Nightingale Residential Care Home Ltd

Cherrydale

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Cherrydale is a residential care home without nursing providing personal care and accommodation to up to 22 older people, including people living with dementia. There were 20 people living at the service at the time of our inspection.

People's experience of using this service and what we found
People were at risk of receiving unsafe care. We observed some unsafe moving and handling practices at the service and environmental risks were not addressed appropriately. People's care records did not always include important information about how to reduce risks associated with their care. There were delays in reporting some safeguarding concerns to the local authority. There were not always adequate staff on duty to meet people's care needs.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Quality monitoring and management oversight continued to be ineffective at identifying and addressing shortfalls in areas such as medicine administration, health and safety and care planning. Incidents such as allegations of abuse had not always been reported to CQC when necessary, which meant we were unable to check the provider had taken appropriate action in response to these events. The provider had systems in place to enable people living at Cherrydale and their relatives to provide feedback about the service.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 17 February 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations. This is the fifth consecutive inspection where the provider has been rated inadequate or requires improvement.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 10th December 2021. Breaches of legal requirements were found. We served Warning Notices in relation to Regulation 11 (Consent to care), Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We undertook this focused inspection to check the provider now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those

requirements.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified continued breaches in relation to consent to care, safe care and treatment, good governance and staffing at this inspection.

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
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Cherrydale

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two 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.

Service and service type
Cherrydale 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. Cherrydale 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. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with two people who used the service and four relatives about their experience of the care provided. We observed people receiving care. We spoke with four members of staff including the registered manager, senior carer and care staff. We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm. This is the fifth consecutive inspection when the key question safe has been rated either requires improvement or inadequate.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
At our last inspection 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.

Not enough improvement had been made at this inspection and the provider remains in breach of regulation 12. The provider had not met the warning notice that was served following the previous inspection. This was the fifth consecutive inspection the provider was found to be in breach of regulation 12.

- Risks to people were not safely managed. Risks were not adequately assessed and the provider was not doing all that was reasonably practical to mitigate risk. There were several people who had been identified by the provider as needing their food served in a certain consistency due to difficulties swallowing however they had not been referred to Speech and Language Therapy (SALT) and risk assessments did not identify them as being at risk of choking. This left people at risk of harm by choking and possibly receiving a diet that was not appropriate for their needs. We observed one of these people coughing repeatedly whilst they were eating which a member of staff told us was common for them. Following the inspection, the provider referred these people to SALT and planned to update their care plans.
- People with limited mobility were sitting for long periods of time in slings which were designed for transfers only and not to be left in place. This meant people were at risk of developing pressure damage although no one at the service had developed pressure damage at the time of the inspection.
- One person had a diagnosis of diabetes and was taking regular oral medication to control this, however there was no information in place or risk assessment about how to support them to manage the risks associated with diabetes. The registered manager told us they were aware the person's care plan needed to be updated in relation to their diabetes but they had not yet done this.
- Checks carried out in March 2022 had identified there was a risk of legionella bacteria being in the water system and actions had been recommended to address this. At the time of inspection none of the recommended actions had taken place. Legionella bacteria puts people at risk of serious respiratory infection. Following the inspection the registered manager arranged for work to be carried out to ensure the risk from legionella bacteria was reduced and assured us they had subsequently received a negative result for legionella in the water system.
- Records showed there were several hot water taps in the building with a water temperature above the recommended limit for care homes. This placed people at risk of scalding. Records also showed that window restrictors had not been checked since February 2020. This increased the risk of window restrictors

failing and stopping people from falling from windows. The registered manager told us these issues would be addressed following the inspection.
● We observed one person being transferred into a wheelchair. The wheelchair was missing a footplate. This meant the person's foot was not supported and was at risk of causing injury by getting caught under the wheelchair or on other objects such as doorways. We raised this with the management team who said that staff had been told not to use this wheelchair and to use other equipment instead. However, no action had been taken to remove the wheelchair or to clearly identify to staff it should not be used. The registered manager told us she would address this following the inspection.
● When observing other transfers of people, we found there was very little communication from staff to engage with people. On one occasion a person being transferred in a hoist appeared to flinch as if distressed but staff continued talking to each other instead of speaking to the person to offer reassurance.

People remained at risk of harm because systems were not in place or robust enough to demonstrate safety was effectively managed. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Improvements had been made to the monitoring of pressure relieving mattresses which help to reduce the risk of people developing pressure sores. These were set correctly in accordance with people's weights and records showed these were being checked regularly.
● Fire safety checks were being carried out regularly and there were contingency plans in place to ensure people's care would continue in the event of an emergency such as a fire or flood which meant people had to leave the service.
● The provider had responded to some changes in people's needs, adapting their care as appropriate. For example, people who were at risk of falls had equipment put in place to help reduce the risk.

