Barchester Healthcare Homes Limited

Cherry Blossom Manor

Inspection report

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Date of inspection visit:
02 January 2018
03 January 2018

Date of publication:
05 April 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection, which took place on 2 and 3 January 2018. Cherry Blossom Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Cherry Blossom Manor accommodates up to 77 people in one adapted building. The building has two storeys built around a secure inner courtyard. The upstairs floor specialises in providing care to people living with dementia and was called Memory Lane. At the time of the inspection, 55 people were living at the service. The provider had closed a section of Memory Lane as it was not used. The home caters for people who require residential, nursing and respite care.

The home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A general manager had recently been appointed. They were in the process of becoming registered.

At the last inspection 25, 26 February 2016 the provider told us they would evaluate findings from their plan to ensure staff were deployed appropriately to meet people's needs. At this inspection we found that this had not happened. There was a new regional director in post and a new general manager who had not seen this evaluation. At this inspection we found people and staff had mixed views about the staffing levels within the home. Improvement was needed around how staff were deployed at meal times and other peak times to make sure people got the person-centred support they required. Whilst the service had introduced a new shift to support evenings other peak times required review.

At our last inspection, we identified that people's social needs were not always being met, people were at risk of social isolation because staff did not always have the time to sit and talk with them. We found that this had not improved. Views about activities were mixed. Some staff and relatives told us activities were not always available on Memory Lane, which meant that people who lived there could not always follow their interests.

This service had been rated as requires improvement in February 2016 and at the previous inspection in March 2015. This is therefore the third time the provider has failed to meet the standards required.

Quality monitoring had been completed in a range of areas however; the monitoring had not identified the issues that we found during this inspection.
Risks to individuals were identified and recorded and risk management plans were in place to reduce those risks. Improvement was needed to some records to make sure all staff intervention was being recorded consistently.

People were supported by staff that had the skills and knowledge to support them and meet their needs. People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible. Where people lacked capacity the service operated within the principles of the Mental Capacity Act 2005.

People had good relationships with staff and were supported in a kind and caring manner. People were involved in making decisions. Staff were respectful of decisions made and maintained people's dignity.

People's changing needs were responded to. People had access to health professionals and other specialists if they needed them in a timely way.

People were protected from potential abuse by staff that were trained and understood how to safeguard them.

Medicines were managed safely, staff were trained to administer medicines and people received their prescribed medicines.

There were safe recruitment practices in place, which ensured appropriate checks had been completed prior to staff starting work at the service.

People were supported to make choices about their meals options and where they would like to eat their meals. Staff adapted their approach to make sure people with dementia were given a visual choice of meal.

People understood how to complain and complaints were managed and responded to in line with the provider's policy. There were comprehensive complaints records, which documented the outcome and the complainant's response.

We found one breach 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 this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff were not always deployed safely to meet people's needs at peak times during the day. People and staff did not always feel there were enough staff on duty all of the time.

People felt safe and staff demonstrated a good understanding of their roles and responsibilities in safeguarding adults.

There were appropriate systems in place to protect people by the prevention and control of infection. The service was clean in all areas and maintenance checks were routinely completed.

Medicines were managed safely and people received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not effective.

People living with dementia did not always receive person-centred support that met their meal time needs.

Where needed assessments of capacity had been completed in line with legal requirements. Deprivation of Liberty Safeguards had been submitted where required.

People received care from staff who were competent, suitably trained and supported in their roles.

People had access to health professionals and specialist services when needed.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion. They interacted positively with people and promoted their independence.

People had their privacy and dignity respected. People told us staff always knocked on their doors and called them by their preferred name.

People and family members were involved in planning and reviewing care where appropriate.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People, relatives and staff had mixed views about activities available. Improvement was needed to create more opportunity for people to have their social needs met. The general manager was planning to improve the range of activity for people living with dementia.

People were involved in reviews and contributed to the care planning process. Care plans for people living with dementia were sensitively written putting the person first.

Complaints were managed according to the provider's policy and recorded in good detail. People told us they knew how to complain and would not hesitate to do so if needed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a general manager in post who was completing the process to become registered.

