Amberbrook Limited

Cherry Garden

Inspection report

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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

Cherry Garden is the only location the provider is currently registered for. The service provides nursing care for up to 36 people. Cherry Garden is situated in the village of Littlewick Green, close to the town of Maidenhead. It is set in large grounds surrounded by countryside. People who use the service live over two floors. There are 28 bedrooms, 2 lounges which look onto the gardens and a single dining room. The garden was designed to incorporate a sensory garden and wild life patio.

At the time of the inspection, there was no 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. The deputy manager was acting in the role at the time of the inspection. We were made aware by the nominated individual that the role was offered to the staff member shortly before our inspection. After the inspection, the provider made us aware that the deputy manager had accepted appointment to the role. The deputy manager has commenced the registration process with us.

Our last inspection of the service was 26 July 2016, 28 July 2016 and 29 July 2016. This was an unannounced, comprehensive inspection. We gave the first rating to the service. We rated the service 'requires improvement' overall, but our key question 'Is the service safe?' was rated 'inadequate'. We found nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served requirements against the provider and requested an action plan. This inspection was a further comprehensive inspection to determine what actions the provider had taken to ensure improved safety and quality of care.

The safety of people who used the service had increased. We saw that risks were better identified, understood, mitigated and documented. Improvements were made in specific areas since our last inspection. These included the decrease of risks like moving and handling of people, premises and the environment, medicines management and infection control. We made recommendations about medicines management and infection control. Some risks to people's safety still required further improvement. This included safe staffing deployment as there continued to be use of inappropriate numbers of agency staff.

We found staff received appropriate support with induction, training and supervisions. Performance appraisals were not completed, but the management team were aware of this. Confusion regarding the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) codes of practice continued since our last inspection. We observed there was a focus to improve this by the home manager and the staff, but training in the area had not addressed the management of consent, mental capacity assessment and best interest decision making. The provider had invested in the premises to improve the physical environment for people who used the service. We made a recommendation about dementia-friendly refurbishment.

There was positive feedback from people and relatives we spoke with at Cherry Garden. They considered the staff were kind and caring. This was also reflected in written feedback the service received. We observed staff were more attentive to people's needs and treated them with increased dignity and respect.

There was an increased effort to improve the personalisation of care documentation and people's support. People's likes, dislikes and preferences were recorded in addition to their life history. Further effort was required to ensure this was in place for all people who used the service. Activities coordinators offered a varied, engaging programme. The provider needed to examine people's access to the local community for social purposes.

Significant changes in staffing had occurred since our last inspection. This resulted in some temporary disruption within the service's workplace culture, but we observed a settled presence amongst staff. Staff held different opinions about management. We did find evidence of good support to staff from the home manager, operations manager and nominated individual. Staff input into the day-to-day operation of the service was limited and the provider needed to increase engagement with the workforce.

Checks on quality and safety were in place. There was some duplication in the audits and some tools required review to ensure their effectiveness. The service had a single, central action plan which was contemporaneous. The service needed to ensure all determined risks that required attention were always documented in the action plan, to prevent them being unintentionally disregarded. We made a recommendation about duty of candour training for the management team.

We determined there were four continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider achieved compliance with five breaches we determined at the prior inspection. You can see what action we told the provider to take at the back of the full version of the 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.

People sufficiently protected against abuse or neglect.

People's care risks were adequately assessed, documented and mitigated.

Staffing deployment remained unsatisfactory.

People's medicines were safely managed.

Infection prevention and control required continued improvement.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff who cared for people received satisfactory training, supervision and support.

The service did not comply with the requirements of the Mental Capacity Act 2005.

People received suitable food and fluids.

People received support from a range of community healthcare professionals.

The physical environment required continued improvement, especially for people with dementia.

Is the service caring?

Good

The service was caring.

People received kind and compassionate care from staff.

People's dignity was respected and their privacy was protected.

People's end of life wishes needed better recording.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had care plans in place, but these required more person-centred information.

People's access to the local community was limited.

People, relatives and others had a satisfactory complaints process available to them.

People and relatives had the opportunity to have their say via meetings.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service required improvement in seeking the views of, and acting on staff feedback.

The quality of care was checked using audits, but required further enhancement to consolidate findings.

The provider took action to address known issues to decrease risks.

Further action was required to ensure management were competent with the duty of candour process.

Cherry Garden

Detailed findings

Background to this inspection

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

This inspection took place on 18 January 2017, 19 January 2017 and 20 January 2017 and was unannounced.

The inspection team comprised two adult social care inspectors, a pharmacist inspector and two specialist advisors. The specialist advisors were a registered nurse and an occupational therapist. An Expert by Experience spoke with people who used the service, relatives and staff. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

In planning the inspection we reviewed all the information we held about the service. This included notifications regarding safeguarding, accidents and incidents and changes which the provider had informed us about. Before the inspection, we did not request a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

In order to gain further information about the service, we spoke with ten people who used the service and five relatives or visitors. We spoke with the provider's nominated individual, operations manager, acting home manager, the maintenance person, chef and two activities coordinator. We also spoke with 10 other staff that provided care to people. We contacted the local authority, commissioners, Healthwatch, the fire authority and clinical commissioning group (CCG) for feedback prior to the inspection.

We looked throughout the service and observed care practices and people's interactions with staff during the inspection. We reviewed 12 people's care records and the care that 9 of them received. We looked at people's medicine administration records (MAR) and the medicines room. We reviewed records relating to the running of the service such as staffing information, documents associated with staff training and quality monitoring audits.

The provider was asked to send information to us after the inspection and we received and reviewed this as part of the evidence we considered.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 26, 28 and 29 July 2016 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care and treatment was not provided in a safe way for people. Staff did not ensure the equipment at the service was safe for its intended purpose and used in a safe way. The service did not do all that was reasonably practicable to mitigate risks to people. We issued a requirement notice against the provider and requested an action plan.

