager on Bramhall unit told us that sixteenof the twenty people on Bramhall unit required two staff for moving and handling, washing etc. We spoke to the registered manager who informed us that they calculated the dependency levels for each individual who used the service but did not take this into account to determine the number of staff required on each unit.

A visitor told us ''There should be more staff,'' and commented that when they had asked for assistance staff say "We are busy''. On the second day of our inspection, one resident needed to attend a hospital appointment. A member of staff had to escort this person, leaving the unit understaffed, with only three care assistants on the floor. A care worker complained to us that they had showered two people during the morning but had not had the opportunity to blow dry the hair of one of them as they had to attend to other people. Without an appropriate number of staff there is a risk that people's needs cannot be met, or that care will be given in a way that is unsafe.

Concerns about poor recruitment and retention of staff had been recognised by the registered manager and the provider. In order to address this the provider had placed a voluntary embargo on admissions, meaning that they would not take any new people into the service until they had ensured that they had enough staff in place to meet need safely. However, this meant that whilst staff were being recruited there was still an over-reliance on agency

staff. We saw that three members of staff had handed in their notice and were leaving during the week of our inspection; one member of staff completed their last shift on the first day of our inspection.

The above examples demonstrate a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were insufficient competent and skilled staff to meet identified needs.

New staff told us that their recruitment had been thorough, and interviews were conducted by the home manager in depth. One told us "When you have an interview, it lasts over an hour; it's not a 'rush job'". We reviewed the records regarding staff recruitment and spoke to staff about their recruitment. We saw that not all staff were checked prior to their employment as suitable to work in the service. Additionally, not all staff files had a record of their initial interview and a copy of their application available.

We reviewed nineteen personnel files and looked to see if checks on staff members' backgrounds were completed with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. These checks help the registered manager to make informed decisions about a person's suitability to be employed in any role working with vulnerable people. We were unable to find evidence that these checks had been carried out for six of the nineteen staff we checked.

Two references were not consistently available. References provided were not checked as valid references. The service's own policy stated that two references are needed; one of which must be the person's last employer. It was not always clear that a reference had been provided by the previous employer; in two cases only one reference had been received, and a further reference was unsigned.

The service had not met its own policy and procedure in making sure staff were safely recruited.

This was a breach of Regulation 19(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the recruitment procedures were not operated effectively.

We looked at how Cherry Tree House managed wounds and pressure relief. We had been told by the Tissue Viability Nurse before we visited that there had been a disproportionate level of referral to their service for pressure sores, with more than 50 contacts made in the past year. Two recent safeguarding investigations concluded that the service had failed to protect service users from the prevention of pressure sores.

We looked at systems in place to monitor and treat pressure sores and found that there were inconsistencies across the three units. On Romiley unit the nurses maintained wound charts and a photographic guideline was displayed on the wall of the medicines room for staff to refer to. Nobody on this unit had any pressure sores. On Marple unit we spoke to one member of staff who told us the unit had had issues in the past, but they had taken steps to prevent pressure sores developing. They explained that the care staff would check for any wounds whilst they assisted people who used the service with personal care, and if they saw any signs such as redness of skin they would immediately inform the nurses who would monitor and prevent any wounds developing. At the time of our inspection nobody on this unit required treatment for pressure sores. On Bramhall unit the systems to measure risk did not always correlate. Audits showed both inconsistent monitoring and missed checks. For example, in one file dependency assessments marked a medium risk of pressure sores whereas Waterlow (an assessment for rating risk of pressure sores developing) scores would mark a high risk. Where risks were identified there was no evidence that plans were put in place to mitigate the risk, and daily record sheets did not record any changes in skin integrity.

We found that when wounds were identified the treatment in place to prevent further risk wasn't clear, and systems to monitor positional changes were not always followed through. For example, on the second morning of our visit we noticed that the care plan for one person who had previous pressure sores and a current pressure sore stated that they required repositioning every two hours. According to the chart they had not been moved between 08.20 and 11.45. Another person was still in bed at 12.15 p.m. They needed changing and this was reported to staff but they did not attend until 1.00 p.m. We noticed that the last entry on the positional change chart was at 6.00 a.m. This meant that the risk of their skin condition deteriorating was heightened, as they were not assisted to turn over a seven hour period.

Inadequate

Is the service safe?

One member of staff was concerned that care workers on the Bramhall unit who were insufficiently trained had been encouraged to change dressings rather than nurses and this was causing problems in maintaining skin integrity; another told us that they had recently been asked to review the care of a person on Bramhall unit they saw that the pressure mattress was deflated; the staff were initially unable to locate the pump, and when they did eventually find it that they did not know how to use it. When we checked, we saw that there was no system in place on this unit for checking mattresses to determine if they are inflated correctly, in good condition, tubing working, or at the correct setting for the resident using it.