There were systems in place to monitor the quality and safety of the service however they had not identified the issues we found during this inspection.

People's views were sought and evaluated to continuously improve the service.

Community links were being explored with initiatives to raise the profile of the service and welcome the local community in.

Cherry Blossom Manor

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection took place on 2 and 3 January 2018 and was unannounced. The inspection team consisted of three 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. Their area of expertise was nursing homes providing dementia care.

The provider had completed a Provider Information Return (PIR). This form asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. Prior to the inspection, we reviewed the PIR and other information we held about the service such as notifications. A notification is information about important events, which the service is required to send us by law.

During the inspection, we observed the care and support being provided and talked to relatives and other people involved in people's care. We spoke with eight people, three relatives, 12 members of staff, three nurses, a health care practitioner, the general manager, the deputy manager, operational training manager, customer relations manager and the regional director. We looked at a range of records about people's care and support and how the home was managed. We looked at 11 care plans, medicines administration records, risk assessments, accident forms, complaint records and quality assurance audits. We reviewed the staff rotas for a four week period between 4 and 31 December 2017 and looked at the call bell monitoring system for a period of one month in November 2017. We also reviewed four staff recruitment files.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in the home. One person told us, "I feel very safe and secure." Another said, "I can keep my room door open and have no trouble sleeping, I feel very secure." Another person said, "I feel very safe, the staff are knowledgeable and helpful." People also told us they would be able to raise concerns if they were concerned about their safety. One person said, "I would certainly raise a concern if I needed to." Another said, "If needed I would raise concerns." People felt they were able to ring their call bells if they needed assistance. One person told us, "I have the means to summon someone whenever needed, I have a pendant and the call bell by my bed." Where people were not able to tell us about their experiences we observed interactions and could see people responded positively to staff that were supporting them.

At the last inspection, staffing was a concern. Staff were not always deployed effectively to support people. The provider told us they would identify the cause of the discrepancy between their identified staffing requirements and the feedback received from people, relatives and staff. They told us the findings from this plan would be evaluated to always ensure staff were deployed appropriately to meet people's needs and wishes. At this inspection, we found that this piece of work had not been completed. There were still concerns about the deployment of staff particularly at peak times of the day. Responses from people and staff were mixed. One person told us, "There are fewer staff than when I first came in, they do take a bit of time to respond to the bell." Another said, "There are never enough staff is there? They seem to manage, occasionally you can feel rushed." Another person said, "It has changed a bit lately, there have been more staff changes." Another person told us they would like to see, "Another couple of staff would be wonderful, particularly at breakfast time". However, some people told us there were enough staff. One person told us, "Whenever I use the call bell they are very prompt, nothing is too much trouble." Another said, "There are carers around when needed, you only have to ask."

Staff we spoke to had mixed opinions on staffing levels. One told us, "I think there's enough staff with the current number of residents." Another member of staff told us, "There are enough staff now, but sometimes sickness is a problem but we have good staff." Another worker told us, "There are enough staff on duty, people can get washed and dressed when they want, get up when they want." "At certain times of the day we need more staff, I pull my hair out sometimes, it is very frustrating." The call bell monitoring system recorded when call bells were activated and how long it took staff to respond. The service completed regular audits of the log. The records demonstrated that most call bells were responded to in less than five minutes. However, there were a number of times when the call bell was not answered for over 10 minutes.

The general manager and regional director were aware of people's concerns but both felt the service had enough staff. The regional director told us that the service was staffed to the provider's dependency tool. The general manager told us following a recent review of staffing levels they had recently commenced a twilight shift to boost current staff numbers. A member of staff worked 6pm until midnight to support a peak time when people wanted to go to bed. We reviewed the rotas and found that this twilight shift was not always filled, this meant there was not always the additional member of staff. We discussed our concerns with the regional director who told us they are going to look at a 'whole home approach' to support peak times. This review with heads of department commenced on the second day of our inspection.

