Ellenbern Holdings Limited

Cherwood House Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Cherwood House on 19 September 2017. This inspection was unannounced. At the last inspection in June 2015, the service was rated 'Good'. At this inspection the service was rated as requires improvement.

Cherwood House Care Centre provides nursing and residential care for people over the age of 65. The home offers a service for up to 119 people. At the time of the inspection there were 97 people living at the service. Some of the people at Cherwood House were living with dementia.

There were two registered managers in post, one for the residential unit and another one who was a Matron for the nursing unit. 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.

Cherwood House did not have enough staff to meet people's needs and keep them safe. Staff told us they often worked short staffed and records confirmed planned staffing levels were not always met. We observed the shortage of staff to have a negative impact on the promptness of support people received and the interaction they received with staff.

Staff at Cherwood House did not always manage risks to people. Where people's needs had changed, risk assessments and risk management plans were not always updated. People did not have any personal emergency evacuation plans (PEEPS) in place. People were exposed to the risk of harm in the event of an emergency evacuation. The provider took action to address this concern.

People's medicines were not always managed safely. Where people were prescribed when necessary medicines (PRN), there were no PRN protocols in place to guide staff. Medicine administration records were not always complete. There was no system in place to monitor boxed medicines. Where people's medicines were being administered covertly, this was not done safely.

The registered manager and staff did not understand the Mental Capacity Act 2005 (MCA) and understand their responsibilities under the Deprivation of Liberty Safeguards (DoLS). As a result people were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible.

People's nutritional needs were met and they were given choices. However, some people did not receive their meals in a timely and dignified manner. Staff sometimes used in appropriate language to refer to people which did not respect their dignity. Support with personal care was not always delivered in a way which met people's individual needs or respected their privacy.

People's care plans were not always person centred and often had conflicting information to that recorded in daily records. People's care records were not up to date and did not reflect current care.

The provider's systems and processes to monitor and improve the quality and safety of the service were ineffective in identifying areas for improvement and ensuring that changes were made to improve the quality and safety of the service. Accidents and incidents were not always recorded and followed up.

People who were supported by the service told us felt safe living at Cherwood House. Staff had a clear understanding of how to safeguard people and protect their health and well-being. The provider followed safe recruitment practices.

Staff worked closely with various local social and health care professionals. Referrals for specialist advice were submitted in a timely manner. Staff knew the people they cared for. People's choices and wishes were respected and recorded in their care records. Where people had received end of life care, staff had taken actions to ensure people would have as dignified and comfortable death as possible. End of life care was provided in a compassionate way.

People knew how to complain and complaints were dealt with in line with the provider's complaints policy. People's input was valued and they were encouraged to feedback on the quality of the service and make suggestions for improvements.

The registered managers informed us of all notifiable incidents. People and staff spoke positively about the management and leadership they had from the registered managers.

We identified five breaches of the Health and Social Care Act 2008 (Regulated Activity) Regulation 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Risks to people were not always assessed and reviewed to keep people safe.

The home did not have enough staff to meet people's needs.

Medicines were not always managed safely.

People were protected from the risk of abuse by staff who had a good understanding of safeguarding procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not have knowledge of Mental Capacity Act (2005)and Deprivation of Liberty Safeguards. Where people were thought to lake capacity, there were no assessments completed nor best interest decisions followed.

People were supported to have their nutritional needs met. However, the dining experience varied.

People were supported to access healthcare support when needed.

Staff had the knowledge and skills to meet people's needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always maintain confidentiality.

Staff did not always treat people with dignity and respect.

People were involved in their care.

People were seen to be relaxed and calm in the presence of staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed and care plans were written to identify how people's needs would be met. However, the care plans were not personalised.

People's care plans were not current and did not reflect their needs.

People received activities and stimulation, however, the variety could be improved. People had mixed views on the activities available.

People's views were sought and acted upon.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider's quality assurance systems were not always effective.

Accidents and incidents were not always recorded.

