

The Fremantle Trust

Cherry Garth

Inspection report

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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

This inspection took place on 1 & 2 March 2016 and was unannounced on the first day.

We previously inspected the service on 2 May 2014. The service was meeting the requirements of the regulations at that time.

Cherry Garth provides care for up to sixty older people, some of whom may live with dementia. Fifty seven people were being cared for at the time of our visit.

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

Overall we received positive feedback about the service. Comments included; "We are loved," "I'm very well looked after – no complaints," and that staff "Sort any problems out and get the job done."

There were safeguarding procedures in place and staff received training on safeguarding vulnerable people. This meant staff had the skills and knowledge to recognise and respond to safeguarding concerns.

Risks to people were identified and managed well at the service so that people could be as independent as possible. A range of detailed risk assessments were in place to reduce the likelihood of injury or harm to people during the provision of their care.

We found set staffing levels were adequate to meet people's needs effectively. There had however been occasions when short-notice absences of staff had put pressure on other staff. The high level of commitment and team work of staff meant these situations had been managed in a way which kept people safe and with minimum disruption to their care.

Staff had been subject to a thorough and robust recruitment process. This made sure people were supported by staff that were suitable to work with them.

Staff received appropriate support through structured induction, regular supervision and annual appraisal of their performance. All the staff we spoke with said they felt able to speak with the registered manager or senior staff at any time they needed to.

We looked at records of training for all staff. We found there was an on-going training programme to ensure staff gained and maintained the skills they required to ensure safe ways of working.

Care plans were in place to document people's needs and their preferences for how they wished to be

supported. These were up to date and subject to review to take account of changes in people's needs over time.

Medicines were managed in line with safe practices. Medicines storage temperatures had sometimes temporarily been above recommended levels although prompt action was taken to address this when it occurred.

The service was managed effectively. The provider regularly checked quality of care at the service through visits and audits.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

People's medicines were managed in line with safe practice. Prompt action was taken to address the temperature of medicines storage when it exceeded recommended levels.

People were protected from harm because staff received training to be able to identify and report abuse if they saw or suspected it. There were procedures for staff to follow in the event of any abuse happening.

Risks to people were assessed and kept under review. This meant the risks to people of injury or harm was reduced or eliminated where possible to do so.

Is the service effective?

Good ●

The service was effective.

People received safe and effective care. Staff were supported to achieve this through structured induction, regular supervision and training.

People were encouraged to make decisions about their care and how it was provided. Decisions made on behalf of people who lacked capacity were made in their best interests.

People received the healthcare support they needed to maintain their health and well-being.

Is the service caring?

Good ●

The service was caring.

Staff treated people with dignity and respect and protected their privacy.

People were supported by staff who engaged positively with them whilst they provided care and support.

Staff supported people to make choices and were patient whilst

doing so.

Is the service responsive?

Good ●

The service was responsive.

There was a detailed care planning process which helped staff provide people's care in the way they wanted them to.

The service responded appropriately when people's needs changed. This ensured their needs continued to be met and that they could remain as independent as possible.

People were supported, when they wanted to take part in activities and social events in order to provide stimulation and entertainment.

Is the service well-led?

Good ●

The service was well-led

The registered manager and staff worked well together as a team.

Staff, relatives and people who used the service were able to talk with the manager and senior staff when they needed information, advice or support.

There were effective quality assurance systems in place to both monitor the quality of care provided and drive improvements within the service.

The manager and staff were open, willing to learn and worked collaboratively with other professionals to ensure peoples' health needs were met.

Cherry Garth

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 1 and 2 March 2016 and was unannounced on the first day. The inspection was carried out by one inspector on both days.

Before the inspection we reviewed the Provider Information Record (PIR) for the service and previous inspection reports. The PIR is a form that asks the provider to give some key information about a service, what the service does well and improvements they plan to make. We also reviewed notifications and other information about the service we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We contacted healthcare professionals, for example, GPs, to seek their views about people's care. We spoke with eight people who lived in Cherry Garth and also to three family relatives and friends of people who lived in Cherry Garth who were visiting the service.

Some people were unable to tell us about their experiences of living at Cherry Garth because of their dementia. We carried out observations on both days over lunch on different units to help us understand the experience of people who could not talk with us.

We spoke with the registered manager and ten staff members including housekeeping, catering staff, activity staff and care workers.

We checked records about how people's care was provided. These included six people's care plans, medicines records for one unit, four staff files containing recruitment checks and details of induction for new staff and supervision and training spreadsheets for all staff

Is the service safe?