The above examples demonstrate a breach of Regulation 12(2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider was not taking practical steps to mitigate the risk.

When we spoke to the registered manager about this she recognised that tissue viability had been a problem prior to her commencement at the service and she had taken steps to address this issue. The registered manager showed us a monthly audit of pressure sores which showed that the number of concerns had reduced over the previous four months. We were shown a copy of a weekly check list that the service are going to implement to check the suitability and efficacy of pressure relieving equipment. The service had reviewed its policies and adopted methods based on the Royal Marsden Procedures, which is a nationally recognised way of minimising and managing pressure wounds. Staff had received training; we asked one carer how they prevent pressure sores, and they were able to describe different pressure points, use of mattress, identification of red areas, reporting to senior staff, good nutrition and fluids, and checking pressure points at each position change.

Cherry Tree House has a medication policy to ensure that procedures are in place to administer medicines appropriately. People who used the service told us they got their medication as necessary. Several received diabetes medication for instance, and were content this was given at the correct time. The deputy manager carried out spot checks of medicines each morning and an audit was held centrally.

We looked at the system in place for the safe storage and management of medicines. Medicines were ordered by the Unit managers and delivered on a monthly basis by the pharmacy using a monitored dosage system with blister packs. This minimises the risk of giving the wrong dose to people and provides an efficient system of storing and accounting for medicines. Prescriptions were checked against delivery, signed for and countersigned to ensure that the appropriate medicines were delivered. Records showed when unused medicines had been disposed of.

Separate medication rooms on each unit were used to store the medication trolley and all other medicines for the unit. The keys to the room and medication trolley/cabinets were held by the nurse on duty. Refrigerator temperatures were checked daily and a record of temperatures was kept, in order to ensure medicines are stored at the correct temperature. If medicines are stored at the wrong temperature they can lose their potency and become ineffective. Controlled Drugs were stored in a further locked cabinet, and the controlled drug register was countersigned when administered. We checked the balance of controlled drugs for four people on two units and found them to be correct.

Each person requiring medicines had a Medication Administration Record (MAR), held within a file which included nurses specimen signatures. This is a form which records the details of any medicines prescribed, when they are taken and if they are refused. All medicines received were recorded on the MAR which also included details of the medication and dose required; a recent photograph of the person and details of GP, condition, and any known allergies.

Where medication was to be taken 'as and when required," for example paracetamol, the balance was normally carried forward to the next month and added to the new MAR, but we found that some balances of this type of medication had not been carried forward at month end so it was difficult to ascertain if the balance on the day we checked was correct.

People told us that they received help with their medication, and we observed this to be the case on all three units.

Medicines were administered by nursing staff who had completed a competency questionnaire and demonstrated their ability to perform the task. We spoke with two nurses on duty who informed us that they had completed regular medication training delivered by the pharmacy used by the

service and confirmed that they were happy with the training received and that it 'was very good'. Regular competency checks were also completed by the unit managers.

We observed medication rounds during our visit. Medicines were given in a calm and unhurried manner; the staff explained what they were doing and asked each person if they were ready to have their medication. We saw one nurse asking a person who had leg ulcers bandaged if her legs were painful and if she needed painkillers. We also watched the nurse patiently showing a person how to use the inhaler appropriately as he had poor technique.

Medication was only given out by registered nurses who wore a red tabard to indicate that they were giving out medication. This meant that they would not be distracted whilst handling medicines. This was in line with the service policy and procedures. Hand-wash and a paper towel dispenser were available on the medication trolley along with gloves and protective aprons.

No one on Bramhall and Romiley units was given medication covertly; Medication given covertly is the administration of any medical treatment to a person in a disguised form. On Marple unit where covert medication was given the reasons and best interest decisions were documented on care records.

We looked at how the service managed external preparations such as creams and ointments. Creams were kept in peoples rooms but there was no consistent system across each unit to show how these should be applied. This meant that if staff were deployed on different units they may be uncertain of the correct procedures to follow which could increase the risk of errors.

On Bramhall unit a new chart obtained from the pharmacist showed a body map of where cream was to be applied. A recording sheet kept in each person's room was signed by carers to say that they had applied the cream. On the Romiley unit some people applied their own creams, and others were supported by care staff. The nurse explained to us that staff will check that the cream has been applied and sign a record sheet to confirm. The senior nurse will then check to make sure the record sheet has been completed. There was no master cream chart. On the Marple unit, care staff applied creams. However, as with the Romiley unit there was no chart to show how and where the cream needed to be applied, and no system in place to ensure that this was done correctly. This meant that people were not fully protected against the risk associated with their skin creams not being applied as directed.

This was a breach of Regulation 12(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider was not ensuring the proper and safe management of medicines

The people we spoke with who used the service told us that they felt safe. People told us they felt safe because staff were kind to them and available when they needed help. We were told by a visitor: "I can go home at night and feel he's safe".