People and staff told us the management team was open and approachable.

The leadership created a culture of openness that made people feel included and well supported.

Cherwood House Care Centre

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 19 September 2017 and was unannounced. The inspection team consisted of three inspectors, a specialist advisor and three Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we received information of concern which included staff shortages, poor staff attitude and poor medicines management. We reviewed the information we held about the service and the service provider. The registered provider completed 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. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We received feedback from five social and health care professionals who regularly visited people living in the home. This was to obtain their views on the quality of the service provided to people and how the home was being managed. We obtained feedback from commissioners of the service.

We spoke with 30 people and 10 relatives. We looked at 12 people's care records and 15 medicine administration records (MAR). The methods we used to gather information included pathway tracking, which is capturing the experiences of a sample of people by following a person's route through the home and getting their views on their care. During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We spoke with the registered manager, the deputy manager and 15 staff which included nurses, care staff, housekeeping, maintenance, catering staff and activity coordinator. We reviewed a range of records relating to the management of the home. These

included six staff files, quality assurance audits, minutes of meetings with people and staff, incident reports, complaints and compliments. In addition we reviewed feedback from people who had used the service and their relatives.

Inadequate

Is the service safe?

Our findings

Prior to the inspection, we received concerns around staff shortages. On the day of our inspection, we found Cherwood House did not have enough staff to meet people's needs and keep them safe. The home had staff vacancies and did not use agency staff. Staff told us they often worked short staffed. They said, "It's a struggle, we all muck in together even if it means staying over shift", "It's hard, everyone is getting stressed" and "Provider won't use agency staff but our own staff are drowning". People told us staff did not always have time to interact with them. Comments included; "They're short staffed, it's difficult to get the right people. When I first came I didn't get that feeling but I do now. They manage very well under the circumstances, they're all very pleasant", "There are not enough staff and they are rushed and stressed and sometimes end up shouting at you" and "Sometimes the carers are very scarce, they are all a bit rushed. They don't have enough time". People's relatives also told us there were not enough staff. They said, "They are often short staffed but I understand", "There should be more of them but they can't afford it" and "I know lots of the staff are on long term sick leave and that they won't have agency staff here".

During our inspection, we observed people in both the residential and nursing communal areas spent significant periods of time with no stimulation and no staff in attendance. During this time most people on the residential unit communal lounge were sleeping. Some people on the nursing unit waited for up to half an hour during lunch time to be supported with meals. During this time, these people did not have any interaction with staff. We reviewed staff rotas for care staff for between July 2017 and September 2017 and these showed the number of staff on duty were not always enough to meet people's needs. There were six occasions when staff numbers were less than planned to meet people's needs. A member of staff said, "We have some staff on long term sickness and staff vacancies. This has been on-going since the beginning of the year".

These findings were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we found people's medicines were not always managed safely. We looked at eight medication administration records (MAR) charts for people on both the residential and nursing unit who were prescribed when necessary medicines (PRN). All eight of them did not have PRN protocols in place. Staff we spoke with who were administering medicines, told us there were no PRN protocols in place. Staff did not have guidance to enable them to safely administer PRN medicines.

We looked at people's MAR charts. Where medicines had not been administered, codes used were not explained. For example, 'Other' code was used on three people's MAR charts but no explanation of what that meant when medicine was not given. People were at risk of not receiving medicines appropriately.

Records relating to the application of topical medicines did not always contain accurate up to date information and were not always fully completed. One person had four creams prescribed on a MAR chart. These creams were transcribed onto a topical MAR chart. The transcription did not indicate when, where or how the creams were to be applied. There were several gaps on the topical MAR chart. Three more topical

MAR charts we looked at had gaps in them. People were at risk of not receiving their medicines as prescribed.

