Island Care Limited

Cherry Blossom Care Home

Inspection report

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Date of inspection visit:
21 June 2016
27 June 2016

Date of publication:
10 August 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on June 2016 and was unannounced. The home provides accommodation for up to 35 older people with personal care needs. There were 35 people living at the home when we visited. All areas of the home were accessible via a lift and there were lounges/dining rooms on both floors of the home. There was accessible outdoor space from the ground floor. All bedrooms were for used for single occupancy and some had en-suite facilities.

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

There were enough staff to meet people's needs although staff were busy. Staff received appropriate training and were supported in their work. The recruitment process helped ensure staff were suitable for their role.

People felt safe and staff knew how to identify, prevent and report abuse. Legislation designed to protect people's legal rights was followed correctly. Staff offered people choices and respected their decisions. People were supported and encouraged to be as independent as possible and their dignity was promoted.

People, relatives and external health professionals were positive about the service people received. Medicines were managed safely and people received these as prescribed. People were positive about meals and the support they received to ensure they had a nutritious diet.

Care plans provided comprehensive information about how people wished to be cared for and staff were aware of people's individual care needs and preferences. Reviews of care involving people were conducted regularly. People had access to healthcare services and were referred to doctors and specialists when needed. At the end of their life people received appropriate care to have a comfortable, dignified and pain free death.

People and relatives were able to complain or raise issues on a formal and informal basis with the registered manager and were confident these would be resolved. This contributed to an open culture within the home. Visitors were welcomed and there were good working relationships with external professionals.

Staff worked well together, which created a relaxed atmosphere that was reflected in people's care. Plans were in place to deal with foreseeable emergencies and staff had received training to manage such situations safely.

The registered manager and provider were aware of key strengths and areas for development of the service. Quality assurance systems were in place using formal audits and through regular contact by the provider

and registered manager with people, relatives and staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from the risk of abuse; staff knew how to identify, prevent and report abuse.

Medicines and risks to people were managed effectively. Staff understood how to keep people safe in an emergency.

Recruitment practices ensured that all pre-employment checks were completed before new staff commenced working in the home and there were generally enough staff to meet people's needs.

Is the service effective?

Good

The service was effective.

People received the personal care they required and were supported to have their healthcare needs met.

Staff followed relevant legislation to protect people's rights and ensured decisions were made in the best interests of people.

Staff were suitably trained, skilled and knowledgeable about people's needs and received support through supervision.

People were given a choice of nutritious food and drink and received appropriate support to meet their nutritional needs.

The environment was suitable for people with the provider identifying how this could be further improved.

Is the service caring?

Good

The service was caring.

People and relatives were positive about the way staff treated them. People were treated with respect. Dignity, choice and independence were promoted.

At the end of their life people received appropriate care to have a

comfortable, dignified and pain free death.

Is the service responsive?

Good

The service was responsive.

People received care that was personalised to meet their individual needs. Care plans were comprehensive and reviewed regularly to help ensure they reflected people's needs.

People knew how to make complaints and they were dealt with promptly in accordance with the provider's policy. The registered manager sought and acted on feedback from people.

Is the service well-led?

Good

The service was well led

There was an open and transparent culture within the home. The management team were approachable. People and visitors felt the home was run well. Staff understood their roles, and worked well as a team.

Quality assurance systems were in place using formal audits and regular contact by the registered manager with people, relatives and staff.

Cherry Blossom Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection which took place on 21 and 27 June 2016 was completed by two inspectors and was unannounced.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed previous inspection reports and notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law.

We spoke with nine people living at the home, three relatives and four health care professionals. We also spoke with the provider's representative, the registered manager, seven care staff, the housekeeper and the chef.

We looked at care plans and associated records for five people and records relating to the management of the service. These included staff duty records, staff recruitment files, records of complaints, accidents and incidents, and quality assurance records. We observed care and support being delivered in communal areas and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The home was last inspected in 2013, when we did not identify any concerns.