One person who used the service said: "I'm safe here; it's just a friendly atmosphere." Another told us: "I like it here, they do look after you, you've got a bell and you feel secure, don't feel left alone".

The home was secure. Access to each floor and all units was secured by number coded keypads. People who had capacity were able to use the keypads if they wished to leave the floor. The main entrance was open during daylight hours with a receptionist on duty. People's rooms were generally kept locked for the security of people's belongings whilst they were in communal areas. This meant that those people who did not have a key to their rooms would require a member of staff to allow them access; we saw staff were on hand to help people to get into their rooms when they wanted to. But best interest decisions were not always recorded so there was no way of determining if people had agreed to their doors being locked.

We looked at the risk assessments in six care records and saw people had risk assessments in place which were regularly audited by a member of the management team. Assessments included moving and handling, falls assessments, skin integrity, nutrition assessments (including weight loss, choking and aspiration, and dehydration) and environmental risk assessments. Where the risk was high a corresponding care plan was put in place, for example, one file we looked at assessed falls as high risk. A corresponding care plan outlined steps for care workers to take to minimise the risk of falls, including actions to take to maximise the person's independence. When falls occurred these were recorded and the reason for the fall explained, but the care plan was not updated or

Is the service safe?

revised in light of the recorded incidents which meant that opportunities to understand the consequences and consider further protective measures in place could be missed.

Reviews of care plans were carried out on a monthly basis, and evaluation sometimes showed attention to detail with instruction and guidance, which was followed up and evidence of changes recorded in daily logs. Whilst some care plans were detailed and instructive, they were not always informative, for example, we looked at the communication care plan for a person who was extremely hard of hearing, yet this was not mentioned when considering how best to communicate with the person.

This was in breach of Regulation 9 (3)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as it did not provide opportunities for relevant people to manage the person's care and treatment

The service had a Safeguarding Adults Policy to identify report and follow up any incidents or allegations of abuse, and systems were in place to ensure people were safeguarded against potential harm from others. Where allegations had been made we saw that the registered manager had taken appropriate action to deal with the incidents through the service's disciplinary procedures and to protect and support the individual concerned. The staff we spoke to were familiar with the safeguarding policy and were able to explain their responsibilities to protect the people who used the service. We saw that the registered manager kept a log of all incidents and liaised with the local authority safeguarding team to ensure full and thorough investigation of all reported incidents.

During the day we saw people being moved by staff using a hoist. We observed that this was done safely and carefully. Two staff members helped the person; they explained what was happening and provided reassurance throughout the manoeuvre. We saw that people were not left sitting in the sling which had been used, and staff ensure that they were comfortable in their seating position

A visitor told us "it's very clean, there's no smell at all." We saw the home was clean throughout and there was no unpleasant odour. Assisted bathrooms contained handwashing signs, as did toilets, along with anti-bacterial gel, soap and paper towels. Anti- bacterial gel was available outside rooms in the corridor in dispensers. The home employed a number of domestic staff who were visible throughout our inspection. They told us they also take responsibility for laundry and used colour coded laundry trolleys to collect anything which requires washing from rooms. The use of colour coded laundry trolleys reduces the risk of cross contamination and risk of infection. After washing and ironing the domestic staff return the clean clothing to the person's room and hang in their wardrobes.

All staff wore uniforms. In addition we saw that care staff used tabards, vinyl gloves and other protective measures when cleaning, handling food or completing personal care tasks. Wearing such clothing protects staff and people using the service from the risk of cross infection during the delivery of care. We asked one care worker about the procedure for handling clinical waste and they were able to explain the safe and effective procedures to reduce risks to themselves and others.

We reviewed records which showed that regular maintenance and safety checks were carried out on the building and equipment, such as lifting hoists, the fire and call alarms, smoke detectors lift and emergency lighting. Where hoists were used people had appropriate hoist slings, and we observed staff were competent in using this equipment.

All assisted bathrooms consisted of bath with appropriate electric bath hoists and thermometers to test temperature of water. We also noticed a 'chair scale' was stored in one bathroom – this was calibrated and in working order. However, on Bramhall unit we saw that there was a bed and mattress cleaning checklist, but nothing had been recorded on this since June 2015. There was also a blood glucose monitoring machine, which should be quality checked on a regular basis but this hadn't been happening. When we spoke to the new unit manager about this she contacted the manufacturer and asked for the appropriate quality checking strips so that the machine could be regularly quality checked.

Requires improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When 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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager was able to demonstrate a good understanding of the legislation to ensure that people's rights were protected, and the majority of staff had recently received training on capacity and consent.

Capacity assessments had been carried out on all people who used the service and the decision recorded in case files. Where appropriate applications for DoLS had been made and a central log of applications was kept, detailing the date of application, when the authorisation was granted and when it was due to expire. At the time of our visit 44 applications had been made to the relevant local authority.