Our findings

On the days of our inspection we found there were enough staff to provide people with the support they needed. Staffing levels were assessed taking into account the number and dependency level of people. We saw staff managed busy times of the day well to ensure people's needs were met appropriately. For example, we carried out two observations over lunchtime and found people received the support they required in a timely manner. People we spoke with told us staff were available when they needed assistance and we heard calls bells were answered promptly.

One person told us they thought staff were "Hard pushed sometimes." However, when we looked at staffing rotas and spoke with staff we found there were, in most cases, the planned number of staff to meet people's needs. When there were short notice absences of staff, we were told staff "pulled together." Staff displayed great commitment to Cherry Garth and the people they provided care and support for. "We are a good team" was how one staff member put it. Those staff we spoke with said they felt able to speak with the registered manager or senior staff at any time they needed to.

There were robust recruitment processes in place. This meant people were supported by staff with the right skills and attributes. The four recruitment files we looked at contained all required documents, such as a check for criminal convictions and written references. The records showed staff only started work after all checks and clearances had been received back and were satisfactory.

We looked at the medicines records on one unit and had a very open and helpful conversation with one of the staff team responsible for medicines administration. We found people's medicines were managed safely and in line with the provider's medicines policy. There were robust processes in place to ensure people received their medicines as prescribed. We saw medicines were given at the correct time and those medicine administration records (MAR) charts we saw were completed accurately to show the medicines people had received.

The temperature of medicines storage were recorded. We found these had sometimes been above recommended levels. When this had occurred, prompt action was taken to move the medicines storage trolleys into the one medicines storage room which had air-conditioning.

Stock checks were completed daily. Staff who undertook medicines administration were provided with appropriate initial and refresher training. We saw staff had completed a competency assessment before they administered medicines on their own. We were told this competency assessment would be re-done if any concerns were identified about the ability of staff to administer medicines safely.

Medicines which required additional controls because of their potential for abuse (controlled drugs) were stored appropriately within the treatment rooms. When a controlled drug was administered, the records showed the signature of two staff were recorded as required.

The service had policies and procedures, in place and being followed, in respect of safeguarding people

from abuse. These provided guidance for staff on the procedure to follow if they saw or suspected abuse. Staff had received training to help them to recognise and respond to signs of abuse. Staff were confident about the actions they would take if they felt someone was subject to abuse. Staff confirmed they had regular updates on safeguarding training. On the second day of our inspection there was previously planned safeguarding training taking place.

Staff were advised of how to raise whistle blowing concerns during their training on safeguarding people from abuse. This showed the home had created an atmosphere where staff could report issues they were concerned about and protect people from harm.

Risk assessments were in place to identify risks to people's health, safety and welfare. These set out how identified risks could be eliminated or reduced, to reduce the likelihood of injury or harm to people. These included, for example, the risks of falls and developing pressure damage. Risk assessments had also been written to assist in moving and handling people safely.

The building was well maintained. There were certificates in place which confirmed it complied with gas and electrical safety standards. Equipment to assist people with moving had been serviced and was safe to use.

People were kept safe from the risk of emergencies in the home. We were told emergency evacuation plans had been written for each person. These documented the support and any equipment people needed in the event of emergency situations.

Appropriate measures were in place to safeguard people from the risk of fire. Staff had been trained in fire safety awareness and first aid. Records showed fire drills had been carried out and there were fire extinguishers and fire alarm test records in place. We also saw records of the testing of portable electrical appliances which had been undertaken.

Accidents and incidents were recorded appropriately at the home and appropriate action taken to prevent further injury to people.

Is the service effective?

Our findings

We received positive feedback from two healthcare professionals about the way the service managed people's healthcare needs. They told us staff were helpful and co-operated with them effectively. "They are very quick to respond to any requests I make" was one person's assessment.

We found people received care from staff who were effectively supported. New staff received induction training appropriate to their work. In their PIR, the service provided information about the staff who had completed the Skills for Care Common Induction Standards or Care Certificate. These are nationally-recognised qualifications/ standards that health and social care workers need to meet in their work. They include, for example, privacy and dignity, equality and diversity, duty of care and working in a person-centred way.

Staff received appropriate training following induction, to help them meet the needs of the people they cared for. They told us they had training on areas the provider considered mandatory, as well as additional specific topic courses, for example dementia care. One member of staff told us; "You only have to ask (for specific training)." Another staff member told us about conferences they had attended, relevant to their specific role within the home.