Good

Is the service safe?

Our findings

Care staff were busy but managed to complete all care tasks and additional non care tasks required of them. People felt staff were very busy. One person told us "staff are really good but pushed [busy]". Another person said staff were "Run off their feet". Whilst others said "poor things [staff] are overworked", and another person said "I don't know how they fit so much into a day". People told us their call bells were usually answered quickly whether day or night and that staff "come and chat". However, a visitor told us their relative had to wait for up to 30 minutes for two staff to be available to assist them to the toilet and was often told they had to wait which upset them. We observed staff were very busy and did not appear to have time to sit and chat with people or provide activities. However, staff were not rushing people and did take time to explain things to people such as before the use of moving and handling equipment and offered people time to make decisions such as where they would like to sit. At lunch time staff provided individual support in an unhurried way.

Care staff told us the needs to people living at Cherry Blossom had increased over the past few years. They told us more people required the support of two staff to move around the home and for the provision of care which increased their work loads. Staff also identified that more people were being admitted who required closer observation due to risks of falling and dementia. As a result the registered manager had changed staff shifts to provide additional staff at times when the home was busier. For example, one staff member now worked a 7am to 11am shift. Whilst staff welcomed this they then identified that after 11am there were only two care staff on each floor with a senior staff member between the two floors. Staff were concerned that when they were both providing personal care for a person who required two staff, no staff were available for other people. Care staff also had to cover additional tasks such as laundry and washing up after all meals. One said "the washing up is a nightmare". One care staff member was also responsible for preparing the evening meal meaning they were not available to provide care at this time. One cleaner was employed who worked five days per week. At weekends staff also had to cover essential cleaning.

Following a safeguarding concern in February 2016 the registered manager completed a dependency assessment tool. This assessed the support individual people required and calculated the overall staffing levels the home needed to ensure people's needs were met. As a result the night staffing levels were increased from two staff to three staff. The registered manager told us that since the staffing numbers at night had been increased there had been a reduction in the number of falls at night. The registered manager said they had not repeated the dependency assessment calculation since February 2016. They stated they had been told by the provider's representative that they could further increase care staffing levels during the day and they were deciding what times would most require additional staff. The provider's representative told us they were also planning to increase the number of cleaning staff hours to provide a cleaner over seven days per week.

Recruitment procedures were in place to help ensure staff were suitable to work at Cherry Blossom. These included reference checks from previous employers and a criminal record check with the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions. The home also employed some permanent staff via a recruitment agency. There were copies of all relevant checks which

had been completed by the employment agency however, a full employment history was not available for either person recruited via the agency. The registered manager stated they would request the staff to provide this information and account for any gaps in their employment. The registered manager said that when an 'in person' interview was not possible they undertook an interview using computer technology to enable them to interview the applicant 'face to face'. Staff confirmed this process was followed before they started working at the home. We saw an interviewee being shown round the home. The registered manager said they assessed interactions with people as part of the assessment process although they did not specifically ask people what they had thought of applicants.

Suitable arrangements were in place for obtaining, storing, and disposing of medicines. One visitor told us there had been a delay in the home obtaining some medicines for their relative. We asked the registered manager about the ordering process for medicines. They informed us that for repeat routine orders there were no concerns however, when doctors prescribed additional items, such as antibiotics, they would do so using electronic prescriptions directly to the pharmacy. This had resulted in delays as the prescriptions sometimes went to different pharmacies. The registered manager told us they now requested paper prescriptions and these were taken by a staff member to the nearby pharmacy and collected immediately.