Several people who used the service have bedrails on their beds to prevent accidental injury by falling out of bed where they were unable to consent to this there was documented evidence that DOLS were in place or had been applied for.

We were told that staff on Marple unit had observed that one person's behaviour became more difficult to manage towards the latter end of the day, and staff thought that this might have been due to the large amount of coffee the person drank. To minimise the risk their behaviour might cause to both themslef and others they switched to decaffeinated coffee on the unit. Whilst this may have made this person's behaviour more manageable neither the person involved nor any of the other people who lived on this unit were consulted or offered a choice of caffeinated or decaffeinated coffee. This meant that they had been denied the opportunity to make choices for themselves.

This was in breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as care and treatment of service users must only be provided with the consent of the relevant person.

We saw that there was a supervision policy, but no consistency in how this had been applied. We reviewed 19 staff personnel files, and saw that of these, 6 staff had no record of a formal supervision in 2015, whilst others had been supervised two or three times in the year. One member of staff on Bramhall unit informed us that they had received supervision, but others said that they had not. We looked at the supervision file for Marple unit and saw that a yearly planner had only three supervision sessions scheduled in for March, This meant that systems in place for monitoring the performance of individual staff members or for allowing collective understanding of issues or concerns were inconsistent.

This was This was in breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people employed by the service must receive supervision as necessary to enable them to carry out their duties.

The registered manager recognised the lack of formal supervision for all staff, and showed us a matrix drawn up to ensure that all staff have a formal supervision session at least once within the next three months. We saw that unit meetings for staff on each of the three units had been scheduled, but had not always taken place. Where these had happened good typed minutes were recorded.

When we spoke with the providers they recognised that communication and documentation had been an issue at Cherry Tree House and acknowledged that the systems for passing on information between staff at the start and end of shifts was orientated to tasks, which needed completing rather than giving a thorough account of each individuals well-being. Not all handover sheets were available. We reviewed handover documents on Bramhall unit, but these only provided basic information regarding anything out of the ordinary relating to each individual.

People told us that they believed they received effective support and staff knew how to meet people's needs. A relative who had been dissatisfied with care at a previous home said "the staff are well trained, there's no aspect of caring, treatment or staff you can complain about."

Requires improvement

Is the service effective?

All staff had received an induction when they began work at Cherry Tree House. The dates were recorded in the staff training matrix. We spoke to a care worker who recently began work at the home and were told that induction consisted of mandatory training presented using a combination of e-learning and face to face interaction, time spent shadowing experienced staff and time to read and access the home's policies and procedures.

We reviewed the staff training matrix which showed that over 90% of staff have received training in a variety of topics including, safeguarding adults, infection control and moving and handling. Additional training is provided for first aid and dementia awareness and all kitchen staff had been trained in food safety. Some staff had recently attended a half day in-house training event for Pressure Sore Awareness and Communication/Record keeping Awareness.

We looked at the training records for 16 care staff and 10 nursing staff. All showed evidence of recent training appropriate to their duties. Files also showed where care staff had a vocational qualification such as NVQ or certificate in health and care. We spoke to 2 members of care staff and a nurse (all of whom had professional qualifications) about their training. They confirmed that they received ongoing training and told us that they were encouraged by the manager to keep up to date with their learning needs.

Cherry Tree House is a purpose built home, providing accommodation across 3 units, Marple unit, Romiley unit and Bramhall unit, and care had been taken to ensure the environment was comfortable. When we visited we found the home well maintained, although there were some signs of wear and tear, for instance, the front of a towel dispenser on Marple unit had been ripped off.

Dining rooms on each unit were well furnished with ample room to seat up to 30 people. Bedrooms on each unit were situated off three long corridors with appropriate lighting and handrails. Corridors were wide and straight which was helpful for people with walking aids and also facilitated those people who used the service who liked to walk up and down. It was also easy for staff to watch without being intrusive.

Each bedroom had a memory box by the door, these provided a personal point of reference for each individual and indicated their interests; some had a range of pictures and relevant objects such as trophies won, while others had little in them. More could be made of signage and objects to stimulate reminiscence for people who used the service. There were some dementia friendly signs on bathroom doors. Some other doors were without appropriate signage and were labelled with written signs which would be difficult to understand for people with visual difficulties. People's rooms had their names on the door. There was no orientation board on Marple unit, which would have been helpful for people living with dementia.

Each of the three corridors had a separate lounge area; some were used as TV lounges, others as quiet areas where people who used the service could entertain their visitors. All bedrooms had en-suite showers and toilets, and there were additional bathrooms located on each unit. When we walked around the home we noticed that, although well equipped, the bathrooms were sometimes used to store equipment, for example in one bathroom on Marple unit items such as pressure cushions, pillows and a deflated mattress were being stored on the bath hoist and around the side of the bath., This did not lend itself to therapeutic bathing as it was unsightly, and could also cause an obstruction and heighten risk. In an assisted shower room on the Romiley unit we saw a pair of crutches left behind the door and an electronic wheelchair was also stored being stored.