At this inspection we found the moving and handling of people had significantly improved since our last inspection. Staff were more likely to gain permission from people and explain the process before they started the moving and handling transfer. We observed 10 moving and handling transfers which included transfers from one seated position to another, full hoist lifts using access slings or full body slings and standing transfers with handling belts and repositioning on the seat. We observed four different staff over one day undertaking the manual handling and spoke with all of them. We checked three sets of people's care records specifically about manual handling.

Manual handling protocols were found to be up to date in all three people's records we looked at and the manual handling observed was consistent with the written protocols. We found the manual handling assessments included a risk score, details of the risks and a handling protocol to reduce risk for the person. We witnessed staff mostly explained what was going to happen before a transfer and asked people's permission. There was one occasion when the explanation was not given.

We found people had much shorter periods of maintaining one position, for example sitting in a wheelchair or armchair. Two people we monitored had a change of position within two hours. At our last inspection, we found these two people were left in one position for much longer than two hours. There was little input from therapists on support for people who had conditions that affect their natural body posture.

One sling we found that was used had frayed straps and clogged velcro. This could have exposed people to harm if it was used in the manual handling process. The operations manager was informed and it was removed promptly. This sling had been passed as safe by an external contractor in November 2016. The service had commenced auditing slings and hoists since our last inspection, to ensure that examination of any potential risks in the equipment were detected and managed. The audit completed by the home manager in October 2016 failed to record examination of the sling's condition.

We observed a person being transferred into an armchair. The staff had difficulty as the chair was not suitable. The person was placed at risk of falls or slips because the chair was not suitable for transfers. We discussed this with the operations manager and asked whether the person could be referred to an occupational therapist. The operations manager was unaware that the Berkshire area community NHS provided a specialist mobility service that could be accessed for support. The operations manager told us they would investigate and set up a full seating assessment for the person.

In all of the care files reviewed, we found risk satisfactory assessments included falls risk, malnutrition

screening, personal evacuation plans, moving and handling information, and pressure ulcer risks. In all instances the risk assessments were reviewed on a monthly basis. Staff told us these were updated more frequently if the person's risk had changed prior to the document review. The home manager explained that risk assessments continued to be rewritten to include more information about each person's unique care needs. In line with the principles of good documentation, the forms did not contain a signature and date panel or the ability to record the name and designation of the staff member who had completed this. Instead, registered nurse signatures were in the margins of the documents.

On the second day of the inspection, we commenced at 7.30 a.m. whilst night staff were still on shift. We checked people in their bedrooms, their fluid and turns charts. The turns charts still required improvement. For people at risk of pressure ulcers and on special mattresses, we found the turn position was often not recorded or unclear. However, we did find that staff had checked at intervals of between two to four hours. People's personal hygiene checks and changes were recorded. Mattress and associated equipment checks were in place to prevent and identify issues promptly. However, we heard one mattress pump's alarm was constantly ringing. This was because the inflation of the air mattress had failed. We alerted staff on the first day of our inspection. However, the next day we saw the mattress alarm was still ringing. Despite raising our concerns with staff, we found staff had failed to record the issue with the mattress. We informed the nominated individual at the next day of our inspection, and the maintenance person changed the mattress promptly.

At our previous inspection we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered person did not ensure the proper and safe management of medicines. We issued a requirement notice against the provider and requested an action plan.

During this inspection we looked at the systems in place for managing medicines. We spoke to staff involved in the governance and administration of medicines, observed medicine administration for four people and examined 17 people's medicines administration records (MARs).

We found registered nurses administered medicines in a safe, caring and dignified way. Staff told us about face-to-face medicines training they received in November 2016 and the home manager showed us training certificates. We saw evidence that regular staff had a competency assessment to make sure they administered and managed medicines safely.

The dispensing pharmacy supplied the MARs. The MARs were not always complete for patients receiving 'as required' medicines. These are medicines taken occasionally, like paracetamol or laxatives. There were multiple blank boxes on the MARs so it was not possible to say if the person refused the 'as required' medicine or if the registered nurses did not offer the medicine. While people had protocols to support the safe use of 'as required' medicines, the information in the protocols did not always match the MARs. For example, one person was prescribed lorazepam for agitation. The as required protocol stated a maximum of 1mg in 24 hours but the MAR instruction allowed 2mg to be given in 24 hours. The home manager said they would clarify the instructions with the GP. Staff completed analgesia medicine patch charts and topical MARs to record the application of creams and ointments.

The provider had processes to manage stock safely. The service had reviewed and improved the process for ordering stock that helped to make sure medicines were available for people. We were told that a pharmacist had carried out medicine reviews for all people who used the service. The registered nurses completed stock balances for the medicines. The home had introduced a daily audit which included a stock tally and checking signatures and omissions on the MARs. Although staff signed to say the audit was

complete, we did not see that the audit was driving improvement through identifying and addressing errors. The audit indicated that all signatures were complete on the MARs but we saw six missing signatures across 11 MARs. The home manager carried out a monthly audit and weekly spot checks.

We recommend that the service review their audit processes to ensure that the use of medicines audits drives improvements through identifying and addressing areas for improvement.

Medicines were stored securely in medicine trollies and rooms. The provider had installed an air-conditioning unit in the clinic room. The daily temperature records indicated that the temperature was consistently below 25°C, which is the correct storage temperature for medicines. The temperature records for the pharmaceutical fridge showed the maximum temperature recorded as more than 8°C for 40 days in December 2016 and January 2017. Refrigerated medicines should be stored between 2°C and 8°C. Staff did not know how to reset the thermometer and had unfortunately received incorrect advice that only the actual temperature recording needed to be below 8°C.

We recommend that the service follows NICE or national guidelines to ensure all medicines are stored within the manufacturers' specifications and that staff know how to use the thermometers.

Medicines no longer required were disposed of in line with regulations and staff recorded what medicines were destroyed.

Medicines that require additional controls because of their potential for abuse (controlled drugs) were stored in line with legislation. When a controlled drug was issued from the stock, the records we reviewed had the signature of the staff member administering the medicine and a witness signature. Staff completed daily stock checks.

