

Parkcare Homes (No.2) Limited

Cherrywood House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Cherrywood House is a residential care home providing personal care for up to 14 people with a learning disability and/or autistic people. The service comprises of the main house and 3 self-contained flats. At the time of our inspection there were 11 people using the service.

People's experience of using this service and what we found

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support

The service design and model did not fully meet the principles of 'Right support, right care, right culture'. This is because the building is larger than what is usually considered practicable to provide person-centred care and support. The service was registered with us prior to the 'Right support, right care, right culture' guidance was implemented. The provider had taken action to address this by accommodating less people than they are registered for. Three people had self-contained flats and one person in the main house had their own lounge and kitchenette alongside their bedroom.

The service did not always give people care and support in a clean and well-maintained environment. The manager and provider had plans in place to address this. People had a choice about their living environment and were able to personalise their rooms.

People were supported by staff to pursue their interests. Staff supported people to achieve their aspirations and goals. The service worked with people to plan for when they experienced periods of distress so that their freedoms were restricted only if there was no alternative. Staff did everything they could to avoid restraining people. The service recorded when staff restrained people, and staff learned from those incidents and how they might be avoided or reduced.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Staff communicated with people in ways that met their needs. Staff supported people with their medicines in a way that achieved the best possible health outcome.

Right Care

People received kind and compassionate care. Staff protected and respected people's privacy and dignity. They understood and responded to their individual needs. Staff understood how to protect people from poor care and abuse. The service worked well with other agencies to do so. Staff had training on how to

recognise and report abuse and they knew how to apply it. People who had individual ways of communicating, using body language and sounds could interact comfortably with staff and others involved in their care and support because staff had the necessary skills to understand them. Staff and people cooperated to assess risks people might face. Where appropriate, staff encouraged and enabled people to take positive risks.

Right Culture

The systems to monitor the quality of the service were not fully effective in ensuring shortfalls were actioned. Staff vacancies were high, vacant shifts were covered with regular agency staff. Permanent and regular agency staff knew and understood people well and were responsive to their needs. Staff morale had been low, the manager and provider had plans in place to address this. Staff evaluated the quality of support provided to people, involving the person, their families and other professionals as appropriate.

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 13 October 2017).

Why we inspected

We received whistleblowing concerns in relation to the environment, cleanliness, people's dignity and the culture of the service. During the inspection we identified concerns relating to cleanliness and the environment. The provider had identified these concerns and was taking action to address them.

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 requires improvement based on the findings of this inspection. Please see the safe and well led sections of this full report.

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

Follow up

We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Cherrywood House

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

The inspection was carried out by three inspectors and an Expert by Experience made telephone calls to people's relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Cherrywood House 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. Cherrywood House 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. The provider had arranged for a registered manager from one of their other services to oversee Cherrywood House temporarily. The provider had also recently arranged for another external manager to oversee the service until a permanent manager

was recruited. They were in post on the second day of our inspection.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

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 reviewed information we had received about the service. We requested feedback from the local authority. We used all this information to plan our inspection.

During the inspection

We spoke with 3 people and 5 relatives about their experience of the care and support provided. Not everyone was able to give us verbal feedback, we therefore spent time observing people and staff interacting. We reviewed a range of records. This included 4 people's care records and medication records. We looked at 2 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

- We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found some areas of the home that were not clean. There were some gaps in the cleaning records. Areas of the environment were showing signs of needing repair, these included flooring and seals around baths and toilets. The medicines room was small and overcrowded. Walls needed plastering. This meant effective cleaning in these areas could not be completed. We also identified some bins that did not have lids.
- The manager and operations manager took immediate actions to address the concerns. On the second day of our inspection the service was clean. Issues regarding cleaning and the environment had been identified by the manager and operations manager and there were action plans in place to address this. There was a refurbishment plan in place to address the environmental areas needing work which was due to commence in January 2023.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

The service was enabling care home visits in line with government guidance.

Systems and processes to safeguard people from the risk of abuse

- Most of the relatives we spoke with told us they thought their relatives were safe. Comments from relatives included, "I do feel [Name of person] is safe as the staff are very good and they have their best interests at heart", and "I am very happy when I visit and think [Name of person] is safe, mainly because I feel I am kept in the loop." One relative told us about some recent concerns they had, we discussed this with the manager who was aware of the concerns and demonstrated appropriate actions were taken.
- People who were able to told us they were safe and happy living at Cherrywood House. One person told us, "Yes I am safe." Another commented, "I am happy here." Not everyone could tell us if they felt safe. We

observed people looked relaxed in the company of staff and there were positive interactions seen throughout the inspection.