The décor was not dementia friendly, for example wallpaper designed to resemble bookshelves and wallpaper which had a recurring pattern of three large clocks, each with a different time displayed, this could be confusing for people living with dementia.

Each unit had a central 'hub' area where the offices were located. Care files and other documentation relating to the people who used the service on the unit were kept in these offices. Adjacent to this was a communal seating area where people who used the service could sit and relax or join in activities.

Outside there was ample parking space to the front of the building and an attractive and well-kept garden, with garden furniture. This could be accessed by people on Bramall unit through double doors from the lounge, allowing good wheelchair access, but it would be difficult for people from the upper units to use the garden facilities without support. Entrance and exit from all three units

were secured by a key code entry. This minimised the risk of people leaving without informing staff, but also meant that they would need to seek assistance if they wanted to move off their unit.

People who used the service and their visitors told us that the food was of an acceptable standard. One person told us "the food is good, but not sensational. There's an adequate amount of food, a reasonable variety, but not many vegetables at the weekends. We seem to get the bare necessities. This resident's visitors told us their friend "thinks the food is plain."

Other people we spoke to said the food was good, and one person said "we eat well and have a good choice of meals", whilst another said they were content with the food, telling us "It's OK, there's enough of it, I could ask for more, but there's always enough."

Throughout our inspection we saw drinks and biscuits being offered in the morning and afternoons, and two people who use the service said that they could get their own drinks if they wanted one.

For breakfast people were offered a choice of cooked food, cereal and toast. On the frist day of our inspection we saw some people had finished their breakfast and were sitting talking at their table.

We noted that one person with arthritic hands had been provided with adapted cutlery to help maintain independence when eating meals.

We observed lunch being served on all three units. People sat at tables of four or less, and could choose where they wanted to sit. Tables were laid with cutlery, napkins, glasses and jugs of water. There were fresh flowers on tables on the Bramhall unit. We noted that tablecloths used were patterned which can be confusing to people living with dementia. We observed a person on Marple unit who kept tentatively touching the darker pattern on the tablecloth as if unsure what it was. When a member of the care staff noticed this she was able to provide reassurance, and moved the tablecloth away from the person.

Where people were unable to get to the dining room to eat, or chose not to, meals were taken to their rooms. Two people on Bramhall unit had difficulty swallowing and were fed prepared food and nutrients via a Percutaneous Endoscopic Gastrostomy (PEG), administered by a trained nurse.

The atmosphere on all units was calm and unhurried, with music playing quietly in the background. Several people in each dining room needed assistance with feeding, and staff sat beside them and engaged appropriately with them, establishing eye contact, and talking with them. People receiving assistance and those who had difficulties were offered aprons to prevent spillage onto their clothes.

Menus were not on display; although there was a menu board in each dining room these were not used. For breakfast people had a choice of cereals, toast and a cooked breakfast including sausage, bacon and egg. The main meal of the day was served at lunchtime. People chose their main meal the day before and were offered a choice of two main meals, their choice was not binding and people could choose an alternative on the day if they changed their mind.

We saw that the portion sizes were good and that the food looked hot and appetising. Some people who had stopped eating, or were a little slow were encouraged in a gentle manner to resume eating. When it was clear that they had had enough they were politely asked if they had finished before their plates were taken away, or offered second helpings.

Special dietary requirements were met, and we saw care staff showed a good understanding of people's dietary needs likes and dislikes. We saw two people on the Bramhall unit given pureed food which was well presented. Diabetic people who used the service told us they thought their particular dietary needs were catered for. The kitchen had copies of any special dietary requirements, including soft diet, and we saw that staff knew how to fortify meals to increase their calorific content for those people identified as being underweight.

We noticed that Weights and MUST (multi nutritional assessment tool: this is commonly used screening tool which helps identify adults who are at risk of malnutrition or obesity) scores were recorded. All people were weighed monthly, but where diet and weight had been recorded at risk the care plans stated either weekly or fortnightly monitoring. However, this information was not carried over onto the weight charts so it was not always obvious from the charts how frequent people should be weighed. We saw that checks were either not completed or not recorded. The lack of recording heightened the risk that danger signs would be missed, leading to greater problems with weight loss or weight gain.

Requires improvement

Is the service effective?

This was in breach of Regulation 17 (1) (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to maintain securely an accurate, complete and contemporaneous records.

People who used the service and their relatives were confident in the support received to enable them to access health care. They told us that they would see the GP, optician and the chiropodist regularly and one person with diabetes told us that the diabetic nurse visits regularly. A relative said "GP and optician are available and she goes for her hospital appointment when she needs to."

Requires improvement

Is the service caring?