We looked at the management of medicines in boxes. There was no system in place to monitor boxed medicines. We reviewed three MAR charts and could not confirm stock balances on any of them. We were not assured people had their medicines as prescribed. Some people were prescribed thickening agents. A thickening agent is prescribed for a person where they have swallowing difficulties or are at risk of choking. We found thickening agents on trolleys and in the kitchen. Some of the thick and easy did not have labels and we saw staff using it. We saw one staff member thicken one person's drink using a container prescribed for another person. The home had not followed safe storage of thickening agents guidance

People did not always have risk assessments in place and risk management plans to minimise those identified risks. One person had fallen four times and a Zimmer frame was provided. However, risk assessments and risk management plans for this person had not been updated following each fall as well as after delivery of new equipment. Staff were not following health professional's guidance on how frequently they should check on this person.

We looked at 12 people's care records from both the residential and nursing unit. These care records did not have personal emergency evacuation plans (PEEPs) in place. PEEPS are meant to contain detailed information on people's mobility needs and additional support required in the event of an emergency. We asked the registered manager and nurse trainer who told us there were none in the service. Therefore people were exposed to the risk of harm in the event of an emergency evacuation.

These findings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to the level of concern that we identified during our inspection, we wrote to the provider asking them what immediate action they were taking to address these concerns to ensure people who used the service were safe. The provider sent us an action plan telling us how they would address these concerns.

People told us they felt safe living at Cherwood House Care Centre. They said, "I feel very safe, help is there if you need it. We can just pull the cord", "Yes, I feel safe here. There are always people around and in the main home too" and "Yes I feel safe, but they [staff] don't have enough time. They are always rushed".

Staff told us they knew how to identify safeguarding concerns and how to act on these to keep people safe. Records showed staff had attended training in safeguarding vulnerable people and were aware of the provider's' safeguarding procedures. One member of staff said us, "I know how to report safeguarding issues externally to Oxford County Council (OCC) or Care Quality Commission (CQC)".

The provider followed safe recruitment practices. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable people from working with vulnerable people. Staff holding professional qualifications had their registration checked regularly to ensure they remained appropriately registered and legally entitled to practice. For example, registered nurses were checked against the register held by the Nursing and Midwifery Council (NMC).

Requires Improvement

Is the service effective?

Our findings

We checked to see if people were supported in line with the principles of the Mental Capacity Act (2005) (MCA). The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff had limited knowledge of the MCA and Deprivation of Liberty Safeguards. We asked staff to tell us their understanding of the MCA and they said, "I have not yet had MCA training. Seniors told me to work with people and give them a choice", "MCA is linked with safeguarding", "We've got one person now who can be quite aggressive and we need to think about his safety" and "If someone can't make their own decisions we have to make it for them. If someone was getting harmed and we needed to protect them. If we put bed rails we ask family if they agree to bed rails. If someone has dementia they may not be able to make own decisions".

The registered manager and staff did not follow the MCA code of practice and make sure that the rights of people who may lack capacity to make particular decisions were protected. Where people were thought to lack the capacity to consent or make some decisions, staff had not carried out capacity assessments. Where people did not have capacity to make certain decisions, there was no evidence of decisions being made on their behalf, by those that were legally authorised to do so, in the person's best interests. For example, one person's consent form for the use of photography was signed by family member who did not have legal authority to do so. Another person's safety care plan stated: 'problem' – 'unsafe in bed' – 'seek permission from patient or relative to use bed rails, consent given by husband'. However the consent was signed by the nurse. Consent forms for bed rails and a strap belt had been signed by a relative. However we could not find any record of the relative having legal authority to do so. We found several examples of relatives signing documents on people's behalf when there was no evidence they had the appropriate power of attorney to do so.

One person had a care plan related to being unsafe in bed. The plan stated, 'seek permission from patient or their relative to use bedrails and sign below when permission obtained'. There was no decision specific capacity assessment or record of any best interest decision discussion. We saw the person used bedrails. This person's liberty was being deprived and we could not be sure this was the least restrictive way.