The care home received pharmacy support from the community pharmacy and clinical commissioning group (CCG). The CCG pharmacist conducted an audit in October 2016 and provided the home with recommendations to improve the management of medicines. We saw evidence of improvements in line with the recommendations, for example, an updated medicines policy and a medicine error reporting system.

We found the service had achieved compliance with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not protected from abuse and improper treatment. Systems and processes were not operated effectively to prevent abuse of service users. We issued a requirement notice against the provider and requested an action plan.

We found the service had improved the prevention of abuse and neglect. We found an increased number of staff had completed safeguarding training. This was evidenced in the service's training records. Policies regarding safeguarding and whistleblowing were available and more staff were aware of these. These were updated to include Berkshire local authority procedures. In various communal areas throughout the service, including reception, information about reporting abuse and neglect was available. The home manager was knowledgeable about safeguarding procedures. From information we received, we saw the provider had worked cooperatively with relatives, the local authority and police under the Care Act 2014. The service had not reported any new allegations of abuse or neglect to us since our last inspection. A folder had been created and stored in the home manager's office to collate information regarding safeguarding incidents.

We found the service had achieved compliance with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because premises and equipment at the service were not clean, properly used or maintained and appropriately located for the purpose for which they were being used. We issued a requirement notice against the provider and requested an action plan.

We examined the service's evidence of increased premises safety following our previous findings. The fire authority wrote to us in September 2016 following our previous inspection. They found that the provider had addressed the seven deficiencies related to fire safety previously identified. The service's compliance manager showed us a new master maintenance checklist. This was a month-by-month document which specified checks the service and contractors were required to complete. Although a new process was in place, we were told the administrator was responsible for identifying and following up overdue safety checks. One concern at our prior inspection was the mandatory thorough examinations of lifting equipment. The nominated individual had commenced a process of ensuring the certificates from contractors were sent to the service. We checked the safety certificates for all lifting equipment and found these were available. A recent water sample for Legionella testing was collected but the result was not available at the time of the inspection. After the inspection, the result was provided to us which showed tap water sampled at the time of the test was free of Legionella.

From the training records, we found staff had completed infection prevention and control training. We observed staff used personal protective equipment correctly and ensured appropriate disposal of waste. Improvement was made in the storage of cleaning equipment. A new 'dirty' utility room was created to store mops, buckets and enable the filling and emptying of them. We found increased detail in the cleaning schedules and records. Soiled furniture was disposed of and replaced. We did observe a cleaner mopped carpet and pointed this out to the home manager. This was due to a lack of understanding about the management of carpet cleanliness. This was resolved through conversation from the home manager with the cleaner. We saw an increased emphasis on hand hygiene. This was evident from increased access to alcohol hand rub, more soap dispensers in bathrooms and better signage. We expressed to the nominated individual that communal areas and the medicines trolley still did not have access to hand hygiene for staff. They organised the maintenance person to install additional hand gel dispensers during our inspection. On multiple occasions, we observed staff wearing long sleeved clothing. This increased the risk of cross contamination and is not recommended in infection control guidance. We pointed this out to the home manager.

We recommend that the service continues to implement and embed the principles of the Department of Health code of practice for infection prevention and control.

We found the service had achieved compliance with Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was unsafe staffing deployment. We issued a requirement notice against the provider and requested an action plan.

We asked the home manager and nominated individual of changes to staffing deployment since the last inspection. A number of key staff had left employment, but were replaced by new workers. A full-time maintenance person worked at the service. This meant the available staff hours spent on maintenance had

increased since our last inspection. The registered manager had resigned and the deputy manager was asked to be the acting home manager. This left the deputy manager post vacant. We were told recruitment for a replacement deputy manager was underway. When we checked job websites, we found evidence that the position was advertised. The activities coordinator had retired, and there were two new activities coordinators. A housekeeper was employed, which was a new role to supervise laundry workers and cleaners. The administrator had resigned, but the provider had increased the position hours to full time and a new staff member had commenced shortly prior to our inspection.

At the time of our inspection, there were 26 people who used the service. This was consistent with the number of people who used the service at the last inspection. A quarter of the people who used the service required two staff to assist them during personal care and transfers. Some people did not leave their bedrooms at all, primarily those who lived on the first floor. We found each person at the service had dependency assessments in place to determine their level of need and complexity of the care. These were reviewed regularly although they did not demonstrate changes of people's complexity. We checked with the home manager and nominated individuals the number of care workers and registered nurses on each shift. This had not changed since our last inspection.

The nominated individual explained there were vacancies for both registered nurses and care workers. They told us they had used various methods to recruit staff to fill the vacancies. The nominated individual stated that staff vacancies were advertised in a number of websites and with various recruitment firms. We saw the provider had conducted multiple interviews of applicants, but this yielded few new staff commencing. We examined the staff rotas for December 2016 and January 2017, including planned staff for the following weeks. We found there continued to be high numbers of agency use, particularly for registered nurses. We spoke with agency registered nurses during our inspection. Some had been to the service before, but not all of them. The rotas showed frequent cancellation and changes of staff. The rotas also showed a lack of bank staff to try to fill shifts at short notice.

Although we found registered nurse and care worker shifts always met the minimum planned establishment level, there were days when the home manager fulfilled the role of a registered nurse. We found this was frequent and despite our prior written assurance from the provider in 2016 that management staff were always supernumerary. We observed staffing deployment of the service during shifts to determine whether people received safe personal and nursing care. We found that care staff were busy at particular periods, such as the morning and meal times. The activities coordinators helped at meal times, which was appropriate. When we asked staff, they provided mixed feedback about staffing deployment. They felt there were insufficient numbers of ancillary staff on particular days. This included laundry and cleaning staff. We did find the housekeeper had little opportunity, according to the rotas, to have supernumerary time in their role.

We found the service had achieved compliance with Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the personnel files of four staff. We found that the service had completed the necessary checks for new staff and had copies of all of the required documents in the personnel files. Contents of personnel files included proof of identity, checks of prior conduct in similar roles, job histories and reasons for leaving prior jobs. We saw the provider performed criminal history checks of new staff using the Disclosure and Barring Service (DBS). The administrator showed us a checklist which was used to ensure necessary checks were in place prior to the commencement of new staff.

