Cherry Tree Care Limited

Cherrytree Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Cherrytree Residential Home is a residential care home providing care and accommodation to younger people living with physical disabilities, mental health needs and older people over the age of 65 years, some of whom were living with dementia. The service can support up to 40 people in one building. At the time of the inspection there were 28 people living at the service.

People's experience of using this service and what we found
People were not safe because unexplained injuries were sustained and were not always identified, investigated or reported. Risk was not always identified or managed.

People were at risk of catching infections because not all areas of the service were clean.

People mostly had their medicines at the right time and in a safe way, however, not all staff had their competency assessed regarding managing people's medicines.

Oversight and leadership were ineffective. The provider and registered manager were not aware of all incidents which had occurred at the service. Some people's relatives expressed some frustration about a lack of communication, missing personal items and restricted visiting arrangements.

Audits had not identified shortfalls such as food and fluid records not being completed for all people who were losing weight. Care plans and risk assessments were not fully reflective of people's needs. Mechanisms for seeking feedback from people using the service were limited. This meant people's views and feedback were not always used for driving improvement.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

The last rating for this service was good. (Published 19 January 2022).

Why we inspected
The inspection was prompted in part due to concerns received about safety and leadership. A decision was made for us to inspect and examine those risks.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

Enforcement
We have identified breaches in relation to safety, protecting people from abuse and leadership.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Cherrytree Residential Home

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by two inspectors.

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

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

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection

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

During the inspection
During the inspection We spoke with three people who lived at the home and one visitor about their experience of care. We observed care and support provided in communal areas. We spoke with the provider, registered manager, deputy manager, a senior carer, a care assistant and a housekeeper. We reviewed documentation including four people's care plans and daily records, sampled medicine records and reviewed four staff recruitment files. We also reviewed a range of records relating to the day to day management of the service. After the inspection We continued to seek validation from the provider regarding staff training and care planned and delivered.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

- Risks were not always assessed or managed. Two people were at risk of harm because of their dementia and cognitive impairment. They also exposed other people to risk of harm. These risks were not identified or not effectively managed.
- Staff did not always have time to monitor and supervise people to make sure they were safe. There was one incident where another person was physically assaulted. Other incidents included verbal aggression and ineffective management of people's continence needs in communal areas and in other people's rooms.
- One person had lost a significant amount of weight in a four month period since moving into the service. Staff reported this to the GP and were advised to monitor, however staff were not recording the amount of food consumed each day so there was no way of knowing if the person had enough to eat each day. The person had not had their weight checked for over a month.
- Not all accidents and incidents were recorded, or any action taken to prevent further risk. This included where people had sustained serious injuries.

Preventing and controlling infection

- Some areas of the service were not clean. One person's room had a strong unpleasant odour. The communal bathroom on the first floor had a dirty bath hoist and the enamel on the bath was peeling off making it difficult to clean. The stairlift chair was ripped, making it difficult to clean, the provider told us this equipment was not currently being used.
- There was no risk assessment in place to manage the risk presented by one person touching and taking other people's food and drinks and spitting on the floor.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes

We received complaints from three people's relatives regarding the restricted visiting arrangements at the service. The provider assured us there was a booking system in place but no restrictions on visiting. However, relatives told us they had been restricted to 30 minute visits and prevented from seeing their family member in their own private rooms. These concerns have been addressed in the well-led section of this report.

Systems and processes to safeguard people from the risk of abuse

● Staff did not always identify or report injuries or there was significant delay in seeking medical attention. One person was found by their family member to have a large bruise and sore skin. Staff were unaware of or had not reported this injury. When the provider was made aware of this injury, they did not report this to the person's GP.
● Another person was admitted to hospital with an injury but there was no record of an accident or incident. Staff were unaware of how this injury was sustained.
● Staff had recorded an incident of physical aggression where a person had been slapped and shouted at by another person who used the service. The provider and Registered Manager were unaware of this incident and the incident had not been reported to the local authority safeguarding team. This meant people may not always protected from abuse and improper treatment.
● Staff we spoke with had received training and could describe the correct procedure for identifying abuse and reporting concerns. However, these actions had not always been taken because staff were not aware of suspected abuse or had not reported it.