We saw a matrix setting out the training received by each member of staff in order to update their skills. This matrix enabled the registered manager to monitor when staff had attended courses or were due updates. We saw dates for forthcoming training were displayed in the office and staff were encouraged to reserve places.

Staff received regular supervision from their line managers. The development files we looked at showed staff met regularly with their managers to discuss their work and any training needs. Probationary assessments were undertaken for new staff, to make sure their performance was satisfactory and to identify any further learning needs. Appraisals were undertaken annually to assess and monitor staff performance and development needs.

Staff communicated effectively about people's needs. Relevant information was documented in a handover log to provide key information for the next shift. Daily notes were maintained about each person, to record any significant events or issues so that other staff would be aware of these and could take them into account as they provided care and support.

The service worked in line with the principles of the Mental Capacity Act 2005. This legislation 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 found the provider was working within the principles of the MCA and had made appropriate capacity assessments and applications when depriving people of their liberty. For example, when medicines were being given covertly. In their PIR, the provider gave details of all the applications made. Two of these related to covert medicines administration had been processed and authorised by the local authority, others were awaiting a response. We found the home was complying with conditions applied to authorisations, to ensure any deprivations of liberty were lawful.

We spoke with the Chef-Manager. They explained how information about people's dietary needs and preferences were recorded in their care plans so that staff were aware of these. We observed two lunch times on different days and different floors. We found people were supported to have a meal of their choice by staff. Staff helped people to make a choice about what they would like to eat. People who needed assistance from staff were provided with effective and sensitive support.

People told us they liked the food and were able to make choices about what they had to eat. "Lovely food", "Good plain food, well cooked" "Food ok" were three assessments made. People's dietary needs and preferences were documented and known by the chef and staff.

People's healthcare needs were monitored and any changes in their health or well-being prompted a referral to their GP or other healthcare professionals. For example, people were referred appropriately to the dietician and speech and language therapists if staff had concerns about their wellbeing. Care plans identified any support people needed to keep them healthy and well. Staff maintained records of when they had supported people to attend healthcare appointments and the outcome of these. The records showed people routinely attended appointments with, for example, dentists, opticians and hospital specialists. GPs visited the home regularly from the local surgery. This provided consistency for the people concerned and enabled the home to plan when people could have a routine consultation. Additional visits by the GP or access to other health services were arranged on an 'as required' basis.

Cherry Garth was purpose built as a care home. The building had been well-maintained and provided a safe and appropriate environment to people through its design, layout and facilities. Routine tests were carried out on fire equipment, water systems and lifts, for example.

Is the service caring?

Our findings

People who lived in Cherry Garth told us they were happy in the home. We saw that staff provided support appropriately and with consideration. Staff spent time talking with people and everyone we spoke with complimented and praised the staff that supported them. "Very friendly", "All very good so far" and "Love the carers, no regrets whatsoever." One person told us "We are loved."

The care plans we saw included evidence that people were involved in decisions about their care and support. People's preferences were recorded; for example, if they preferred a male or female member of staff to assist them with personal care and how they like to be addressed. The care plans provided staff with clear instructions to encourage people to be as independent as possible, while providing information on the level of support required. We saw staff involved people in making decisions, such as whether to participate in activities, where they had their meals and before they assisted them with personal care.

During our observations we found staff made meal times social occasions by involving people in conversations. We heard people being given choices and that saw drinks were offered to people. We saw one person being assisted through the use of a hoist to sit for their meal. Staff spoke with them throughout the process. We saw people talking to one another and where staff provided support, this was done sensitively and in an unhurried manner.

When we spoke with care staff they knew individual people well and understood their preferred routines. This included, for example, what time they usually like to get up or go to bed, what activities they enjoyed in particular and who and what was important or significant for them. People's bedrooms were personalised. We saw people had brought in items such as pieces of furniture, ornaments, pictures and houseplants to make their rooms homely and comfortable.

People received care and support from staff who knew them well. The relationships between staff and people who received support demonstrated dignity and respect at all times. We spoke with the senior housekeeper about how care was taken of people's laundry. Staff showed concern for people's well-being in a caring and meaningful way, and they responded to their needs quickly. People told us they were happy with the care they received.

Staff knew about people's individual communication needs. People could move freely around the home and choose where to spend their time. Staff respected people's choices to be in their rooms if they wished. There were areas in the building where people could sit and talk with visitors and family.

Where people and/or their families had been prepared to provide it, records included information about how they wished to be supported at the end of their lives. In their PIR, the registered manager confirmed the home sought, wherever possible, to provide end of life care in Cherry Garth. This involved close working with the person concerned and their families, and with the support of the GP, District Nurses and specialist nursing staff, for example Iain Rennie Hospice staff.