People's care files contained risk assessments and risk management plans relating to risks such as falls, malnutrition, dehydration, pressure ulcers and choking. Risk assessments had been regularly reviewed and we found appropriate interventions were in place to ensure people were protected from risks. For example, one person had been assessed as being at high risk of developing pressure ulcers. Their risk assessment stated that they required a pressure-relieving air mattress on their bed; we found that the appropriate equipment had been provided. The pressure mattress had been set at an inflation pressure appropriate for the person's weight. They did not have any pressure ulcers. Whilst risk assessments and risk management plans were in place, we found some gaps in the pressure ulcer monitoring records. This meant that the service could not demonstrate people had received the care they needed to reduce the risk of pressure ulcers.

Medicines were managed safely and people were happy with the support they received with regard to medicines. One person told us, "They [nurses] are good with medication, they bring it regularly." Another person told us, "I'm on lots of medication so I'm quite happy that they manage it." Another person told us, "The nice thing is I don't have to think about or remember it, they look after my medication." One relative told us, "Perfect, always on time, I have no concerns."

Medicines administration records (MAR) reviewed had people's photographs along with details of allergies and how they preferred to take their medicines. Protocols were available for 'as required' medicines, which meant nurses, had guidance on when to administer 'as required' medicines.
However, there were two occasions where handwritten amendments on MAR sheets had been signed by the person transcribing but had not been signed and witnessed by another staff member. Witnessing handwritten amendments is good practice as it may reduce the possibility of transcription errors.

It was the responsibility of the health care assistants to apply prescribed topical medicines, such as creams and lotions. Application records were kept in people's rooms. The name of the medicine was stated on the chart along with the frequency of application. The area of the body the cream of lotion was to be applied to was indicated on a 'body map'. There were some gaps in the records that health care staff signed to record their administration of topical creams; this meant the service could not always be sure creams had been applied as prescribed. The general manager was aware of these shortfalls and had planned to address them at the next team meeting.

One person required the use of a prescribed thickening agent in their drinks due to problems swallowing. Information from a speech and language therapist relating to the consistency required was detailed in the person's care plan. The staff we spoke with were aware of the consistency of drinks required and the amount of thickener to use. The thickening agent was securely stored.

The necessary recruitment checks had been completed. All staff had a check made with the Disclosure and barring service (DBS). This check makes sure new staff members had not previously been barred from working in adult social care settings or had a criminal record, which made them unsuitable for the post.

Staff we spoke with were knowledgeable about the different types of abuse and knew their responsibilities to keep people safe. Staff told us they would not hesitate to report any concerns and were able to tell us signs they are vigilant for. All staff had received training in safeguarding adults and refresher courses when needed.

Accidents and incidents were reported using appropriate forms, which included body maps. Forms were reviewed by the manager and any actions required documented. Information was collated to indicate any trends or patterns and monthly summary forms were produced. Incidents and major events were discussed

at the daily 'stand up' meetings with heads of departments so that lessons could be learned. Incidents were shared so the senior team could discuss what had gone wrong, what was the learning required and how the service could be improved.

Communal areas of the home were clean and there were no malodours. Bedrooms seen were clean as were en-suite facilities. The head housekeeper showed us their cleaning schedules, which were comprehensive and up to date. People told us they found their home to be clean. One person said, "I believe they keep everything infection free." Another person said, "Everything is kept clean, staff wash their hands often and I have seen them wearing gloves and aprons." Another person told us, "They deep clean the rooms when necessary." "The whole place is clean and tidy, even the residents and staff."

The service had recently had an inspection by an environmental health officer from Hampshire County Council who had awarded the kitchen a "five" rating. This meant that the kitchen had very good hygiene standards.

Staff had access to personal protective equipment such as aprons and gloves. We observed that they wore these items when needed. People told us they saw staff wearing gloves and aprons when supporting them with personal care.

The service had comprehensive risk assessments for all areas of the environment and all maintenance tasks. There were effective systems in place to report any faults, damage to equipment or the environment and when reported repairs were organised as soon as was practical. The premises were well maintained. Maintenance staff were employed and daily checks were carried out to make sure the environment and equipment remained safe.