A person and a visitor we spoke with told us they felt the service was safe. The person told us, "It's very safe.

There's a bell I can ring, which I do often, and they come, but it can take a long time. They're very good at keeping it clean. I feel safe when they take me upstairs for a bath" and the visitor said, "[My relative] feels safe in her chair and when they use the hoist, [my relative] says the hoist doesn't bother her."

Requires Improvement

Is the service effective?

Our findings

At our previous inspection on 26, 28 and 29 July 2016 we found a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's care was not always provided with their consent. Where people were unable to give such consent because they lacked capacity to do so, the provider had not acted in accordance with the Mental Capacity Act 2005. We issued a requirement notice against the provider and requested an action plan.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that staff general knowledge and practice about consent had improved. We observed that staff now asked and told people what task they were assisting with prior to commencement, for example during transfers and meal service. Consent paperwork was present in people's care documentation, but clarity was required in the forms about what consent was obtained for. In addition, where a person had an attorney or a court-appointed deputy in place for consent or finance, this was unclear and not always recorded within the care documentation. The service was also unable to produce reasonable evidence they knew which people who used the service had an attorney or deputy and the type of decisions which could be made. Where people had 'relevant others' for decision making about health or finance, copies of the documents to prove this were not always obtained. We previously pointed this out to the provider at our last inspection.

We saw there was consent, MCA and DoLS training recorded for staff since our last inspection. A new mental capacity assessment form was introduced and present in care files we examined. The staff demonstrated confusion about the form's use. The form was in place for people who did have capacity to make decisions. This was not needed, and therefore people did not require a mental capacity assessment. Where staff found that people had fluctuating mental capacity or were unlikely to have the ability to consent, the form was correctly used. The form used the steps and principles of the MCA to reach a decision in the best interest of the person. For example, we saw this was used for people had bedside rails installed for their safety.

We spoke with the home manager and operations manager about applications for standard DoLS authorisations with the relevant commissioners or local authority. They showed us evidence they worked towards having an ongoing list of people's applications and approvals. However, when we looked at their list with them, we found four people had DoLS applications submitted to the local authority where they

were not required. This was because the people had the capacity to make decisions for themselves. Once we pointed this out, the home manager contacted the local authority to withdraw the applications. There was evidence that an inconsistent process was in place for the management of DoLS.

This was a continued breach of Regulation 11 of the Health and Social Care Act 208 (Regulated Activities) Regulations 2014.

At our previous inspection we found a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was ineffective adaptation, design and decoration of the service. We issued a requirement notice against the provider and requested an action plan.

The provider had commenced works to improve the decor of the premises. We looked at the progress of the capital expenditure programme the provider had committed themselves to. We saw that throughout both levels of the service, central heating was repaired and operational in time for the commencement of autumn. Replacement of carpet in people's bedrooms had commenced, with four bedroom floors completed at the time of our inspection. We observed the maintenance person replacing flooring during the inspection. Flooring in the communal areas was also entirely replaced. The home manager and nominated individual explained this had attracted positive feedback from relatives and other visitors. A new sluice room was created on the ground floor, however when we looked inside the room, access to the sluice machine was blocked by equipment. A new staff desk was installed at one edge of the communal lounge. This allowed staff to store records and complete documentation whilst supervising the communal area. This also ensured staff did not have to enter the home manager's office as frequently and avoided interruption of the administrator's work.

At our last inspection, storage of mobility equipment was unsatisfactory. We saw the provider installed a storage shed at the back of the premises, close to the communal lounge entry. This allowed staff to remove and replace mobility equipment in the shed to avoid storage in communal areas. We observed staff used the storage area appropriately. However, we did find that some areas still contained equipment that blocked access or entry. For example, in two people's bedrooms, the ensuite was cluttered with equipment that presented access to toilets and handwashing basins.

We found the service had achieved compliance with Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people who used the service had dementia. People were encouraged to personalise their room with belongings. We viewed some people's rooms where they had brought memorabilia with them upon their admission. However, we found no further implementation of a dementia-friendly physical environment. There was no evidence of good practice such as photos or colour-coding of people's bedroom doors, memory boxes or personalisation that aided people increase their recognition of key locations in the building. On each day of the inspection, the menu board was not updated early in the morning and no pictures were used to demonstrate food that would be served. Although staff wore coloured uniforms which helped identify their role, very few had identification badges so that people could see their name.

We found the front door of the service remained a risk. People could unlock the door and leave the service of their own volition, particularly if they were confused or disorientated. In addition, if the door was not secured by others, there was easy access into the building from the outside. We had received notifications that people had left the building alone, which resulted in the service calling police for assistance in locating them. Signage placed on the door did not prevent people opening the door. At this inspection, we again

found the door unsecured on a number of occasions. This meant signage and the current lock mechanism did not mitigate the risk of the door being inappropriately open. CCTV had been installed for the front door and car park area. The monitor for this was in the home manager's office. Constant recording of the camera footage was in place, but did not include continual supervision by any staff. The provider is aware of our concerns regarding the front door access and is exploring options to overcome the risks the current front entry arrangement poses.

We recommend that the service reviews best practice guidance about physical environments for people with dementia, and implements appropriate changes in the premises.

At our previous inspection we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because were not trained to have the knowledge and skills they needed to carry out their respective roles. In addition, staff did not have a regular schedule of supervision with their managers or effective performance planning and appraisal. We issued a requirement notice against the provider and requested an action plan.

Training records were examined to observe the level of staff training. We found an improvement in staff support. There was a training matrix in place with records of up-to-date training in a number of topics. These included hazardous substances, fire safety, health and safety awareness, principles of care and moving and handling. We saw six staff had completed induction training in November and December 2016. We checked the training matrix against certificates of attendance. Training certificates were present within the staff records and matched the recorded training saved in the matrix. However, at the time of the inspection a number of certificates related to recent staff training in moving and handling were not present at the service. This was due to the external training company not sending them promptly.