Our findings

People who used the service and their relatives spoke warmly about staff at Cherry Tree House. One person told us "staff are very friendly, helpful and caring." Another informed us "the staff are lovely; they will always come and have a chat with me".

A visitor told us that on one recent occasion her family had arrived to see their relative and heard staff who were helping her being very kind and encouraging. They were impressed as "they had no idea we had arrived; they were in the bathroom with her."

Some of the people we spoke to knew about their care plan and had been consulted about the delivery of care. One person told us "The care plan is okay, I saw it two or three weeks ago, they went through it with me." Not everyone was aware that they had a care plan in place; one told us that he had never been told about a care plan and another person visiting their friend who had lasting power of attorney (legal authority to make decisions on a person who is unable to make their own decisions due to lack of capacity) for their friend – who had no living relatives - told us that they were unaware of any care plan

Information held on individuals included a brief life history document, although we saw that not everyone had a completed document. Those that had been completed provided a concise biography of the individual, including likes and dislikes and what things were important to the person. This helps staff to understand people and provide care that follows the person's preferences. However, this was not always followed up, for example one life history document we looked at provided a very good summary of past achievements, life story, hobbies and interests and people who had been important to the person in their life. However, staff did not capitalize on this information, for example, reference to tastes in music were not reflected in the choice of CD's available. This showed a lack of consideration for the wishes and personal preferences of people who used the service.

People who used the service looked well cared for, clean and tidy and well turned out with appropriate clothing.

We saw some good interaction between staff and people who used the service, for example, we observed speaking kindly to people and engaging in appropriate touch. We watched one of the care staff who was talking and interacting warmly and compassionately with a person on Marple Unit, clearly demonstrating knowledge of the person and their likes and dislikes. One person was toying with his breakfast, the care worker addressed them by name asking sympathetically, "Are you alright there; try and eat some more. I know you're not feeling too good today."

We observed another person looking out of the window to a field outside where there are often animals to be seen. A carer took time to stand with this person and talk about what they could see or might see. The carer returned to the table to help a visually impaired person walk slowly back to the lounge, she was singing with this person which he was enjoying and joining in with.

People who were able to articulate their needs appreciated the talks they had with care staff, especially those who thought there were few other people who used the service that they were able to have conversations with. One person told us that "The staff are very pleasant and can hold a conversation." This person's visitors told me "We notice staff are cognisant of him, they're very aware of [our relative] and their needs. Staff are very helpful, friendly and caring; [our relative] is well cared for." However another person complained to us that the staff do not always have time to sit with them and talk.

People who used the service and their visitors were content their privacy and dignity were respected. One visitor told us "Staff make it easy for us to be here and visit, we are made to feel welcome, and they respect the fact that [our relative] has visitors." They also told me "They are not over solicitous with him; he still has a sense of independence."

People were treated with respect and compassion, and staff remained courteous and polite, for instance, knocking on people's bedroom doors before entering. Where options were available people were given choices in a meaningful way. For example, at lunch time on Marple unit, when one person was unable to say which meal they preferred, the carer put the options to the person in a way they could understand and helped them to make a meaningful choice rather than make an assumption about which dish this person would prefer. We also saw that people were asked if they wanted to listen to music and helped to choose a compact disc to put on.

We saw that staff would ask for permission before intervening to support a person, for example, we observed

Requires improvement

Is the service caring?

a member of staff asked for permission to go into a person's room to set up some equipment whilst the person was in the lounge. One man told us he could always go to his room if he wished with his visitors.

Requires improvement

Is the service responsive?

Our findings

Some of the people we spoke to told us that staff responded to their needs. They told us they were provided with support when they required it, and staff respected the choices they made for themselves. One person said "I can choose when to get up and go to bed. I can go for a walk, go downstairs, join in, visitors can come whenever. If I need any help, staff are there to support me".

Others thought they were supported to do what they wanted. One person told us they liked to go to football matches and occasionally, there had been arrangements made for this to happen.

One person said "I can't leave on my own, I know, I have to have a 'keeper' with me, but friends take me out to lunch frequently." This person also told us they could go and make a drink whenever they wished.

Not everyone felt the same way however, particularly on Bramhall unit. We saw that some people were still being brought from their rooms in the mid-morning. A member of staff told us that the night staff began to get people up and gave morning medication, but one staff member informed us that it is "Sometimes nearly 12 o'clock before people are up and washed ready for breakfast". One visitor commented to us that over several visits their friend would be in bed at 1.00 p.m. but this person liked to get up much earlier. When the visitor enquired why this was they were told "we are busy".

On the second day of our inspection, we were invited into a person's bedroom. Their visitor told us that they had asked for help as the person needed changing, but no assistance was received for a further 45 minutes, leaving the person in wet garments.