Staff administering medicines had received appropriate training and had their competency assessed yearly. We observed staff administering medicines to people and saw they followed best practice guidance by administering and recording them individually. Where changes or additions had been made to Medicines Administration Records (MARs) these had been handwritten and signed by one staff member. The registered manager stated they would ensure two staff were involved when amendments were made to the MARs. Guidance had been developed to help staff know when to administer 'as required' medicines, such as pain relief. Individual guidance was available which showed what indicators each person may have that they required an 'as needed' medicine. These were viewed and contained a good level of detail as to when a person may require pain relief medicines. MARs contained no gaps and demonstrated people had received their medicines as prescribed. An appropriate system was also in place to help ensure topical creams were applied when needed and not used beyond their safe 'use-by' date. Medicines audits were completed. These were comprehensive and included observing staff administering medicines, checking medicine administration records and the stock levels of some medicines. Where necessary the results of audits were discussed with the relevant staff.

People told us they felt safe at Cherry Blossom. One person said, "The staff treat me nicely". Another person told us, "Yes I feel safe here, the staff are all nice". A visitor said they had no concerns about their relative's safety. Staff knew how to identify, prevent and report abuse, and how to contact external organisations for support if needed. The registered manager described the action they would take should a safeguarding concern be brought to their attention. The actions described would help ensure people remained safe. Investigations into safeguarding incidents were thorough and where necessary, appropriate steps had been taken to protect people.

Risks were managed safely. All care plans included risk assessments, which were relevant to the person and specified the actions required to reduce the risk. These included the risk of people falling, nutrition, moving and handling and developing pressure injuries. Risk assessments had been regularly reviewed and were individualised to each person. These procedures helped ensure people were safe from avoidable harm. Risk assessments had been conducted and measures had been put in place to reduce identified risks such as the likelihood of people developing pressure injuries. These included staff training in tissue viability, encouraging people to eat well and mobilise as often as possible. Staff were aware of people who needed to use special cushions or mattresses and we saw these being used consistently. Records showed staff supported people who were cared for in bed to change their position regularly reducing the risk of skin

damage.

The risks of people falling were managed effectively. Staff knew the support each person needed when mobilising around the home and provided it whenever needed. When people fell, their risk assessments were reviewed and additional measures put in place where needed. For example, one person had fallen so staff had placed a pressure alert mat in their room to inform staff that the person may be trying to mobilise. The risk of them tripping on the pressure alert mat had been considered as part of the risk assessment.

People were supported to take risks that helped them retain their independence and avoid unnecessary restrictions. For example, one person preferred to eat their meals sitting in a lounge chair in their bedroom rather than going to the dining room and sitting at a table. This placed them at a low risk of choking. Their risk assessment showed that this was the person's choice and they understood the decisions they were making. Staff said they therefore monitored the person more frequently from a distance to ensure they were safe during meal times. Another person was managing some of their own medicines. Risk assessment had been completed and they had been provided with a safe place to store their medicines. Staff checked the medicines monthly when reordering to ensure the person was continuing to manage these independently.

An appropriate system was in place to assess and analyse accidents and incidents across the home and action lessons were learnt from them. For example, a person had left the home via a side door and later been returned to the home by the police as they had been found near their previous address. New procedures had been put in place for staff to regularly check the door alarm (operated via a numerical keypad) was activated. Immediate action had also been taken to consider other possible routes by which the person may have left the home and a higher side gate was fitted the following day.

Environmental risks were assessed and managed appropriately. Records showed essential checks had been completed on the environment such as fire detection, gas, electricity and equipment such as hoists were regularly serviced and safe for use. There were arrangements in place to keep people safe in an emergency, such as in the event of a fire. Staff were aware of the correct procedure to take should the fire alarms sound and told us they had completed fire awareness training and fire drills had occurred. Fire detection and emergency equipment was in place and was checked regularly to ensure it would work in an emergency. Personal evacuation plans were available for people; they included details of the support each person would need if they had to be evacuated and were kept in an accessible place. Arrangements were in place with a nearby business which could be used to shelter people in an emergency and staff had been trained to administer first aid. Staff had access to essential emergency phone numbers and a business continuity plan which detailed the action staff should take in a variety of potential emergencies.

Good

Is the service effective?