Requires Improvement

Is the service effective?

Our findings

We observed meal times on both days of our inspection and on both floors. People had a choice of where they wanted to eat, some people preferred to eat in their rooms, some chose to eat in the dining rooms. People's views about food were mixed. People who live on the nursing floor were able to tell us their views about food and the meal time experience. One person told us, "It's not bad apart from they will serve hot food on cold plates." Another person said, "I am disappointed with food choices." One relative told us, "Food could certainly be improved, I bring things in for her such as fruit." Other people were positive about their food. One person told us, "On the whole it's [the food] pretty good. There are two main meals a day and two choices." Another person told us, "Food is very good, there is enough choice and a good service." Another person said, "If there is something you don't like they will make a sandwich. Drinks are always available, if you want a cup of tea you only have to ask." The chef told us they had been going to 'residents meetings' to talk about food, this had stopped more recently. Food was an agenda item at 'residents meetings' so that feedback could be sought. People were complimentary about the chef, one person told us," chef has been very helpful." Another said, "chef is very good."

People who lived in Memory Lane were not always verbally able to tell us their views however we were able to observe their dining experiences. Our observation identified that meal times in Memory Lane were an area in need of improvement. Staff supported people to eat in their rooms and in dining rooms at the same time. There were not sufficient staff on duty to support all the people who required assistance to eat their meal. For example, on the first day of our inspection there were five members of staff working in Memory Lane, during lunchtime three members of staff supported people eating in their rooms, which left two members of staff in the dining room. One member of staff was plating up from a hot trolley, one member of staff was trying to support 17 people with dementia throughout the lunch time experience. This was not enough staff to effectively meet people's needs. It meant that people could not have the support they needed when they needed it.

We observed there were at least three people in the dining room who would have benefited from encouragement and support to eat their meal. One person slept through the meal time, they would have benefitted from a member of staff sat with them, offering encouragement. One person continually stood up and sat down, this was distracting for the people they were sat with. One person wanted to engage in social interaction, they tried to talk to people sat at their table but had no response, after a short while they gave up. There were not enough staff around to sit with people and offer verbal or physical support and encouragement. One member of staff told us, "I don't have time to sit with them [people], to me that is important." The dining experience was not a social activity, whilst there was some background music playing people were mostly sat in silence. We observed this on both days of our inspection. We raised this with the general manager and regional director during our inspection. They told us they were working towards a 'whole home approach' to meal times. This meant that staff such as the activity workers could be deployed to support meal times in the dining room.

Whilst a whole home approach may prove beneficial when all the staff are available, the service cannot be confident activity workers are going to available at every meal time. For example, during our inspection one

of the activity workers was on sick leave. The regional director told us they hoped to introduce protected meal times. This meant the sole focus of staff would be to support people with their meal. This had not commenced as we observed people being interrupted from eating their meal to take their medicines.

People living with dementia did not always receive person centred support that met their needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed weight records for people who were being supported to eat. Records indicated that people who required support to eat had not lost any significant amount of weight over the preceding six months. People's individual preferences with regard to food and specific dietary requirements were recorded in their care and support plans. We observed these preferences and requirements were also available to the chef in the kitchen. The chef told us they kept up to date records of people's needs. They attended the daily 'stand up' meeting so they could be updated of any changes to people's health or individual needs.

At our last inspection, we found improvement was needed in relation to training at the service. At this inspection, we found these improvements had been made. The provider had employed a dedicated training person who was based at the service. They supported a cluster of homes in the local area but had made a difference to the training at Cherry Blossom Manor. They told us that the provider had its own learning and development team who provided management of training and support to make sure the service was up to date. This support enabled the general manager to monitor training effectively and plan future courses.

Training was recorded on a matrix and displayed on a notice board so that staff were aware when their refresher training was due. The trainer provided a report weekly to the manager. Records seen indicated that a high percentage of staff had completed the provider's mandatory training. Staff had the opportunity to achieve diplomas in health and social care. Two staff were undertaking a qualification at level two, one at level five and two were working towards a care practitioner qualification. Dementia awareness training was also available for staff and documentation training for health care assistants was being introduced.