Where people received medicines covertly, no mental capacity assessments had been completed and no best interest process had been followed. Covert allows for safe administering of medicine when people are either resistant to take them or they refuse and the medicine needs to be given to them in their best interest. One person was thought to lack capacity and received six different medicines covertly. There was no record of a mental capacity assessment having been completed. There was no record on a best interest process having been followed. The person's care plan stated 'Medicines to be given in liquid form or to be crushed as recommended by the pharmacist'. We asked one member of staff how they administered this person's medicines covertly and they said, "We give it in sandwiches". There was no evidence of the pharmacist

having been consulted to ensure that it was safe to administer the medicines in this way. This was not in line with national guidelines that state 'A best interests meeting should be attended by care home staff, relevant health professionals including the prescriber and pharmacist' and 'the medicines must be review by the pharmacist to advise the care home how the medication can be covertly administered safely'.

These findings were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed the midday meal experience on both the residential and nursing unit and saw it was varied. On the nursing unit we observed people being seated in the dining area that adjoined the lounge. Most people were supported in a timely manner with their meals. However, we saw three people sat on the lounge side facing a TV which was switched off. These three people waited for up to half an hour after other people had finished their meals, to be supported with their lunch. During this time they did not have any interaction with staff.

On the residential unit, during lunch time we observed one member of staff supporting two people with their meals at the same time. Both these people required one to one support during meal times. We also observed that both people did not receive support at a pace that matched their individual needs. There was little interaction between the member of staff and the two people. People on the residential unit dining room told us they, at times, have to wait for meals. They said, "The food is very good. We have to wait, there's a shortage of staff" and "We wait until last, we don't mind".

People told us they enjoyed the food. Comments included; "The food is very good but we get too much", "It's very tasty", "The food is very good, it's all food we like" and "The quality of the food is excellent and it is cooked to perfection".

People's dietary needs and preferences were documented and known by the chef and staff. Some people had special dietary needs and preferences. For example, people having soft food or thickened fluids where choking was a risk. The home contacted GP's, dieticians, speech and language therapists (SALT) as well as care home support if they had concerns over people's nutritional needs. Where people were identified as being at risk of malnutrition a malnutrition universal screening tool (MUST) was used to assess, monitor and manage this risk.

People told us they received care from knowledgeable staff. People's comments included; "The staff seem to know what they're doing pretty well", "They seem knowledgeable and they are always clean and presentable" and "The girls know what they are doing".

Newly appointed care staff went through an induction period which gave them the skills and confidence to carry out their roles and responsibilities. This included training for their role and shadowing an experienced member of staff. One member of staff told us, "Training prepared me well for the role. I had manual handling, safeguarding, fire, food hygiene. Also did two weeks of shadowing".

Records showed and staff told us they received mandatory training before they started working at Cherwood House. They were also supported to attend refresher sessions yearly. Mandatory training included; infection control, manual handling, safeguarding, fire safety and first aid. One member of staff told us, "We always get mandatory refreshers". Nursing staff were supported to attend specific training to their roles which included catheter care, depression and percutaneous endoscopic gastrostomy (PEG) training.

The provider had a supervision policy which stipulated staff to receive supervision every two months. Staff

records showed they received supervisions at least every four months. However, staff told us they felt supported. They said, "I get two to three monthly regular supervision. I can air my concerns, it is a two way process" and "Yes, I do get supervision every two months or so".

People's care records showed relevant health and social care professionals were involved with their care. People were supported to stay healthy and their care records described the support they needed. The provider facilitated weekly GP visits to review residents as needed. Health and social care professionals were complimentary about the service. One healthcare professional told us, "The management and staff have always been very helpful and carried out any instructions that I have requested". People's care records showed details of professional visits with information on changes to treatment if required.

Requires Improvement

Is the service caring?

Our findings

People felt staff treated them with respect. However, we found some occasions where staff did not refer to or treat people respectfully. We observed two members of staff and two members of the management team referring to people who needed support with meals as 'feeders'. Feedback from one healthcare professional sighted that 'The environment is quite institutional. Residents who require support at mealtimes are labelled 'feeders''.