The provider had failed to protect people from abuse and improper treatment. This was a breach of regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● The provider's recording system for managing people's medicines was online so staff used a laptop when administering and recording prescribed medicine. This system allowed the provider to monitor and audit medicines given and to check they were given correctly.
● One person told us they had not had any of their medicines and were experiencing pain. Medicine administration records showed the person had not taken any of their 'as required' medicines to relieve pain. The registered manager told us they had been offered these but had refused. We were not assured this medicine had been offered and refused as records seen did not support this.
● The registered manager told us staff received online training about managing people's medicines and had their competency assessed. We were shown three staff members medicine competency check records, there were no other staff competency check records available. This meant we could not be sure all staff responsible for administering medicines had their competency checked.
● Shortly after our inspection, a safeguarding alert was raised regarding the safe management of medicines for people transitioning to other services.

Staffing and recruitment
● The provider told us required staffing numbers were assessed and analysed monthly and a staffing tool was used to determine required numbers and skill mix of staff.
● People and staff we spoke with told us there were enough staff on duty to meet people's needs and keep them safe. However, we could not be assured as there were only two staff on duty at night. Two people required the assistance of two staff because of their mobility needs, seven people were at risk of falling. One person was frequently awake and up and about during the night and required supervision and monitoring to keep them safe. It would be difficult for two staff members to manage people's needs and keep people safe.
● Staff recruitment files were not available at the service, but the provider made three staff records available for the second day of our inspection. Staff had references and police checks in place to make sure as far as possible, only staff with the right skills and character were employed.

Learning lessons when things go wrong
● The registered manager told us they had introduced a professional visits form to improve communication following feedback from community nurses.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.

● Systems and processes were ineffective in identifying or addressing issues with the safety of care. Records minimised the seriousness of incidents and some incidents were not recorded at all. For example, staff recorded in daily notes and behaviour charts incidents of physical and verbal aggression towards staff and other people who used the service. However, there was no risk assessment review or revised management plans in response to these incidents, so risks were not reduced or managed.
● The provider failed to have oversight of incident records. One person who had a short stay at the service was found to have a wound on their arm when they returned home. There were no accident records regarding this incident and nothing had been communicated to the family member.
● The provider failed to have oversight of accidents. The relatives of two people told us their family members had fallen while at the service but there were no records of these falls and no record of action taken to reduce further risk.
● The provider's audits failed to identify the issues and issues and concerns we found. On the first day of our inspection we found records for food and fluids had not been completed for the previous day. When we looked again on the second day, we saw records had been competed retrospectively. This posed a risk of incorrect or inaccurate records of the amounts of food and fluid consumed by people known to be at risk of malnutrition and dehydration.
● Two people we spoke with had concerns about their care and support which staff had not identified or responded to. Four people's relatives expressed their frustration regarding communication with the registered manager and felt their complaints had not been investigated or responded to. These included concerns about visiting, people's access to healthcare and missing/lost items.
● One person told us they were experiencing difficulty communicating because of sensory loss, however staff did not use any assistive methods to support communication during the inspection.
● Another person experienced chronic discomfort in their mouth and throat. Their relative told staff they liked a particular type of drink which also helped to relive this discomfort but this was not provided and was not recorded in their care plan.
● Mechanisms for seeking feedback about people's experience of care and support was limited. 'Residents

meetings' were held and newsletters were used as a method of communication. However, minutes of meetings did not contain any record of people providing their feedback or evidence of changes made to meet people's preferences. Care plans were reviewed monthly, but again there was no evidence changes had been made in response to what people said or asked for.

The providers systems and processes failed to assess, monitor and improve the quality and safety of the services provided. This was a breach of Regulation 17, (1), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

● The provider sent out surveys to people, staff, relatives and visiting professionals. The results and analyses were mostly positive. Action plans had been developed. However, action plans had not always resulted in the required change or improvement. The action plan from the staff survey completed in March 2022 was developed to improve communication about changes to people's wellbeing and to discharge planning but shortfalls in these processes were identified at this inspection.

● The provider had introduced an 'employee of the month' system to encourage innovation and good practice. People were encouraged to nominate staff for this award.

● The provider told us staff training had increased and all staff were paid above the living wage in order to encourage staff retention and job satisfaction.

Working in partnership with others

● Staff consulted with healthcare professionals and other authorities such as the local authority.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse or improper treatment.