Nurses we spoke with told us that they had received training relating to clinical areas of practice such as medicine management and end of life care. They told us they required refresher training with regard to the use of syringe drivers and this had been arranged. The regional director told us they had recently recruited a clinical development nurse who supported a cluster of homes in the area. Their role was to focus on clinical practice and governance. They would be supporting the nurses to maintain good quality clinical care.

New staff undertook induction training, which covered a range of topics such as infection control, moving and handling, safeguarding, health and safety, fire safety and tissue viability. New nurses also had training in end of life care, medicines management and accountability. New staff worked alongside an experienced team member of staff for a period of time for support and guidance. Regular refresher training was provided thereafter, which was a mixture of face-to-face and e-learning. We spoke to a new nurse about their recent induction; they told us they thought it had been "excellent". New staff we spoke to told us they had been given time during their induction to read people's care plans and found this to be valuable for their knowledge.

In addition to training staff were given regular supervision. One member of staff told us, "I had supervision a couple of months ago; I had more when I first started but you can have it any time if you're concerned about anything." A supervision matrix indicated that staff had received around six supervisions each over the past year along with an annual appraisal. Some staff recognised that the service had been through some changes but felt things were getting better. One member of staff told us, "I feel supported, if I need anything I go to the manager, they will try to sort things out for me."

People told us they found the staff had the skills and knowledge to meet their needs. One person told us, "Most of the staff are very efficient." Another said, "They [staff] make sure we are well and looked after." One person told us, "I have a named nurse but usually anyone will respond." Another person said, "They [staff] get on well together, I believe they understand our needs." One relative told us, "Staff and administrators always meet and greet me. There is excellent team work throughout."

People had been assessed prior to them moving into the service. These assessments were completed by the manager or a nurse so that all nursing needs could be assessed in full. Within the assessments we observed that people had been asked how they wished to receive their care and from whom, people were able to state if they particularly wanted a female or male carer for their personal care. We saw that preferences around showering or bathing were recorded and respected.

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. We found the service was working within the principles of the MCA. Assessments of capacity had been completed where appropriate, where people lacked capacity best interests decisions had been made involving relevant people and professionals where needed. We found capacity assessments and best interest decisions had been recorded for people in relation to use of bedrails, receipt of personal care and receipt of nutrition via an enteral feeding tube. Nursing and care staff that we spoke to all confirmed they had received training in relation to MCA and understood how it applied to their work.

People can only be deprived of their liberty so that they receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards. We found there were people with an authorisation in place. The service had met the conditions attached to these authorisations.

People saw healthcare professionals when they needed them. At the time of our inspection we saw a GP was doing their weekly round, they visited every Tuesday. Records in people's care files indicated that they were able to access healthcare professionals. These included dieticians, podiatrists, opticians, hospital consultants, speech and language therapists, physiotherapists and general practitioners. A nurse said that tissue viability, Parkinson's disease and diabetes nurse specialists had been consulted and were involved where needed in the care of some people living in the home.

Cherry Blossom Manor was purpose built and designed around a secure courtyard outdoor space. This meant that people living with dementia could enjoy the outdoors and remain safe. Corridors were wide and bright with chairs available so that people could sit and rest. Toilet doors were painted a contrasting colour to support people to identify the door from the wall. The dining rooms were bright and at mealtimes it was clear what the room's purpose was. There was good signage throughout the service to help people orientate.

Good

Is the service caring?

Our findings

We observed care interactions that demonstrated staff treated people with kindness and with patience. People had developed positive relationships with the staff that supported them. We observed positive interactions between people and all staff, this included domestic staff and the maintenance manager. One person told us, "The staff are all very friendly, helpful, thoughtful and considerate. If they move things they will always put them back so they are within my reach." Another told us, "They [staff] are all very caring and kind." Another person told us, "Cherry Blossom Manor has friendly staff who are all super helpful." One person told us, "Most of the staff are cheerful and interested in you." One relative told us, "The staff are very respectful, they treat [relative] very well." One person told us," They [staff] are so loving and kind. I think staff are chosen for their kindness and personality, they are always ready to help."