Our findings

Training on a range of relevant subjects was provided for all staff however, not all staff had attended all necessary training. The training plan showed some staff had a number of gaps in their training. The registered manager said they booked training however, staff did not always attend. As a consequence they were now informing staff that if they failed to attend planned training a supervision session would be held and the staff member may be charged for the training they did not attend. Training was provided by an external training company and we saw training was planned with staff identified to complete the training. New staff received induction training which followed the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. Most longer term staff had obtained vocational qualifications relevant to their role or were working towards these.

The registered manager told us of plans to improve the environment to make it more suitable for people living at Cherry Blossom. We saw work had commenced to clear an area adjacent to the car park and were told that planning permission was to be sought to move the car park to this part of the grounds. This would then enable the existing car park to be redeveloped as a garden which people could access independently. Planning permission was also to be sought to increase the height of the first floor lounge windows to enable more light to enter the room and take full advantage of the river views. On the ground floor doors to the front of the home leading directly to the road provided the only option for fresh air from the lounge dining room. Due to the needs of people in this part of the home these could not be opened. We were told planning consent was required before these could be changed to windows which could then be safely opened and left open.

The registered manager told us they and the providers representative had recently attended dementia awareness training which had included information about making environments suitable for people living with dementia. They were planning to incorporate this training into improvements in the environment. There was an on-going programme to redecorate the rest of the home including bedrooms as they became available. New carpets and furniture was also planned for the downstairs lounge.

People's legal rights were protected as staff followed the principles of the Mental Capacity Act (MCA) 2008. The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Some people had a cognitive impairment and assessments showed they were not able to make certain decisions. These included for example, decisions around the delivery of personal care and the administration of medicines. Care plans also considered the support a person may need to make a decision. Staff had documented decisions they had made on behalf of people, after consulting family members and doctors where appropriate.

Staff sought verbal consent from people before providing care and support by checking they were ready and

willing to receive it. Records confirmed that staff complied with people's wishes; for example, they recorded where people had declined baths or other personal care. Staff described how they respected the person's decision and would then return shortly after and try again. Staff were aware that if a person was unable to make one decision they may still be able to make other decisions. For example, they described how they would show people clothing options which helped the person make the choice as to what they would wear. The registered manager was aware of the lead person for the local authority for the MCA and told us how they had sought guidance from them when required.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found Cherry Blossom was following the necessary requirements. The registered manager had applied for DoLS authorisations where necessary and was waiting for these to be assessed and approved by the local authority. Staff understood their responsibilities and knew how to keep people safe in the least restrictive way.

People were positive about the meals at Cherry Blossom. They said they liked the food and they were able to make choices about what they ate. One person said, "very good, but can get repetitive, you can tell what's coming the next day". They added that there is always a choice between main meals and that for breakfast they could request a cooked breakfast such as scrambled egg or bacon. They said "You get what you want for breakfast". Another person told us "The food is fine and if you can't eat it they give you something else." We saw people were able to change their minds and could request a different meal to that ordered. At lunch time deserts were served from a trolley so people could see the choices and decide immediately prior to receiving it. People received a varied and nutritious diet including fresh fruit and vegetables. Staff were aware of people who needed special diets or had particular food preferences and we saw these were provided. The cook was also aware of people's preferences and specific dietary needs which they said they were able to meet. Daily records showed people had received sandwiches and snacks in the evening and at night when requested.

Staff monitored the amount people ate and drank using food and fluid charts. Fluid charts were fully completed. There was guidance for staff as to how much each person should be encouraged to drink daily and staff added up the amount people had drunk each day to assess whether this had been sufficient. Some people needed to be encouraged to eat and this was done in a discrete and supportive way. Staff said they had time to support people and we saw they did not rush people with their meals or drinks.