- Staff told us they thought people were safe. Staff told us if they had any concerns about poor standards of care, they would not hesitate to report them. One staff member said, "I feel able to speak up about anything. If I was worried about care, I would speak to [Manager] and I think they would sort it out. If not, I would whistle blow." Staff received safeguarding training.
- The service had reported safeguarding concerns to the local authority and the Care Quality Commission (CQC) as required.

Staffing and recruitment

- We received some mixed feedback from people's relatives about the staffing in the service. Relatives commented about the turnover of staff, although they said there were a core team of regular staff available who knew their family members well. Comments from people's relatives included, "There seem to be different staff all the time, there are a few regular workers that work with [Name of person]" and "I recognise the same staff on the whole although there are also new staff."
- Relatives also commented on the staffing levels, comments included, "There always seems to be enough staff around when I visit" and "There seems to be quite a few staff which means [Name of person] can do the things, they like cooking and going out." One relative however commented on their family member not always receiving their 2 to 1 hours to enable them to go out in the community. We discussed this with the manager and operations manager who provided evidence that people's hours were being met. They had implemented new recording systems to evidence this.
- The service had staff vacancies; these were being filled with regular agency staff to assist with continuity.
- Staff gave mixed feedback about staffing levels. Comments included, "We are using agency at the moment, but we do block book our agency staff, and they're almost like part of the team. Our minimum is eight staff and we never go below that, so things never have to be cancelled" and, "Some days we have enough staff, but not all the time. Usually we have the same agency staff, but we do get the occasional new one."
- During both days of the inspection we observed there were enough staff available to meet people's needs. People were going out and engaging in activities in the house.
- The service operated recruitment processes to check staff's suitability for the role. This included requesting references from previous employers and completing a Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Assessing risk, safety monitoring and management

- Risk assessments provided guidance for staff about how to keep people safe in areas such as accessing the community, choking and falls
- Care plans contained easy to read information about people's known health conditions. Protocols directed staff when further escalation and action was required.
- Some people could become anxious leading to incidents where they harmed themselves, others or the environment. There were detailed plans in place to guide staff at these times.
- Staff told us incidents were manageable, they knew people well and were able to identify and act to support people at these times.
- Restraint had been used twice in the past year, the staff we spoke with told us they didn't use restraint, they were able to deescalate incidents before they got to that point. The training staff received was certified as complying with the Restraint Reduction Network Training standards.
- Regular checks were conducted on fire, electric and water safety systems. Drills took place to ensure people could be evacuated safely.

- Personal Emergency Evacuation Plans (PEEPs) assessed the level of support people required.

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.
- People were able to make most day to day decisions for themselves as long as they were given the right information, in the right format at the right time.
- Where people lacked the capacity to make decisions Mental Capacity Assessments and best interest decisions were in place. These were in the process of being reviewed and a restrictive practice audit had been carried out to look at where any restrictions could be reduced.

Using medicines safely

- Medicines were managed and stored safely. Medicines were stored in individual cabinets for people. Although medicine room temperatures were monitored, individual cupboards were not. We discussed this with the manager, and they said they would put thermometers in each person's medicines cabinet to ensure accurate temperature monitoring going forward.
- Nobody using the service was prescribed controlled medicines. However, there was no designated controlled medicines storage cupboard in place because the door on the previous one had broken. We discussed this with the manager during the inspection and a new cupboard was subsequently ordered.
- Medicines were administered by staff who been trained to do so and who had their competencies checked. Competencies were reassessed and refresher training was provided if medicine errors occurred.
- Medicines had been regularly reviewed. People attended annual health checks which included a review of their medicines, in line with STOMP recommendations. STOMP stands for stopping over medication of people with a learning disability, autism or both with psychotropic medicines. It is a national project involving many different organisations which are helping to stop the over use of these medicines. STOMP is about helping people to stay well and have a good quality of life.
- People's preferences for how they liked to take their medicines were recorded.
- Regular stock balance checks were carried out. Discrepancies were recorded and investigated.
- Some people had been prescribed additional medicines on as required (PRN) basis. There were protocols in place which described how people might express if they needed additional medicine such as pain relief. The protocols included how people might display signs of pain, and whether they would inform staff verbally or through their body language.
- There were PRN protocols which were personalised and described when people might require them. When PRN medicines were administered, staff usually documented how effective they were. This meant it was straightforward to monitor if medicines worked as planned.
- Some people had been prescribed topical medicines. Topical record charts were in place and had been signed by staff when they had applied them.