The visitor informed us that the person is unable to speak or use the call alarm, but is often left alone in their room - which was at the end of a long corridor - where they were socially isolated. This visitor told us that this person likes to be in the company of other people, where they can enjoy the stimulation of others. However they felt the staff did not know this person as an individual. Later that afternoon, we heard the person calling out – they are unable to speak or use call bell. We saw they were crying, and asked the person if they would like to go into the lounge. They appeared to nod in agreement, so we found a member of staff to take the person into the lounge, where they appeared to settle.

We spoke with another visitor who told us "[The staff] don't spend any time to get to know [the person]. They don't know their likes and dislikes, and didn't know or acknowledge their birthday".

This was a breach of 10(2)(b) dignity and respect: supporting the autonomy, independence and involvement in the community of the service user

One Care worker on Romiley Unit told us that the nurses completed the care plans and that the plans "Do the job they are intended to do. You get chance to read through them and get to know the person." A personal profile included a photograph, and information was available for health professionals such as hospital staff if a person required admission to hospital.

Care plans were kept up to date and reviewed by the unit manager on a monthly basis. Any changes were noted and taken into account at the review. People's care records documented their needs in a number of areas including medication, communication, nutrition, continence, personal cleansing and dressing, mobility, social activities and interests, cognition and mental health, and behaviour. They provided clear instruction on how to support people in a way that reflected their individuality. Care Plans were instructive and written in a person centred way focussing on their strengths, and showing how people wanted their care delivered, but sometimes important information was missing.

We saw that the staff were responsive to changing health needs. For example, we saw that a person who had diabetes was recording high blood sugar levels, and this was referred to the diabetic specialist nurse for review. Another resident complaining of tooth ache was referred immediately to the dentist, and when the nurse saw a person who had leg ulcers which were weeping, she arranged for this person to receive antibiotics from her GP.

Each unit had an Activity Coordinator who worked individually with people who used the service as well as in groups. However, we were concerned that some people on Bramhall unit may not have had opportunity to engage in activities, as they were left for long periods in their rooms.

Requires improvement

Is the service responsive?

A list of activities for the week was displayed for each unit and included exercise class, reminiscence, Christmas crafts, poetry reading, a primary school concert, cinema, and Sunday religious service.

During our inspection one unit was holding its Christmas party, which was enjoyed by the people who attended. On Marple unit we observed the Activities Coordinator actively engaging with people who used the service and helping them to make Christmas decorations.

On the first day of our inspection there was a personal trainer at the home, the personal trainer visited every week and offered activities to encourage movement and good postural exercises to help people to remain relatively fit. People were encouraged to take part, but could decline if they wished. One man told us he was supported to join in and did with the exercise group, but mostly preferred his crosswords in his own room. On the second day of our inspection we saw a volunteer who had been invited to provide hand massage. One Activity Coordinator told us that they like to ensure variety in activities, so if there is a fairly strenuous activity one day they like to provide a more relaxing activity the following day.

A selection of newspapers were delivered to each unit on a daily basis, and there were separate lounges for people to sit quietly or to watch television. One person who used the service told us “we get a lot of activities as well, which we can choose to participate in or not”. This person preferred to stay in his room often and also went out with friends. One of his prime reasons for choosing this care home was that aside from being “More than reasonably content, I like that it is close to home, I have lots of friends around here.” His visitors were happy that they were made very welcome.

We noticed that the service kept a variety of CD’s and we heard the activities co-ordinator on Marple unit offering the people who used the service a choice of what they would like to listen to. On this occasion they chose a compilation of recent popular music rather than songs from the past.

The service had a policy and procedure in place for dealing with complaints and this was on display in the reception and accessible on all the units. We looked at the complaints file and saw that when complaints were made these were recorded and thoroughly investigated with a report detailing any appropriate action taken and a copy of the response. Most of the people we spoke with had not had to make a complaint. They were, however, content that they could speak to the manager if they wanted to do so. One of the visitors we spoke with told us about a complaint they had made, which they were satisfied was addressed. They received an apology from the registered manager and were informed of the actions taken.

Requires improvement

Is the service well-led?

Our findings

We spoke to people about their experience as at Cherry tree and received some positive comments. One person who used the service told us: "I think it's excellent, everything is marvellous, I can't complain." A relative said: "You always get a positive response. The manager is pleasant and accommodating, she's very nice and if there are any issues, I know I can always phone and speak to her."

The home had a registered manager who was newly appointed and had been registered with the CQC since September 2015. Since her arrival the home has shown encouraging signs of improvement. The staff we spoke to were confident that she was helping to improve the service. One told us "She is well organised, very professional, [and] manages situations that are difficult."

There was also a deputy manager, and both received support from Clinical Lead and Governance Lead Managers employed by the provider.