Staff spoke positively about the people they supported. They knew people and their needs well. One member of staff told us, "I love the residents here, I particularly like working in Memory Lane." Another member of staff told us, "I love working here and feel like I am making a difference, I enjoy getting a smile from people." Another told us, "There are some great characters here, our residents are great."

People felt they had been supported with dignity and their privacy had been respected. One person told us, "They always knock and wait to be asked in. I like to keep my door open so I can see what is going on." Another told us, "They [staff] will knock before coming in, close doors when helping me and they are very polite and helpful." Another person said, "Although I've only been here a short while they always greet me and my visitors by name. I haven't had any problems whatsoever." Another person told us, "I am very independent so I can manage my own personal care. They [staff] will knock if the door is closed before coming in." One person told us they liked to have their room door open so they could see what was happening, they told us, "I can close the door but request it is kept open, they do close it when giving personal care and close the curtains." Our observations of practice supported these views. Staff respected dignity by demonstrating respect for people. People were addressed by their name, we observed doors were knocked before entering rooms, choices were respected and people's feelings were validated.

People's differences were respected; we observed staff adapted their approach to meet individual needs and preferences. We observed one person had poured their drink onto the tablecloth during lunch; they placed their food around their placemat. We observed that a member of staff gently encouraged this person to eat their meal; they changed the tablecloth without any fuss or reference to the person's behaviour. There was no loss of dignity experienced by this person.

Communication needs were recorded in care plans and we observed staff using the information to communicate with people. People were given information in picture format, in larger print or could have it read out to them. People were supported to make choices where possible. We observed people living with dementia being offered a visual choice of meal. The staff plated up the options and showed people what the meals were, this enabled people to see and smell the menu options. We observed staff taking this approach on both days of our inspection. We observed a drinks and snacks trolley going around the service at different times of the day. People were able to see the snacks on offer and choose what they wanted from a range.

People told us they had been supported to express their views and be involved in their care. One person told us, "I think they [staff] know me very well." Another person told us, "I am always able to make my own decisions about what I want." Another said, "I am still quite able to make my own decisions and ask questions." Another person told us, "They [staff] are very willing to listen to me."

How people chose to spend their time was respected. If people chose to spend time in their rooms this was supported. Visitors were welcome at the service at any time, there were no restrictions on when relatives or friends could visit. There were areas around the home where people could meet with their visitors in private.

Confidential information about people was kept securely and only accessed by those with authority to do so. Care and support records were stored in offices on each floor that were secure, handover meetings between staff were held in the care offices with the doors shut.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in February 2016, we had concerns that people's social needs were not met. Due to the issues with staffing people did not have stimulation. At this inspection, we found it was still an area that requires improvement.

People, relatives and staff had mixed views about activity provision at the service. One person told us, "I don't get involved in much, they don't do any one to ones." Another person told us, "There is always something going on but I prefer to be on my own." Another person told us, "I like to sew and knit, I do go to craft activities and go out with activities girl." Details of planned activities for the week were displayed on a board in the entrance lobby. On the day of our inspection, we observed a reminiscence activity taking place in Memory Lane. One relative came to look and told us that was the first activity they had seen in Memory Lane since their relative had moved in. Another relative told us, "I've been really impressed, they even took her out on a canal boat in her wheelchair." One staff member on Memory Lane commented, "We never see activities, it's all for your [CQC] benefit yesterday and today."

Opportunity for social stimulation had been missed due to staff not having the time to engage with people. We observed staff during our inspection and they were busy with personal care activity so opportunity to sit with people and talk was limited. Staff wanted to sit and talk to people, one member of staff told us, "There is enough time to give care needed to a point, could do more if there were more of us."

There were four dedicated activities workers at the service who were part of the lifestyles team. The lifestyles team produced a monthly newsletter for people at the service. We saw it contained 'home news', 'this week in history', a quiz and three weeks of activity plans. We reviewed the plans and saw that four trips into the community were planned, there were activities on most days. It was not always clear on which floor these activities were taking place. People were supported with their religious beliefs and we observed religious festivals and celebrations were included in activity planning.