During lunchtime on the residential unit, we saw people who required assistance to eat were all moved to one large table in the dining room. Two staff members then assisted these eight people to eat their meals. Both staff stood up whilst doing so and moved from one person to another. One staff member had minimal interaction with the people they were giving their meals to and took little time to allow people to eat at their own pace. We heard a senior member of staff, whilst in the dining room; refer to 'the feeder's table' and 'assisted feeders'. We saw recorded in one person's care plan, '[Person] to be sat on the assisted feeders table for meals'. This marginalised those people who required support to eat from the rest of the residents and their dignity was neither promoted nor respected.

We heard staff throughout the day refer to toileting people. One member of staff called to another member of staff down a corridor, "Can you help me start toileting please?" Another member of staff told us when they came on shift, "We start toileting now. There are set ones (people) that we toilet as they can't talk". We found a 'Toileting chart' in a communal corridor on the residential unit, on which were recorded people's names and whether they were found 'wet or dry' when they had been taken to the toilet. We saw people queued up to be toileted after lunch. This exposed people to the risk of harm through institutional abusive practice.

These findings were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received care and support from staff who were caring. They commented; "The staff are kind and compassionate yes, their attitude, they're all very good", "As far as I know they are kind, they always listen" and "As a generalisation they are kind and compassionate. They vary like anywhere - they are sympathetic".
People received care and support from staff who had got to know them well. People told us, "I've been here for two years now, they know me well", "Most of the staff I meet know all about me" and "They do know me well. They are different ages and maturity, the relationship is professional but still with humour". Most of the staff had been with the provider for a long time and had developed meaningful relationships with people. One member of staff told us, "All residents know who we are so they get the continuity".

Staff told us they enjoyed working at the home. They said, "This job is rewarding to me, you picture yourself when older, thoroughly enjoy it" and "I like coming here in the morning and making somebody feeling better for the day".

We observed some people being attended to and assisted in a caring and patient way. Staff offered choices

and involved people in the decisions about their care. People told us staff treated them respectfully. One person said, "They treat me with respect, they knock or ring the bell before they come in and they're all friendly". People received care in private. We saw staff knocking on people's doors and asking if they could go in. Staff told us how they protected people's dignity when giving personal care by making sure doors were closed, covering people appropriately and explaining what they were doing. One member of staff said, "When delivering personal care, always keep door closed".

Staff spoke with us about promoting people's independence. They said, "We try to encourage people to wash themselves as much as they can to promote independence, or to keep their mobility" and "We have some residents who can wash their own face, teeth, and we work as a team with people". We observed staff supporting another person from a wheelchair to a chair using a Zimmer frame. Staff took time to encourage the person and praised them throughout the process.

People's preferences relating to end of life were recorded. This included preferences relating to support. People and their relatives where appropriate were involved in advanced decisions about their end of life care and this was recorded in their care plans. For example, one person had an advance end of life care (a plan of their wishes at the end of life) and a do not attempt cardio pulmonary resuscitation (DNACPR) order document in place. We saw the person and their family were involved in this decision. Another person's record indicated they wished to be resuscitated. Staff described the importance of keeping people as comfortable as possible as they approached the end of their life.

The provider's equal opportunities policy was available in the home. This stated the provider's commitment to equal opportunities and diversity. This included cultural and religious backgrounds as well as people's gender and sexual orientation.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed before they came to live at Cherwood House to ensure they could be met. Each person had an assessment of their needs and these were used to create a plan of care which included people's preferences, choices and interests. The care plans covered areas such as personal care, eating and drinking, mobility, elimination and communication needs. However, we found people's care plans were not always personalised. The provider used pre-printed care plans which staff were expected to adjust to meet each person's needs. However, we found staff did not always adjust these care plans. For example, one person's care plan stated 'safe clothing and footwear to be worn whilst walking'. The person was immobile and required a wheelchair. Their care plan for prevention of pressure sores stated that their position should be changed 'every two to three hours' however they did not have any pressure damage and used a pressure relief cushion and mattress. Another person's pressure sore care plan stated that the person was at risk and needed turning every 2 to 3 hours. We checked and found the person was not bed bound and did not require any turning. The person's care plan did not have the correct information for staff to provide the right care.