Using medicines safely
● People were not always administered their medicines safely. One person was having medicines administered to them covertly mixed with their food but this was not mentioned in the person's support plan and there were no guidance from the prescriber or pharmacist recorded to indicate what to mix the medicines with or how to do this safely. The support plan was updated and written guidance was provided by the GP on how to administer the medicines covertly following the inspection.

The failure to ensure the proper and safe management of medicines was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had received relevant training before they were able to give people their medicines. The registered manager regularly checked staff competency to ensure they had the appropriate knowledge and skills.
● Medicines were ordered, stored and disposed of appropriately. Staff completed medication administration records (MAR charts) following the administration of medicines. MAR charts were regularly audited to ensure any discrepancies could be identified and rectified quickly.

Staffing and recruitment
At our last inspection the provider had failed ensured there were appropriate numbers of trained and supervised staff at the service to support people in a safe way. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remains in breach of regulation 18.

● The provider had made some improvements to staffing levels since our last inspection however we found there were still times when there were not enough staff on duty to meet people's needs.
● There had been an increase in the number of staff on duty during the daytime however a member of care staff was required to come away from their caring duties each day to do people's laundry. This reduced the number of care staff available to support people.
● There were only two staff on duty in the evenings after 8pm which meant that people who required two carers for personal care could not choose to go to bed after that time as it would have left no other staff available at the service.
● Some people were cared for in bed either due to their choice or difficulties supporting them safely to access communal areas. We observed interactions with staff for these people were minimal and limited to essential care only such as providing personal care. There was very little mental stimulation or meaningful activities provided to people who were in their rooms. One person told us, "There is not enough staff here. Staff are rushing around and not having enough time just to catch up. Every member of staff seems to be rushing from one person to another."
● The registered manager told us they recognised staffing was an issue and they were working to try to improve recruitment, however this was challenging due to a shortage of available workers in the adult social care sector.
● Staff were not always recruited safely. We found one member of staff had no references on file from their previous employers.

The failure to ensure there were enough staff to meet people's needs was a continued breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding concerns were not always reported appropriately as described in the well-led section of this report. We found there had been two incidents in June 2022 which should have been reported to the local authority as safeguarding concerns however this had not been done. The registered manager reported these incidents to the local authority following the inspection.
● Staff had received safeguarding training and told us they would report any concerns they may have about abuse to the registered manager.
● People and their relatives told us they felt safe at Cherrydale. One person told us, "I feel safe being here." A relative told us, "I think [person] is safe. They have lost a lot of mobility, when they walk with a walker there is always someone with them and when they've had enough, staff get them a wheelchair."

Preventing and controlling infection
● At our last inspection we found the laundry room was visibly dirty and very untidy. At this inspection we found the laundry room had been refurbished and it appeared clean and uncluttered.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visits for people living at the home were facilitated in line with the current guidance.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. This is the third consecutive inspection when the key question effective has been rated requires improvement.

Ensuring consent to care and treatment in line with law and guidance
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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At our last inspection we found effective MCA systems were not in place. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11. The provider had not met the warning notice that was served following the previous inspection.

- Decisions had been made by the provider for some people who had not had their capacity assessed to see whether they could make those decisions for themselves. For example, one person was receiving medicines without their knowledge sometimes mixed with their food however there was no mental capacity assessment or best interest decision relating to this.
- Another person was being given food only in a pureed consistency due to a decision taken by the provider, with no record of any consultation about this with the individual or their representatives.
- There was CCTV in operation in communal areas the service however mental capacity assessments and best interest decisions had not been carried out for people unable to give informed consent about being recorded in their home.
- We observed people being weighed in turn on chair scales in a communal area. Staff did not explain to

people what they were doing or ask for their consent to weigh them. We heard a member of staff say to one person who we had seen become distressed during an earlier transfer, "it's your turn" without asking whether it was OK to proceed.
● We saw one person ask a member of staff where they should sit in the lounge after lunch and the response from staff was to point to a chair rather than offer them a choice of where they would prefer to be seated.

The failure to ensure mental capacity assessments and best interest decisions took place appropriately was a continued breach of regulation 11 (Consent to Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● DoLS had been applied for appropriately for people who had been assessed as not having capacity for aspects of their care and support.
● Some improvements had been made to ensure that where mental capacity assessments and best interest decisions were recorded, these were decision specific and complied with national guidance.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed by the management team prior to them moving to the service to ensure that Cherrydale was able to meet their needs. Assessments from health and social care professionals were also used to plan effective care.
● Assessments guided by national framework and standards were completed to ensure that people's needs were assessed and met. For those people living with dementia this included how they were affected by this.