The general manager told us activity provision was an area they wanted to develop. They told us about their plans to improve sensory activity for people living with dementia.

The service had a mini bus, which they used to access the local community. The maintenance manager told us they were often asked to drive the bus to take people on outings to various places in the local area. One relative told us the service had offered to take their relative to a family wedding in a different county. The general manager had offered transport to and from the wedding and a bed in another Barchester home in the local area. The relative told us they were very grateful for this offer. Another relative told us, "I've been really impressed, they even took her out on a canal boat in her wheelchair."

The service had on occasion provided end of life care. Staff had received appropriate training in this topic. We reviewed one person's records whose condition had deteriorated. They had been reviewed by their GP who recorded the person was able to swallow small sips of water, but was nearing end of life. We saw that the GP had prescribed appropriate medicines to ensure they were pain free and comfortable. People had

the opportunity to record their end of life wishes, for example, people had recorded where they wished to die. The general manager told us people's wishes were always respected.

We saw thank you letters that relatives had sent to the service in response to end of life care that had been delivered. One relative had written 'The professionalism displayed, the nursing care and daily running of Cherry Blossom all provided my [relative] with a dignified and comfortable end to her life'. Another relative had written 'To a wonderful team and organisation, thank you very much'.

Care plans we reviewed were based on assessments and related to needs such as communication, moving and handling, tissue viability and hopes and concerns for the future. Care plans had been reviewed monthly by a registered nurse. We found care profile reviews had been completed approximately every six months with the person or their relative. For people who had dementia and difficulties communicating we saw that the service used a pain assessment tool to observe for signs of pain. This made sure that pain relief medicines could be administered promptly when staff observed indicators of pain.

The care plans on both floors were written by staff who knew the person. The care plans in Memory Lane in particular were sensitively written and gave staff a full picture of the person and how to support them. Any behaviour that required additional support had been recorded in a positive way to encourage staff to see the person first. People told us they had been involved in care planning and could tell staff about their preferences in relation to any aspect of their care. One person told us, "I have total control over my care."

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We spoke to the general manager about this standard and they were aware of the need to make sure people were supported. We found where people had a sensory loss this was identified in people's records with detailed guidance on how to communicate. For people with dementia there were clear guidelines on how best to communicate with people, for example people were more receptive to hearing information at different times of the day, or from a specific person. There were life histories in care plans, which gave staff key information to support communication and focus on people's strengths. Staff used life histories to help them understand people's behaviour.

There was a complaints policy and procedure which people told us they would use if they needed. We reviewed complaints records and found they were routinely investigated and recorded in full. Where needed the provider had appointed an investigating manager from outside of the service. The outcome was recorded and whether the complainant was satisfied with the outcome. Complaints were discussed at the daily 'stand up' meeting so that all departments were aware and could be involved in putting things right if needed.

Requires Improvement

Is the service well-led?

Our findings

Since the previous inspection in February 2016 the registered manager had left and there was no-one registered as manager. People told us they felt the service was being well-led. One person said, "I think it is very well run. There have been changes but this hasn't affected us." Another person told us, "It seems quite good, seems to run smoothly." One relative told us, "I think it is very well-led."

There was a new general manager in post, they started at the service at the end of November 2017 and have had experience in managing nursing homes. They are in the process of becoming registered as manager of this service. The last registered manager had left the service early in 2017. The provider had made sure the home had an interim manager during the absence of a permanent manager.

The provider had systems in place to assess, monitor and improve the quality of care provided. We observed that the general manager and regional director both completed audits and monitoring on a regular basis in a variety of areas. In addition, the provider had a quality specialist team who visited the home unannounced and checked quality and safety. The regional director told us they were always looking for continuous improvement. All action plans from audits went to them to be signed off; they told us if they did not believe the required improvement had been made they would not sign the action plan as completed. The audits completed had not identified the issues we found with regard to deployment of staff at meal times. A more robust dining audit would have identified our concerns. The regional director and general manager did hold a meeting on the second day of our inspection with the heads of department to discuss deployment of staff at meal times. Any improvement agreed would need to be consistent at the service so people could be assured of the support from staff being available when they required it.