People's care records were not always up to date and did not reflect current care. One person's daily records stated '4/8/17 severe back pain, Oramorph given, 10/8/17 pain patches were introduced by GP, 24/8/17 pain patches were increased by GP. None of these changes were reflected in the care plan. This person's care plans had not been reviewed since 11 May 2017. This person was at risk of harm because staff did not have appropriate guidance to enable them to support this person safely. One member of staff told us, "Seniors are allotted to so many care plans and it's been hard to keep up with paperwork".

These findings were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider used a 'This is Me' document which captured people's life histories including past work and social life to enable staff to provide person centred care and respect people's preferences and interests. For example, one person enjoyed gardening and cricket. We saw no evidence to support that this information had been used to support the person's interests.
People's care records contained information about their health and social care needs. For example, one person's care plan showed their medical history, how they should be managed and how this affected their day to day life. The care plan for this person detailed the support the person required to maintain their independence. Care plans reflected how people wished to receive their care and support. For example, people's preferences about what time they preferred to get up.

Handover meetings between staff ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Staff shared information about any changes to care needs, activities attended, planned appointments and generally how people had spent their day. This meant staff received up to date information before providing care in order to maintain consistency.

The provider used a key worker system. A keyworker is a staff member responsible for overseeing the care a person receives and liaises with families and professionals involved in that person's care. This allowed staff to build relationships with people and their relatives and aimed at providing personalised care through consistency. One member of staff commented, "We have set care plans that we look after. We know those people well and do their reviews".

The provider employed activities coordinators. One of the coordinators also did caring duties. They were both passionate about their roles. On the day of the inspection we saw people going out for a coffee morning. The provider had links with 'Friends of Cherwood' who often were involved with activities. People told us they enjoyed going out. One person said, "I did go on the trip down to Tesco on Monday and that was good". However, people also had mixed views about the activities. Comments included; "I have a programme of the activities but am not interested in any of them", "I prefer to stay in my room and watch the television. I would like to go out into the garden but there are not enough staff to take me" and "I do not want to do any of the activities". We observed a cheese tasting session during our inspection. We saw a few number of people attended, however, they appeared to enjoy the activity. We asked one person why they did not attend the activity and they said, "I only want to join in some of these things".

Feedback was sought from people through regular family meetings, suggestion boxes as well as satisfaction surveys. Records showed that some of the discussions were around what changes people wanted. For example, people had been involved in discussions about activities. People and their relatives told us they attended the resident/relatives meeting.

People and their relatives knew how to make a complaint and the provider had a complaints policy in place. People and their relatives commented that the registered manager was always available to address most issues. One person said, "If I had a complaint I would go to the owner, he'd want to know and he would action it. To be honest, I have no reason to complain. I like all the staff, they work hard". We looked at the complaints records and saw all complaints had been dealt with in line with the provider's policy. Records showed complaints raised had been responded to sympathetically and followed up to ensure actions were completed. Since our last inspection there had been many compliments and positive feedback received about the staff and the care people had received.

Requires Improvement

Is the service well-led?

Our findings

The provider had some quality assurance systems in place. However, some of these systems were not always effective. For example, record keeping audits had not identified the shortfalls we found in risk assessments and care plans. On the nursing unit, the medicine audits were not effective enough to pick up any of the concerns we found.

On the residential unit, we found no medicine or care plan audits had been completed since August 2016. The registered manager told us due to the staffing shortages and they prioritised delivering care to people over completion of audits.