Learning lessons when things go wrong

- Accidents and incidents were reported and recorded. These were reviewed by the manager and actions

were taken to prevent reoccurrence. Risk assessments and care plans were updated following incidents. There had been a decrease of incidents for people in the service.

- There were systems in place to share learning amongst the team.

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 requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There were systems in place to monitor the quality and safety of the service. Whilst the systems were identifying most of the concerns we identified during the inspection and action plans were in place to address them, they had not always ensured these were all rectified.
- Regular infection prevention and control audits had been carried out, but these took place 6 monthly which meant issues were not always addressed in a timely manner. Daily manager walk rounds had not identified broken bins or dusty air vents for example.
- Although regular medicine audits were carried out, these did not provide the auditor with an overview of how well medicines were managed. We discussed this with the manager during the inspection and they said they would review the audit form to cover all aspects of medicines management.
- The operations manager and manager took immediate action to address all of the concerns identified during the inspection.
- There were a range of other audits and visits carried out in the service by the manager and operations manager. The operations manager and manager had a range of action plans in place prioritising the work that was required in the home. They demonstrated where they were making progress against these plans.
- Statutory notifications were submitted as required. Statutory notifications are Important because they inform us about notifiable events and help us to monitor the services we regulate.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- We received mixed feedback from staff about the morale in the home. Staff commented about the number of managers that had been working in the service over the past 9 months, they felt this impacted on the team morale. Staff also commented that information was not always shared effectively amongst the team and they had not always felt listened to. The manager and operations manager had been working with the staff team to improve the service culture, communication and morale.
- Although staff morale was low, staff commented positively about the people they supported. They supported people to achieve their chosen outcomes. People's care plans were person centred, detailed and up to date. People were supported to do what they wanted to do, this included trips out on the Polar Express, café trips, birthday parties, bowling and shopping. One person was proud to show us their room, they had chosen the colour scheme, they also showed us their current goal's they were aiming to achieve.
- Relatives commented positively about the staff team. One relative told us, "The thing they really do well is the care they give [Name of person] and it seems a genuine care that comes from knowing them well."

- There had not been a consistent registered manager at the service for some time, the provider had taken action by appointing a temporary manager who would be overseeing the service until a permanent manager was recruited.
- The operations manager told us they were actively recruiting to this post, there had been an experienced manager from another service in post for the past few months to support the service.
- As part of the next steps identified by the operations manager they told us they were introducing culture assessments to promote the values and visions of the organisation.

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 manager and provider were aware of their responsibility to act openly and honestly when things went wrong. Relatives told us they were informed of any incidents that occurred. We saw examples of where the service acted on their duty of candour.
- Staff knew they had to report concerns to the manager and were confident that these would be acted upon.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There were systems in place for people, relatives and staff to give feedback and engage in the service.
- 'Our Voice' meetings had been held for people to give their feedback and views on the service. This included a communal meeting and individual meeting to obtain people's feedback. Areas covered included; anything they would like to change in the home staying, healthy, keeping safe and activities. The information from the meeting fed into a regional meeting and two people living at the home were representatives for this.
- People's relatives confirmed they had the opportunity to give feedback via an annual questionnaire.
- 'Your Voice' meetings were held for staff to give their views and be updated on any changes, training opportunities and the organisational goals and strategy.
- An annual survey was held for staff to give their views. An action plan had been devised based on the feedback received.
- The provider had arranged a listening group for staff to discuss ways of improving things and implementing management changes.

Continuous learning and improving care; Working in partnership with others

- The operations manager and manager were committed to improving the service. They demonstrated how they had applied learning and had plans in place to improve the service and people's experience.
- The provider arranged management meetings for managers to share learning and any updates.
- The provider held 'Care and safety huddles' which were ways to feedback any actions from incidents.
- Staff worked in partnership with health and social care professionals to ensure people had the care and support they needed to maintain their health and wellbeing.