There was some evidence that action had been taken in response to audit findings. For example, an agency worker information folder and induction checklist had been introduced and staffs competency relating to medicines management had been reassessed. The general manager showed us a new form they had implemented in response to staff stating they did not always have time to read the care plan when a person moved into the service. It was a summary of needs. We saw one that had been completed for a recent admission. It was a comprehensive summary giving staff an overview of the person's needs. It recorded a brief medical history, needs in relation to personal care, eating and drinking, communication, mobility, continence, sleeping and hobbies.

The general manager told us they were getting to know the home, the organisation and the systems used for day-to-day management. They recognised that improvement were needed in some areas such as activities and monitoring records and told us they hoped they were changing things in a positive way. They had a clear vision for the future of the home, they told us, "I am excited about 2018 and can see lots of potential." They spoke to us enthusiastically about the improvements they were hoping to make. One of these improvements was to identify 'ambassadors' – people living at the service who may want to take on responsibility such as chairing meetings or welcoming new people to the service. We saw that the provider had organised a 'meet the manager event'. Cherry Blossom Manor had organised a session where people could come and meet the manager whilst having a mulled wine and a mince pie. Leaflets had been

distributed to local homes and businesses in the area.

Some people and staff had met the new manager some had not had the opportunity yet. One person told us, "It's a tightly run ship, management have their eye on things and the new manager has popped in." Another person told us, "It is well run." Another person told us, "There have been changes recently; I haven't met new manager yet." One staff member said that, "Things are getting better now the new manager is in place". They added, "She [the manager] supports us with everything we do." Another member of staff felt different saying, "Staff don't feel supported. She doesn't come up here [Memory Lane] much."

The general manager was supported by a regional director who visited the home at least twice per month. They told us they supported the general manager during their induction by visiting regularly and making sure the general manager completed the provider induction. The regional director discussed the provider values with us and explained how they were a key part of the manager induction process.

The general manager was aware of and understood their responsibilities. We saw the rating from the last inspection was on display. The service submitted notifications of incidents promptly as required by law. The provider was open and transparent and expected this practice from the general manager. They had commenced daily 'stand up' meetings for all heads of departments. We observed a meeting, which was attended by the chef, the nurses, the activities worker, maintenance manager and head housekeeper. Information was cascaded and any changes to people's needs were discussed.

People had been given the opportunity to give feedback. Regular residents meetings were held. One person told us, "We have a residents meeting, they do listen." Another person told us, "They have meetings for us, the activities lady also asks us often what we would like to see and do." One relative told us, "There was a recent relatives meeting, I was very impressed at how they brought relatives together." The provider had a 'you said, we did' board in the foyer area to demonstrate listening to feedback and complaints. There was not one available in Memory Lane.

The service employed a diverse workforce who all told us they felt welcome at Cherry Blossom Manor. The general manager told us that they were aware of the cultural needs of some of the staff. They told us that where possible consideration was given to rota planning when certain festivals were being observed. The general manager told us that respect was expected for people living at the service and amongst the staff. The provider's vision and values were displayed at the service and were part of the staff induction.

The service had reached out to the local community with various initiatives that were produced both at local and provider level. The service opened up to the local community on the first Monday of every month with a coffee morning. We spoke to the customer relations manager who told us they were a dementia champion. As part of the Alzheimer's Society dementia friend's campaign, they had completed the one day training to facilitate dementia friend's sessions. Sessions had been held in the home to encourage the local community to visit and they had visited the community to facilitate sessions.

Where needed the service worked in partnership with other agencies. The general manager told us they had good working relationships with medical professionals, the local authority link workers and nursing colleagues from clinical commissioning groups. They told us they recognised that these relationships were important for people to make sure the service could meet individual needs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person-centred care and treatment appropriate to meet all of their needs.