People had confidence in the knowledge and the ability of staff to provide effective care. One person said, "They [staff] look after us very well". Another person told us "On the whole they look after us very very well". A visitor said staff were very good at meeting people's care needs but felt that people's emotional needs were less well met and people could become isolated. Staff demonstrated a good understanding of the needs of the people they cared for and how to communicate with them effectively. For example, we saw staff give people time to process information when speaking with them and supported them to make choices. We observed staff using moving and handling equipment correctly with two staff always present. Staff were able to describe the support they provided for a person who was cared for in bed. This corresponded to the person's care plan and was appropriate to meet the person's needs.

People were supported to access healthcare services when needed. Records showed people were seen regularly by doctors, specialist nurses and chiropodists. A person told us the registered manager had arranged for them to see a dentist. The registered manager had arranged for an optician to visit the home

enabling everyone who wished to have their vision checked and purchase new spectacles if required. Health information about people was known and records showed that when required staff consulted GP's and out of hour's services such as paramedics and 111. Four visiting health professionals were positive about the way Cherry Blossom met people's health care needs. They told us they were contacted appropriately and that staff followed their guidance.

People were cared for by staff who were appropriately supported in their work. Staff received a range of supervisions with the registered manager or a senior member of staff. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. In addition there were yearly appraisals of staff. The registered manager also worked some direct care shifts, including night shifts, which they said enabled them to supervise how staff provided care for people.

Good

Is the service caring?

Our findings

People were cared for with kindness and compassion. One person said of the staff, "They treat me nicely". We asked another person if the staff had a caring attitude and they replied "Course they do". These comments were echoed by other people and visitors we spoke with. A visiting health professional said "They [care staff] are caring".

People were relaxed and comfortable in the company of staff. Without exception, all the interactions we observed between people and staff were positive and friendly. We saw staff kneeling down to people's eye level to communicate with them. Staff gave people time to process information and choices were offered. Although busy staff did not rush people when supporting them. We heard good-natured banter between people and staff showing they knew people well. Staff spoke warmly about people and knew how to relate to them in a positive way. We saw a person come into the lounge/dining room and sit on a hard chair. Staff noticed and suggested they may be more comfortable sitting in a softer lounge style chair. The person agreed and staff assisted them to a more comfortable seat. One person was distressed by the use of essential moving and handling equipment. Staff spoke with them throughout the procedure and did not leave the person until they were settled and calm again.

Staff treated people with dignity and respect and described the practical steps they took to preserve people's dignity when providing personal care. This included keeping people covered as much as possible and telling people what they were about to do. Staff were able to tell us if people preferred a specific gender of care staff to provide personal care. This information was also included in care plans and staff said they were able to meet these preferences. Care plans included specific individual information as to how people's dignity should be maintained. For example, in one person's care plan we saw 'Dress upper body before [person's name] stands to dress lower body to avoid them being naked'. Another care plan stated 'Always provide as much privacy as possible, avoid leaving them completely uncovered. Undress and dress upper body before removing lower clothing'. Staff were seen to respect people during interactions. For example, staff apologised to people if they had to pass them in corridors. At tea time staff apologised to a person whose meal was not what they thought they had ordered and arranged an alternative.

People's privacy was respected at all times. Before entering people's rooms, staff knocked, and sought permission from the person before going in. Confidential care records were only accessed by staff authorised to view them. All bedrooms were for single occupancy providing privacy during personal care and bathrooms had lockable doors to prevent anyone entering when these were in use. People told us staff always remembered to close curtains and doors before providing care.

People's independence was promoted. A person told us about the support they received when having a bath. They told us the staff helped them into and out of the bath but as they were able to wash themselves staff did not wash them. At lunch time staff encouraged a person to eat without taking over. A staff member said to the person, 'you hold the spoon' then when the person was managing they said 'well done'. Where needed people were provided with suitable crockery and cutlery to maximise their independence. Care plans specified what people could do for themselves and what they needed help with.