Staff support: induction, training, skills and experience
● Staff told us they had the opportunity to raise any concerns they had with management when they needed to. One member of staff told us, "We have a handover when we can discuss any issues."
● Staff received the regular training they needed for their job roles. For example, all staff received dementia awareness training. One relative told us, "From what I've seen the staff understand the different people that live there. They understand [person]."
● Staff received an informative induction when starting work at the service which included opportunities to meet people living at the service and time to learn how equipment worked. New staff also shadowed other staff before providing any care themselves.

Supporting people to eat and drink enough to maintain a balanced diet
● People spoke positively about the food options available to them. One relative told us, "[Person] adores the food. They say it's the best bit about being there. They look forward to the meals." Another relative said, "There's a variety of food. They always make sure if [person] wants a cheese sandwich, they get a cheese sandwich as it's their favourite. If [person] wouldn't eat anything else, they would make that for them."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● As reported in safe, people were not referred to SALT appropriately. However, people told us access to other agencies and healthcare services was well supported. One person told us, "The GP has a regular visit, a day I went to hospital he wasn't due here, but he came out to see me." A relative told us, "They have been razor sharp, [person had an infection two weeks ago, they were soon on anti-biotics and the doctor was called."
● The registered manager and staff team worked with healthcare professionals to ensure people's healthcare needs were met. They worked with services including GPs, social workers and community-based health professionals.

● People's oral health care needs were met. People received support with their oral care and care plans included information to guide staff on how to promote good oral hygiene.
● We received positive feedback from health care professionals we spoke to about working with the service. One visiting professional told us, "[I have] no concerns really, staff are very caring, take care of the residents, they do escalate and follow up the advice we give."

Adapting service, design, decoration to meet people's needs
● People told us they were happy with their bedrooms and the communal areas. People had personalised their bedrooms with their own decorations, pictures and ornaments
● The provider ensured the design and layout of the home was suitable for people living there. Communal areas were comfortable and homely.
● There was new flooring in all communal areas which was more visually appealing than how it had been previously and better suited to the environment.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated 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. This is the fifth consecutive inspection when the key question well-led has been rated either requires improvement or inadequate.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

At our last inspection we found monitoring of the service was ineffective. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17. The provider had not met the warning notice that was served following the previous inspection.

● There is a history of regulations not being met at the service. Cherrydale has been inspected five times since September 2019 and breaches of regulations have been found at every one of these inspections. Governance systems had been ineffective at addressing the concerns raised at the previous inspection in relation to mitigating risk, ensuring the Mental Capacity Act is followed and record keeping. Some of the concerns found at this inspection were similar to those found at the previous one.
● Quality monitoring systems at the service were not effective. They had not identified and addressed the shortfalls we found. This included issues such as mental capacity assessments and best interest decisions not being recorded, inconsistencies in people's care plans or gaps on people's food and fluid charts.
● Medicine administration audits had failed to identify that someone was being administered medicines covertly without any guidelines recorded to support this.
● The provider and registered manager had not taken action to reduce the risk from legionella that had been highlighted to them.
● Some risks had been identified but the provider had not taken any action to address these. As reported in safe, there was a risk of scalding from some hot water taps. These had been identified as being too hot through health and safety checks however no action had been taken to resolve this.
●The provider did not always meet their regulatory requirements. There were four open safeguarding enquiries at the service relating to allegations of abuse. There is a regulatory requirement to notify CQC of these however this had not been done.

The provider had failed to implement effective systems and processes to assess and monitor the service.

This was a breach of regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Residents' meetings were taking place regularly and gave people the opportunity to give their views about the menu and activities they would like to try.
- There was a positive atmosphere in the communal areas at the service. One person told us, "We are together as one like a happy family here." Another person said, "I like it here and I like the service."
- People and relatives said they had the opportunity to feedback about their care. One person told us, "I was given a questionnaire a couple of days ago." A relative said, "They constantly say, 'let me know if there is anything you are concerned about.' It's all perfectly appropriate to me."
- There were regular team meetings when staff were encouraged to contribute their ideas and staff told us there was good teamwork at the service. One member of staff said, "We are a strong team. Staff will come in at short notice to cover sickness."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager understood their responsibilities regarding the duty of candour. They worked openly with families and kept them updated. One relative told us, "They have telephoned me several times what's going on. They have a policy that the relative needs to know what is happening." Another relative said, "Information process seems to be there, they inform me."
- Staff and people living at the service told us they felt comfortable raising any queries with the registered manager, and that the culture was an open one.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure mental capacity assessments and best interest decisions took place and were recorded appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that risks to people were appropriately managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient staff on duty to meet the care needs of people living at the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure quality monitoring at the service was effective.

The enforcement action we took:

Impose condition