At the time of the inspection, there was evidence of 33 staff supervisions since September 2016. We noted these were recorded as conducted at regular intervals, and there was a planner and matrix in place. We looked at a sample of three supervision sessions and determined these were satisfactory. Performance appraisals were not however completed in a timely manner.

We found the service had achieved compliance with Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked whether people received effective nutrition and hydration. A number of checks were in place to ensure people's risk of malnutrition or dehydration was reduced. This included use of the 'malnutrition universal screening tool' (MUST) which determined people's risks of inadequate dietary intake. We found MUST assessments ranged from low to medium risk and where needed there was involvement of the GP and dietitian. People's weights were recorded at in all instances and were monitored on at least a monthly basis. We saw two people had fluid intake charts used and these were based on the risk of dehydration. The fluid charts were correctly completed and tallied. This ensured these people had adequate oral intake.

Changes were made to the management of thickening agents in fluids for people with swallowing concerns. At our last inspection, we were concerned with the system in place for thickening fluids. At this inspection, we found storage of thickening agents in the dining room in a drawer. People now had their own tins of powder and these were used specifically. Additional information about how to make the thickened drinks was prominently displayed for staff, including which product to use and the amount of powder and fluid. We noted that kitchen assistants continued to thicken people's fluids, rather than registered nurses or care workers. We considered this was a risk to people as the kitchen staff were neither trained nor competency assessed to complete this. We found one example where the care plan and thickening product used for the

person did not match. We showed this to the home manager and they corrected this.

People we spoke with were satisfied with the food provided. One person told us, "The food is good and I get enough choice. I'm not aware of alternatives; never come across that. They set me up for meals in my room, which is my choice." Another person commented, "The food is all right." The menu, planned on a rotating four-week system, included a choice of a meat and a vegetable dish on most days, battered fish but no other types of fish. There was no mention of alternatives to the set puddings for each day such as ice-cream, yoghurt, or fresh fruit. There was a hot meal offered in the evening, which we were told was prepared by chef, who left at 2 p.m. The evening meal was left in a warm oven until served by staff at supper time. Sandwiches and a single pudding were also offered in the evening but there were no alternative or light menus offered. We saw drinks and biscuits are readily available in the communal areas. When we asked staff at the start of each day of the inspection the menu for lunch and supper, none could tell us what was going to be served.

People continued to receive satisfactory support from external healthcare professionals. Visits were written by the healthcare professionals in people's notes or letters were sent to the service. When the GP visited, they did not make written entries in notes and staff were required to write notes about the outcome. On one occasion we found a GP had visited and staff had failed to record the consultation. People were supported by staff or relatives to external appointments.

Good

Is the service caring?

Our findings

At our previous inspection on 26, 28 and 29 July 2016 we found a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always treated with dignity and respect. We issued a requirement notice against the provider and requested an action plan.

During our observation of the care in communal areas, we noted a pleasant atmosphere and more person-focussed care provided. Staff walked over to where people were sitting or standing before communicating with them. We also saw staff knelt down or sat down with them, for example when they were supported with eating or drinking. At mealtimes we noted staff did not get distracted and their attention stayed with the person they had commenced assisting. We also observed more pleasant communication from staff with people who used the service. One person with a hearing difficulty used a pen and paper with staff to communicate. At this inspection, we did not observe staff calling out across communal spaces. Staff were pleasant with us during our inspection. We noted the same when visitors or friends arrived at the service.

We observed that in communal areas, people's dignity was observed by staff who ensured personal hygiene care was carried out only in the privacy of their bedrooms or communal bathrooms. We observed doors were closed during personal care and staff knocked and asked before they entered rooms.

We found the service had achieved compliance with Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they liked living at Cherry Garden. People had 'named nurses' and 'key workers' although most people we spoke with couldn't remember the staff names. One person told us, "The night staff leave at 8 a.m. and they have to get me washed and dressed before they leave. I need the help. They are very good." We discussed this timing with the person who said he did not know why night staff were required to assist with his personal hygiene. We also discussed it with the person's 'key worker' who said he was unsure why this happened. He said he would prefer to help the person himself, as a way of bonding. The 'key worker' told us he had not raised it with management but said he would do so.

When we spoke with relatives, there was a positive appreciation of the staff. One relative told us, "The staff are lovely. The carers are lovely the way they treat the residents." Another relative said, "They really look after me as well, and give me dinner. I would like to come here if the need arises." A third relative we spoke with told us, "Compared to other places this is good. The staff are very good. Always two of them and they are supportive. [My relative] always chooses the time to leave and return to her bedroom. The staff make a point of positioning [my relative] in the lounge so she can see the TV and watch people, which she loves." A further relative commented, "They do residents' hair and nails and I'm impressed how they make allowances for the hard of hearing."

We also asked staff how they made the service caring. One staff member we spoke with said, "One resident smokes [in their bedroom] and arrangements are in place to allow him to do so [in his bedroom]. All the staff

are warned that he smokes". We observed one person become distressed in the communal lounge during lunch service. We pointed this out to staff as the person had commenced repetitively calling out. When the staff member approached them and asked them how they could assist, the person wanted to go outside. Despite being a busy period for staff, the person was taken outside. Another person displayed ad hoc aggressive verbal behaviour. We saw several instances where the person was loud and disruptive to other people sitting nearby. Staff recognised when this occurred, and spoke with the person or sat down with them. We observed staff knew the strategies to use to calm the person and found out what they wanted.

Confidentiality of people's information was maintained, including electronic records and communication. We noted computers required a user password to log in. Computers and paper-based records were stored in the home manager's office or at the staff desk. Some records, like turn charts and personal hygiene records, were stored in folders in people's bedrooms however this was appropriate. We did not observe any instances of people's personal information being located at an inappropriate place within the building. At the time of the inspection, the provider was not registered with the Information Commissioner's Office (ICO). The Data Protection Act 1998 requires every organisation that processes personal information to register with the ICO unless they are exempt. We informed the nominated individual at the time of the inspection that the provider was not registered with the ICO. They took action to correct this.