Staff confirmed they had received training in equality and diversity and how this should be reflected in appropriate and sensitive care provision. The staff team was reasonably representative of people who lived in Cherry Garth.

People had access to advocacy services when they needed them. Advocates are people independent of the service who help people make decisions about their care and promote their rights.

Is the service responsive?

Our findings

People had their needs assessed before they moved to the home. Information had been sought from the person, their relatives and other professionals involved in their care. Information gained through the assessment was then used to draw up an individual care plan.

Care plans were personalised for each individual. They detailed daily routines and preferences specific to each person. There were sections in care plans about supporting people with different areas of daily living, for example, their health, dressing, washing, continence and mobility. Care plans showed evidence of regular reviews taking place, involving the person concerned, their family where appropriate as well as key staff with knowledge of the person. This meant any changes to people's circumstances, for example, to their mobility or weight could be identified. This meant people whose needs had changed continued to receive appropriate support.

From what people, their relatives and staff told us and from what we observed during the inspection, including a lunchtime observation, people were offered choice. They could, within reason, determine how their care and support was provided. Staff were able to tell us in detail about people's needs and how they were met. People's views about their support were respected. For example, if they had a preference for their care to be provided by staff of the same gender as them or specific times for getting up and going to bed.

We received positive feedback from healthcare professionals about the way the home responded to changes in people's health and wellbeing. Staff were very positive about the regular weekly 'surgeries' which took place and confirmed they provided information and any assistance required during them.

People's cultural and religious needs were taken into consideration, for example, services were held at the home led by local churches. Activities were arranged to reflect different cultural celebrations, important national events and other special occasions, for example Christmas and New Year and on the first day of the inspection St. David's day.

We talked with an activity co-ordinator. They explained how they supported people to take part in a range of social activities. A programme of activities was displayed around the building. Some past activities had included cinema trips, the zoo and riverboat excursions. Home based 'specials' had included an ice cream van and there was a regular 'cinema club'. The activity co-ordinator was very positive about the support they received from the registered manager and provider, for example through specialist training events and conferences.

There were procedures for making compliments and complaints about the service. Information about this was displayed prominently in the home. We discussed with the registered manager how one recent complaint had been handled. The registered manager had kept CQC informed of the process and had copied them into appropriate correspondence. The registered manager had recognised where there had been any failings and had taken steps to learn from them and make changes or re-inforce good practice with staff to avoid any repetition.

Is the service well-led?

Our findings

There had been a change in a long-standing registered manager since the previous inspection. Staff told us whilst it could be unsettling when there was a management change, the transition had been handled well, with little if any disruption to the service. They were very supportive of the new manager. The newly registered manager told us how they were getting to know the staff team and how the home operated. Throughout our two visits to the service we observed and people told us, that staff, visitors and people who used the service were comfortable approaching the registered manager and other senior staff. The registered manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe. The home worked in partnership with health and social care professionals to promote people's well-being.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. People's experience of care was monitored through regular visits from senior managers and audits. There was an annual quality assurance audit which looked at how the service performed as a whole. The home was also subject to external audit on specific key areas of its operation. For example, in February 2016 the home had been awarded five stars by the relevant environmental health authority.

The service had a statement about the vision and values it promoted; these were displayed in the home. We saw staff consistently treated people with dignity, respect and compassion. There was a relaxed and informal 'feel' to the home. The lounge area just inside the entrance, adjacent to the manager's office, was a popular place chosen by some people to sit and watch what was going on. They were able to interact with staff and some relatives used this space to talk to the people they had come to visit. The newly appointed manager told us they had relocated their office to this position to improve their contact with and accessibility for service users, staff and visitors. The home had good links with the local community, such as local schools and visiting clergy.

Records were well maintained at the service. Every record or information we asked to see was provided promptly. Staff had access to general operating policies and procedures on areas of practice such as safeguarding, restraint, whistle blowing and safe handling of medication. This meant staff had ready access to the detailed guidance they required.

Where areas for improvement were identified following any failures in practice we found these were dealt with constructively. This enabled the registered manager and their senior staff team to identify what had happened and why and to prevent recurrence. In a recent case, CQC had been kept fully informed and included in the communication. This displayed openness and candour in reporting when things went wrong.

We found there were good communication systems at the service. Residents' meetings were held regularly. These provided an opportunity for communication between people who use the service and staff about concerns or improvements that were being made. Staff and managers shared information in a variety of ways, such as face to face, during handovers between shifts and in team meetings.