When people moved to the home, they and when appropriate, their families were involved in assessing, planning and agreeing the care and support they received. People, or where necessary their relatives, had signed care plans to show involvement and agreement with their care plan. Senior staff told us they reviewed care plans monthly "where possible we do this with the person or their relatives". Family members told us they were kept up to date with any changes to the health of their relatives.

Care files contained information about people's lives, preferences and what was important to them such as how they liked to spend their leisure time. One staff member said "I like to know a bit about the resident's life, I can talk to them about it and it's interesting". Staff were able to tell us about people's life histories, such as their previous occupations. Cherry Blossom supported people to maintain family relationships. We spoke with two family visitors, they said they had been able to stay with their relative who had been receiving end of life care. The visitors said staff had ensured they received drinks and snacks and they felt they had also been looked after. The registered manager described how family members were able to join their relatives for meals if they so wished. Care plans detailed any spiritual beliefs or needs a person may have. For example, one care plan stated '[name person] is C of E practising'. The local vicar visited the home each month and the registered manager was aware of how to access other religious leaders if required.

At the end of their life people received appropriate care to have a comfortable, dignified and pain free death. We spoke with three visiting health care professionals who were supporting the home to meet the needs of a person at the end of their life. The health professionals were all positive about the care the person was receiving and told us staff had contacted them appropriately to provide additional support with symptom management.

Good

Is the service responsive?

Our findings

People received personalised care and support that met their needs. Staff demonstrated a good awareness of people's individual support needs and how each person preferred to receive care and support. For example, they knew which people needed to be encouraged to drink; the support people needed with their continence; and when people liked to get up and go to bed. They recognised that some people's mobility or cognitive ability varied considerably from day to day and were able to assess and accommodate the level of support they needed at a particular time. We joined the handover between the morning and afternoon care staff. Information was provided to the staff in a clear and informative manner in relation to any particular concerns about individual people. Staff told us they felt they received the right amount of information at the start of their shift to ensure they could meet people's needs.

Care plans provided information to enable staff to provide appropriate care in a consistent way. Records of care viewed confirmed that people received appropriate care and staff responded effectively when their needs changed. People or their relatives had signed care plans demonstrating they had been involved in identifying how their needs would be met. Care plans contained specific individual guidance where necessary. For example, we saw in one care plan there was guidance for staff as to how to respond if the person became agitated during personal care. This directed staff to 'Ensure [person's name] is safe and inform them you are leaving. Return when they are more settled'. Care plans detailed people's emotional care needs as well as their physical care needs.

People said they could choose to join activities and one relative felt there should be more mental and physical stimulation for people. They told us "Although all the basics are looked after I'm worried that there is a lack of [mental] stimulation". A person said that they "missed having things to do, miss cooking, miss work and looking after my home". We saw an activities plan for the week of the inspection and in several bedrooms examples of craft activities people had taken part in. a person told us about the "exercise man" who came in every couple of weeks. However, on both days of the inspection we did not see any activities occurring. People spent their time watching television and care staff did not have time to provide activities. Activities were provided by an external company. The registered manager told us they were reviewing the activities arrangements to ensure these met people's needs.

The registered manager sought and acted on people's views through meetings and surveys which were sent out yearly to people and relatives. We viewed the returned surveys for the previous year. These were all positive about the care people had received. People also felt able to raise issues with the registered manager at other times. A person told us how the registered manager had arranged for them to move to an alternative bedroom following their request for one with a private toilet.

People knew how to complain and there was a suitable complaints procedure in place. One person told us, "I've never made a complaint but I would talk to the manager". Another person said, "I've got no complaints". One person told us they had made a complaint once and that the registered manager had sorted the issue out to their satisfaction. There was information about how to complain available for people or visitors in the home's hallway along with a suggestion box where anyone could place anonymous

comments if they wished to do so. We viewed the records relating to complaints, which showed that they had been investigated appropriately. The person raising the complaint was provided with a written response apologising and where indicated detailing the action the registered manager had taken in response to rectify the problem. The registered manager's office was by the front door and we saw they frequently answered the door to visitors throughout the inspection. They were therefore available to visitors and identified that by speaking with people or relatives when they visited they were able to rectify most minor concerns before they became formal complaints.