At the time of the inspection, a small number of people received end of life care. When we looked in care documentation, we found documentation about end of life wishes and preferences was lacking or avoided. For example, in one file where the document asked about the person's choices after death, the file simply stated 'my brother will make the decision' in response to all questions. The staff had not documented the person's choices. People's files did not contain care plans specific to end of life care.

We looked at do not resuscitate (DNAR) documentation (often referred to as 'lilac' forms). We found incorrect documentation in some people's files we looked at. For example, one person's DNAR form dated November 2015 was completed by a hospital consultant. The form had the person's previous address on it. This was not reviewed on admission to Cherry Garden. That could mean it was not a current reflection of the person's wishes. Another DNAR we reviewed was signed by the GP in July 2016. The DNAR was a photocopy. We spoke with the home manager and they contacted the GP surgery to discuss the form. The home manager told us the surgery did not provide original copies of the DNAR forms. As the original form must accompany the person in the event of a hospital visit, this could present a problem if resuscitation was required. Another person's DNAR signed by a hospital consultant was dated December 2016. The form had the incorrect address which related to the person's previous address. There was no updated form completed by the GP.

We discussed our findings related to incorrect documentation for some people's DNARs during feedback with the nominated individual and the home manager. The issue with end of life care planning and associated documentation was on the service's action plan, which we viewed. The service was also working with an external compliance consultant to improve this aspect of people's care. The management team provided assurance to us they would address this area of people's care as a priority.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection on 26, 28 and 29 July 2016 we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not designed care or treatment with a view to achieving people's preferences and ensuring their needs were met. The provider had not enabled and supported relevant persons to make, or participate in making, decisions relating to care or treatment to the maximum extent possible. We issued a requirement notice against the provider and requested an action plan.

We looked at 12 peoples' care documentation during our inspection. For people who had moved to Cherry Garden since the last visit, pre-admission assessments were comprehensively completed in all instances. We saw they contained some relevant information such as likes and dislikes along with baseline observations and people's pre-admission weight. In addition, there was the person's medical history and mental status assessment. This was a new document that was introduced to measure a person's baseline mental capacity prior to arrival at the service. The document would then be used to continue monitoring throughout the person's stay at the service.

We saw there was a document which highlighted people's life history. This tool gave a better insight into a person's social, work and family chronology and was evidence that the service aimed for an increased person-centred care delivery. We also found care plans indicated people's interests in activities.

Care plans we reviewed were not always person-centred and required better information specific to the individual needs. For example, we looked at three people's diabetes care plans. The three people had different types of diabetes with varying medicines regimes and some common care. The care plans were repetitive of each other. Whilst clinical information like monitoring the blood glucose levels was required in all of the three, there was no information about what was 'normal' for the person and when staff should seek help. Care plans were reviewed monthly with some evidence of people's relatives' or friends' involvement. We found little evidence that care plans were written or reviewed with people who used the service. No one we spoke with could tell us of any involvement in planning their care. One person told us "I don't get a say in my care. They've got a system and they stick to it but I'm happy with that." When care plans were reviewed, staff often wrote that there were simply no changes since the prior month.

There were some improvements in staff being responsive to people's social interaction. We met with one relative who was pleased that her mother was admitted to the service. She said, "[I am] very happy with the care she has been at Cherry Garden since last year." We asked why she felt this way. She went on to say that her mother didn't speak English, but the staff took time to communicate with her and, "...it works." The relative told us that she couldn't have come to a better place as a visitor. She explained that she too felt welcomed, and often visited for meals with her mother.

There was an effort by the activities coordinators to increase stimulation for interested people and encourage physical and mental wellbeing. The activities coordinators were not present every day, but some weekend coverage was observed in the rotas we examined. We saw a printed activities programme was

available upon entry to the service. One activities coordinator was able to play the guitar and piano, and people participated in songs and were encouraged to sing along. We saw some people, who did not communicate routinely, sang lyrics when they recognised the tune. At other times, music CDs were played to encourage people to sing and improve their participation in the everyday running of the home. We observed the television being on in one communal lounge and activities occurred in the other, side by side. This led to periods where there was loud commotion and people found it hard to focus on one or the other.

At our previous inspection, people enjoyed the outdoor areas of the service. However, since the weather was cold at this inspection, no one went outside for activities. When we asked people about leaving the service to go elsewhere such as shops or cafes, none could tell us about outside trips. People felt they would like to go outside the service, even in the colder part of the year. One person said, "I go outside in the garden in the summer. I've not heard of any [trips] being organised but I would like to go on a bus trip. I'm stuck in this room all winter." We heard differing responses on faith visits to the service. The service user guide stated weekly visits and communion every week, but one person we spoke with said, "A vicar comes every couple of months or so." One person told us they were a practising Christian but rarely had the opportunity at the service to embrace their religion. They commented, "I would go to church if I could." Further improvement is required to ensure effective care for people.

There were two cats as pets in the service since our last inspection. People told us they enjoyed the cats and felt they were a form of relaxation or therapy. We noted the cats were not present during the inspection. When we asked multiple staff members the location of the cats, they told us they were removed. When we asked why this was, staff were unable to answer. One staff member told us it was because of our inspections. People expressed dissatisfaction that they did not have the cats as pets anymore. There continued to be chickens and a rooster outside in the yard. We noted they often approached glass doors and people enjoyed seeing and hearing them. We overheard one staff member talking with a person about their presence, which provided some entertainment, although short-lived, for the person.

This was a continued breach of Regulation 9 of the Health and Social Care Act 208 (Regulated Activities) Regulations 2014.

There was complaints information displayed in the reception but we could not find anywhere else that is was available to people who used the service. In the majority of rooms, people's service user guides were not present. The poster in reception also stated if a complainant was dissatisfied with the response by Cherry Garden, we should be contacted to investigate. However, we did not have regulatory remit to investigate individual complaints, but will help the public with finding organisations which can. The poster did not mention organisations like the Local Government Ombudsman, the Parliamentary and Health Service Ombudsman or Citizens Advice. We pointed this out to the home manager who noted our comments and explained the poster would be amended with accurate information.