At the time of our inspection the registered manager had appointed unit managers for each of the three units, and had reached agreement with the provider for these positions to be supernumerary to the general staffing levels for each unit. This meant that they would work over and above the staffing levels identified for each unit. It would allow for greater management oversight, and provide a higher level of support to staff than currently available. The unit manager on Bramhall unit had taken up their position the week of our inspection, the other two unit managers were to take up their posts in January 2016.

Before our inspection we checked our records to see if any accidents or incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant that we were able to see if appropriate action had been taken by management to ensure that people were kept safe. We saw that the registered manager had reported all incidents to us. In addition we spoke to the local authority and reviewed other information sent to us since our last inspection.

There had been a number of reported safeguarding issues which had been investigated. Some of these highlighted issues around tissue viability and pressure area care. We asked the registered manager how she was dealing with this. She acknowledged that there were issues but needed to do more to remedy this. She showed us a monthly audit, she had implemented which showed that the number and severity of pressure sores had been decreasing in the last four months, but she recognised more action was required to spot danger signs and provide a proactive response. Inconsistencies in approach meant that some units had systems in place to monitor and observe any changes in skin integrity to minimise the risk of harm, but this procedure was not always followed on all the units. This meant that quality assurance systems were not yet robust enough to ensure that practices across the whole of the service were delivered effectively to meet a consistently good standard of care. Previous poor practice had not been questioned, which led to a culture where staff lacked the competence and confidence to ensure good practice.

Documentation and records were kept but these did not always reflect the needs of individuals and discrepancies had not been identified during reviews. We looked at one care record which showed a person had a series of falls which were being charted, but there was no evidence that any action was being taken to investigate the reasons behind the falls, or that notice was taken of any previous occurrences; one record was logged as the first incident, for instance, yet it was clear that there had been a number incidents logged prior to this one. This meant that opportunities to analyse and learn from incidents were missed. The service's policy was to review and audit accidents and incidents, but not all incidents had been analysed and there was very little follow up action recorded. When we spoke with the manager and provider about this they acknowledged issues of poor oversight and agreed that there was a need for greater scrutiny of care plan reviews.

Audits completed had not highlighted the concerns we raised during this inspection and detailed in this report, nor had the providers quality assurance and governance systems resolved some of the concerns raised at our last inspection of Cherry Tree House in March 2015.

The lack of robust systems being in place to monitor the quality of service people received was a breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a service user guide which was available in the reception area along with the home's complaints policy and procedure. The provider told us that "We aim to deliver safe care. We want people here to be comfortable, happy and safe". This was reflected in some of the comments we

Requires improvement

Is the service well-led?

received. One person told us they were happy and content with the care and the approach of the registered manager and staff. They told us: "If you ask them something they will do it, they do what they say they will." The home's philosophy also stated that the provider wanted to create "an atmosphere of individual care and attention for our clients." We found that these values were not reflected on the Bramhall unit where people using the service were left unattended for long periods of time.

Staff were confident that the new registered manager was helping to improve the service. One member of staff told us that they felt valued for their contribution and effort, and went on to say "The registered manager is absolutely excellent – she knows exactly what she is doing, the door is always open and she is always available to speak with you, you can go to her in confidence. She interacts with the residents and staff on a daily basis." "She is well organised, very professional, manages situations that are difficult." This view was echoed by another staff member who told us: "I am very happy with the new manager – she has an open door policy, she listens to you and responds to what you say or ask her, things are certainly improving." We saw that both the manager and the assistant manager were active and spent time out of their office on the units providing a visible presence.

The registered manager had started to review policies and procedures and systems in place for documenting information. Along with the provider's Governance Lead they were looking to amend all policies and paperwork to allow for a more person centred response to need.

We did not see any evidence that the service sought the views of people who used the service or their relatives, and when we spoke to people they did not report any systematic, regular efforts to ask them their views of the care home. If operated efficiently this would allow the provider to learn from the people who use the service and enable them to deliver a better response to need. However, people told us they were content that the staff were responsive to any requests for information. One person told us "I don't recall any meetings but in some ways it feels like home."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Care plans did not provide opportunities for relevant people to manage the person's care and treatment** Regulation 9 (3)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider was not supporting the autonomy, independence and involvement in the community of the service user** Regulation 10 (2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider was not taking practical steps to mitigate the risk to the health of service users** Regulation 12(2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider was not ensuring the safe management of topical creams** Regulation 12(2)(g)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems of governance were not operated effectively. Audits did not highlight concerns raised or resolve all the issues raised at our last inspection Regulation 17 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Accurate, complete and contemporaneous records in respect of each service user were not being maintained. Regulation 17 (1) (2) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were insufficient numbers of competent, skilled and experienced persons employed Persons employed by the service did not receive appropriate supervision and training to carry out their duties Regulation 18(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider was not arranging to recruit staff safely Regulation 19(2)(a)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent care and treatment must only be provided with the consent of the relevant person Regulation 11(1)

This section is primarily information for the provider

Enforcement actions

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