Good

Is the service well-led?

Our findings

People were positive about their experience of living at Cherry Blossom and felt that it was well run. One person said "This is my home and I'm very happy here". Another person said that if they had any problems they could "ask to see [the registered manager] who will come up". They also commented on other senior staff who they felt were very good. Relatives were aware of who the registered manager was and people knew her name. Visiting health professionals said they felt the home met people's needs well and they were aware of who the registered manager was.

The registered manager said they would like to increase the home's involvement in the local community. There were some links with a local primary school and some people attended shows or events at the school. Where possible local services were used such as the nearby gp and pharmacy.

We observed staff worked well together. Care staff told us the staff team supported each other. Staff said the aim of Cherry Blossom was to make sure people were looked after and, if able, to meet all their requests. One care staff member said the goal was to provide a "home from home atmosphere, providing people with a safe, happy secure environment and friendly". Another care staff member said they aimed to "treat people as individuals, to provide person centred care".

There was an open and transparent culture within the home. Visitors were welcomed and there were good working relationships with external professionals. External professionals said would be happy for a relative to be at Cherry Blossom. We saw positive, open interactions between the registered manager, staff, and people who appeared comfortable discussing issues in an open and informal way. The registered manager told us they regularly worked as a member of the care staff team and were aware of people's needs. Care staff were also complementary about senior care staff. Staff said they were able to raise issues or concerns with the registered manager and were aware of the different organisations they could also contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission (CQC) if they felt it was necessary. The registered manager was aware of their responsibilities under the duty of candour requirements. We saw where necessary people or relatives had received an apology and a written explanation including what action would be taken to reduce the risk of any repeat incidents or complaints. Providers are required by law to notify CQC of significant events that occur in care homes. This allows CQC to monitor occurrences and prioritise our regulatory work. Checks of CQC records showed all incidents had been notified as required.

Formal and informal systems were in place to monitor the quality of the service people received. The registered manager undertook formal audits of the service including those relating to infection control, health and safety, medicines, care plans and other records. Systems were in place to monitor incidents and accidents. The registered manager described the action they had taken when a person had experienced repeated falls. This had included the use of falls alert equipment, consultation with the local safeguarding team and supporting the person to move to a more suitable home. The registered manager identified that the increase in night care staff had resulted in a decrease in the number of falls occurring at night. There was also evidence that showed action was taken when staff identified people had skin marks or injuries of which

the cause was unknown. The registered manager said that working directly with care staff enabled them to informally monitor the way staff worked and thus monitor the quality of care provided.

The registered manager identified that the main pressures on the service were the recruitment of senior care staff and ensuring there were adequate staff due to the increased needs of people living at Cherry Blossom. There was a development plan in place to improve the quality and safety of the service. This included enhancing the environment and increasing cleaning and care staff hours. Other formal quality assurance systems were also in place, including seeking the views of people about the service they received. Surveys had been sent to people, visitors, and external professionals. The surveys could be completed anonymously and those already completed showed everyone was happy with the service provided at Cherry Blossom.

The provider's representative was present at Cherry Blossom during the inspection and said they visited the home most weeks and was available by telephone at other times. The providers representative did not have a background in care but was attending relevant training to give them an understanding of the way the service should be provided. They told us about a four day dementia training course they had attended and how they planned to implement this within the home.

Policies and procedures were available to all staff at all times with a copy available in the main office. This ensured that staff had access to appropriate and up to date information about how the service should be run. The registered manager said they received updates from websites about any medical or equipment alerts and changes in guidance from the National Institute for Health and Care Excellence (NICE). The registered manager was undertaking further training in care management at level 5. They identified this was making them explore their practice and implement changes. The provider's representative was a member of the local care home's association and they had links with other providers in the area.