Since our last inspection, we had received no complaints or issues of concern from the general public. However, there was one ongoing concern from prior to our 2016 inspection, where the provider had worked with us to investigate in order to reach a conclusion. We noted the provider worked with the complainant in addition to our own enquiries. At the time of our inspection, this matter was not resolved and required further action. The provider was kept informed by us of progress in the matter. We saw that three complaints were recorded by the service in late 2016. When we checked relevant records, we found satisfactory completed investigations. There were no other complaints in progress at the time of the inspection. The service could not demonstrate what learning from the complaints they had used to improve the quality of care.

We found there were feedback forms in reception but no collection box. There was no targeted process to obtain feedback, so we were not able to see any analysis or action plan related to people's or relatives' feedback. People and relatives we spoke with confirmed they were not asked for any feedback. One visitor said, "I'd fill the form in if I was offered one." There had been issues with the passenger lift breaking down, and this had occurred once since our last inspection. A visitor told us "[My relative] was on the first floor and the lift broke down. This meant she was trapped there and could not come down to the lounge as she does every day. [Another person's] husband pointed this out and [the other person] was transferred to a ground floor bedroom when it came up." This issue was addressed with the nominated individual who explained that the passenger lift was given comprehensive maintenance since the last breakdown, and had not ceased operation since. There was no formal procedure in place for management and staff to follow when the lift stopped functioning. This could include communication with others to prevent complaints and explain the situation.

Although the service did not seek regular feedback from people and relatives using surveys or questionnaires, the service did received compliments in writing. Examples we viewed included comments like, "Many thanks...for your help and support and wonderful care of my sister...", "A very special thank you for looking after [person's name]" and "We would like to take this opportunity to thank all the staff at Cherry Gds for the love and care and devotion and understanding that they all showed to my mother [person's name] while she was a resident with you." These comments were not centrally logged or stored.

We were told there was a 'residents and relatives' meeting every 3 months. We were shown notes for a meeting held in September 2016, which was the last meeting. The meeting did tell people and relatives about changes at the service. We were not provided with evidence that showed feedback at the meeting was included in the provider's action plan. The home manager told us the next 'residents and relatives' meeting was planned, but throughout the service there was no signage to indicate dates of meetings for 2017. This would assist people to plan their ability to attend.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection on 26, 28 and 29 July 2016 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not monitor and improve the quality of the service and experience of people who lived at Cherry Garden. In addition, the provider had failed to adequately mitigate the risks related to the health, safety and welfare of people and others. We issued a requirement notice against the provider and requested an action plan.

The provider supplied an action plan to us after the previous inspection. This addressed the breaches of regulations and what actions would be taken to attempt to achieve compliance for them. The action plan was comprehensive and had noted areas of concern from our last inspection. We saw times for achieving actions were included, but for some regulations these were vague or non-specific. For example, timeframes for achieving compliance with some regulations stated 'completed and ongoing' or similar. Despite this, we found the action plan was action-based and attainable.

After our last inspection, the provider appointed a consultant from an external agency that specialises in auditing adult social care locations, producing reports, working with management and implementation of action plans to deal with a service's established risks. The consultant visited the service in varying frequency, ranging from monthly to more recently weekly. We received and reviewed a report from November 2016, and two reports from January 2017. We found the consultant's reports were comprehensive and focussed on areas where we determined prior breaches of the regulations. The reports were set out in the same style as our five key questions, which made it easier for Cherry Garden's management team to interpret.

In conjunction with the service, the consultant constructed a separate action plan to the one requested by us. The action plan did however have information from the last inspection and the action plan previously submitted to us by the provider. The action plan also took into account findings of the clinical commissioning group's pharmacist visits. We received copies of the consultant's action plan from the provider between our inspections. The action plan was divided into specific areas which required attention, such as 'client/care matters', 'staff matters', the Mental Capacity Act 2005, medicines and maintenance. There were stipulated dates for actions to be completed, the responsible person for the action and a column to measure progress. We saw each action had contemporaneous rating of the progress recorded. For example, red meant the action was overdue from the projected completion date and green meant the action was completed or in place. We reviewed the progress of 68 documented actions in the plan. We considered that a good improvement had occurred and there was steady progress in achieving the documented actions. A small number of actions were considered overdue by the consultant, but these were known to the home manager and operations manager.

We spoke with the operations manager about audits and checks that were in place to monitor the safety and quality of care at Cherry Gardens. They showed us several tools in use. The first was the 'weekly compliance' form. This was a one-page summary sent by the manager on a set day each week to the operations manager. The tool contained reported on a number of set statistics, including the number of people who used the service, admissions and discharges, health and safety concerns, any pressure ulcers

people experienced, the number of falls and others. We could see that, over time, this tool could be used to determine trends of particular significance of care, and also drive action by the operations manager and home manager. Where necessary, issues that required escalation to the nominated individual or provider could be documented.

Another tool that was already in place at our prior inspection was the 'manager's monthly checklist'. This document was not revised since the last time we viewed it, and we examined the documented findings for December 2016. We could see that checks were completed on care documentation, medicines management and aspects of administration. The home manager was also required to complete the 'annual' and '6 month' checklists. It was not evident at the inspection how the findings from these checks or audits were used to improve the service. There was some evidence that where deficiencies were identified during the checks, relevant action was taken. This was not recorded in the single central action plan to show a continuous chronology of risks assessed and managed at the service. There was also reliance that the home manager was responsible for the audits and few, if any, other staff were given the opportunity to undertake the checks.

There were a number of other audits completed. These included a monthly nutrition audit, a monthly care plan audit, a monthly pressure ulcer audit, the 'matron's daily checklist', a laundry audit, and a 'catering/dining room' audit. Some of the audits contained repetition of checks in the home manager's checked. This lead to confusion about which result to take as the established outcome of the check. We found registered nurses completed the 'matron's daily checklist'. This was a simplistic tool which the staff did not understand the purpose of. They explained to us they simply 'ticked the boxes' at the end of their shift. The service could not be assured that the staff members had actually completed the checks identified in the form. In addition, if items were not completed or required action, the form did not provide the opportunity to record this. We spoke with the operations manager about this and they were receptive of our feedback.

The nominated individual and operations manager logged their visits and what they did, who they spoke with and what they found during their visit. The nominated individual visited frequently and the operations manager attended once or twice a week. We looked at the documented visits. We saw that there was an improved connection from management speaking with people who used the service, staff and others. We did find evidence in the documents of reasonable support from the provider's management to the home manager. The home manager confirmed to us they received appropriate support.

We examined how incidents and accidents were recorded and managed. We looked at all those recorded since the last inspection and through audits completed in relation to them. We found there were 12 falls, with three of the falls resulting in a skin tear and two of those falls resulting in bruises. There was little information from investigation against each of the logged incidents. We determined there was no evidence of any trends analysed in the incidents which were recorded. For example, the service did not periodically look into the cause of falls, which people and staff were involved, the time of day the incidents occurred and subsequent documentation of aftercare. We were however shown a new tool in place for staff to record further information specifically about risks and mitigation of people's injuries from falls.

The operations manager explained that review and revision of policies and procedures was a continued task at the service. We saw some progress was in place to ensure current information was available in the documents. However, we noted key policy areas like medicines and infection control were not complete or in place. This was despite our findings and those of other agencies, given to the service after inspections. We noted the task of reviewing policies was in the service's action plan but was not marked as complete.

This was a continued breach of Regulation 17 of the Health and Social Care Act 208 (Regulated Activities) Regulations 2014.

At our previous inspection we found a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not act in an open and transparent way with people or 'relevant persons' (people acting lawfully on their behalf). This was in relation to 'notifiable safety incidents' (medium or severe harm sustained by people) that may occur during care and treatment provided. We issued a requirement notice against the provider and requested an action plan.

Providers are required to comply with the duty of candour regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity.

At the time of the inspection, the service had an appropriate duty of candour policy. The document set forth clear steps for the management to follow if the duty of candour requirement was triggered. We saw a folder was in place in the home manager's office which included the service's policy, the regulations, details of incidents to report and a flowchart of actions to take. However when we asked, the home manager was not familiar with the requirements of the duty of candour and was unable to explain their legal obligations in the duty of candour process. We also asked the operations manager what process would be followed at the service if a safety incident required the duty of candour. They were also not completely aware of how the process would apply at Cherry Garden. No training was provided to the home manager or staff about candour and how to apply steps required after 'notifiable safety incidents'. Since the last inspection there were no occasions where the duty of candour requirement required use at Cherry Garden.

Some reasonable and proportionate steps were taken by the provider to comply with this regulation. Based on this, we found the service had achieved compliance with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, further improvement is required to ensure management have good knowledge of how to act in the event of relevant safety incidents where the duty of candour applies.

We recommend that provider's management team completes relevant training in the duty of candour process.

We asked people, visitors and staff about the culture within the service. We received varied feedback. One person told us, "I don't know who's in charge, nobody comes in to ask. They don't do the rounds". "The acting manager is lovely and approachable but lacks confidence in sorting things out. If it's a massive problem it's not dealt with. There are lots of staff issues around culture and language." Another staff member said, "[Management] is not focused on the home and has no interest in it. Everything is financially driven and [they are] tight with money".

We spoke with an agency registered nurse who had never worked in the service before. They confirmed they had received an induction on their first day. This consisted of being shown the fire procedure and discussing people's specific needs. They told us they felt the service was well-managed and said they would feel comfortable asking senior staff and management if they were unsure about anything. They confirmed all their mandatory training required was up to date and the service had evidence of their training details

relevant to the environment they worked in. We were aware the service tried as far as possible to book the same agency staff to ensure continuity of care.

Staff we spoke with confirmed they had not participated in any surveys to gauge their opinions or ideas. We were provided with evidence that meetings occurred with some staff. We saw minutes and action plans from meetings with the chef, cleaners, and laundry workers. We noted these were role-specific meetings, rather than staff meetings. The action plans contained tasks that the staff members were required to complete. However, although some tasks were signed off as completed, others were blank. The meetings were not repeated to follow up or check progress. We saw that one staff meeting had occurred in August 2016. The content of the minutes showed the management discussed areas of risk and required actions for staff. The focus of the meeting was about improvement, but did not document staff ideas, opinions or suggestions.

The service was required to have a statement of purpose. A statement of purpose documents key information such as the aims and objectives of the service, contact details, information about the registered manager and provider and the legal status of the service. We found the statement of purpose for the service was appropriate. The statement of purpose was not available in reception or another communal area for members of the public to view if they desired. The document was also not updated or sent to us following the prior registered manager leaving. We pointed this out to the operations manager at the inspection. The provider sent an updated statement of purpose to us shortly after the inspection.

There were times when the service was legally required to notify us of certain events which occurred. When we spoke with the home manager, they were able to explain the all of circumstances under which they would send notifications to us. Our records showed that the service sent required notifications to us, as required by the relevant regulations.

A condition of the provider's registration set by us is that a registered manager must be in post for the service. At the time of the inspection, there was no registered manager in place. The deputy manager had acted as the home manager during the provider's attempts to recruit a new registered manager. When we asked about the delay, the nominated individual reasonably explained set backs they had encountered in finding, interviewing and appointing a suitable candidate. The provider had attempted to find a replacement but at the time of this inspection, no one had registered as the manager. The nominated individual told us the deputy manager was interviewed and offered the post. Shortly after the inspection, the provider confirmed that the deputy manager had accepted the job offer and would register with us as the manager. When we checked our database, we found the deputy manager had commenced the process to apply for registration with us.

We saw the service's previous inspection rating was conspicuously displayed in the premises and on their website. This meant people and the general public could easily find and clearly see our prior inspection ratings for Cherry Garden.

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
Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had not designed care or treatment with a view to achieving service users' preferences and ensuring their needs were met. The registered person had not enabled and supported relevant persons to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not provided with the consent of the relevant person. Where service users were unable to give such consent because they lacked capacity to do so, the registered person had not acted in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes did not enable the registered person to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.