Staff were provided with guidance in relation to confidentiality and were aware of the provider's policy on confidentiality. Staff told us, "We had training around data protection and I'm aware not to discuss confidential information about people" and "We can't give information. Only yesterday I had a call from someone's ex-sister in law and did not give any information". However, we found on the nursing unit people's records were kept in an open office in open cabinets accessible to anyone. We brought this to the attention of one senior member of staff and they said, "I don't think anyone would come in here. We have never seen anyone do that". This was contrary to the provider's storage of records policy which stated 'If records are stored where staff are not always in attendance, they must be able to be locked away securely'. Staff did not follow the provider's policy.

These findings were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a clear procedure for recording accidents and incidents. Accidents or incidents relating to people were documented, investigated and actions were followed through to reduce the risk of further incidents occurring. Staff knew how to report accidents and incidents. However, we found two incidents which had not been documented. One person's daily record stated 'Bruising to back of leg, inner thigh above knee on both legs'. We found no record of this in the accident and incident record book. There was no evidence of any follow up having been completed.

Cherwood house was led by two registered managers, one on each unit. Both the managers had been with the provider for several years. On the day of our inspection only the registered manager for the residential unit was on duty. The provider was actively involved in the day to day running of the home although not present on the day of our inspection.

There was a clear management structure in place, with staff being aware of their roles and responsibilities. Staff felt they could approach the registered managers or other senior staff with any concerns and told us that management were supportive. Staff comments included; "I can go and knock on [manager's] door anytime" and "I've never had a manager like that. She's hands on, fair and hard worker. She would not give you a job she wouldn't be able to do herself" and "We have a lovely manager, she's very supportive". Staff told us the registered managers had an open door policy and were always visible around the home.

During the inspection we saw the registered manager interacting with people. People knew the registered manager and were very relaxed and comfortable talking to her. People and their relatives knew the management team and were complimentary of them. One person told us, "I know who the manager is. I let my family deal with things for me". Another person complimented, "I see the manager all the time. She works with the girls and not afraid to gets her hands dirty".

Throughout our inspection we observed good direction for staff from the registered manager. There was positive engagement with all staff. Communication amongst staff was good and systems such as staff meetings and handover sessions used effectively to support verbal communication. Team meetings were regularly held where staff could raise concerns and discuss issues. "One member of staff told us, "We have handovers every day". Another member of staff said, "Had a staff meeting two months ago. [Manager] had an agenda and if we have any questions we can ask. We get two lots of dates so everyone can attend".

We received complimentary feedback from health and social care professionals. They spoke highly about their relationship with the registered manager and staff. They commented on how well staff communicated with them in a timely manner. One healthcare professional told us, "The home is very well led. The managers are extremely dedicated to ensure that the residents' needs are met in a professional manner".

The registered manager told us their biggest challenge has been staffing shortages in the last months. They said, "Staff recruitment and retention has been a huge challenge. Staff shortages are affecting staff well-being".

People benefited from staff who understood the whistleblowing procedure. Whistleblowing policy is a guidance aimed at encouraging employees and others who have serious concerns about any aspect of the provider's work to come forward and voice those concerns. The provider had a whistle blowing policy in place that was available to staff across the home. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening. Staff were confident the management team and organisation would support them if they used the whistleblowing policy. One member of staff told us, "I am aware of whistle blowing policy. I can take it further and it remains anonymous".

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered managers were aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were queued up to be toileted after lunch. Staff including the management team referred to people who needed support with meals as 'feeders'.

The enforcement action we took:

Urgent imposition of a condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Management and staff had limited knowledge of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Where people were thought to lack capacity to make decisions, no mental capacity assessments had been completed. People on covert medicines had not had any best interest processes followed.

The enforcement action we took:

Urgent imposition of a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely. There was no system in place to monitor boxed medicines. There were no prn protocols in place. People did not always have risk assessments in place and no risk management plans to mitigate such risks.

People did not have personal evacuation plans in place.

The enforcement action we took:

Urgent imposition of a condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's care records were not up to date and did not reflect current care. Systems and processes to monitor and improve the quality and safety of the service were ineffective.

The enforcement action we took:

Urgent imposition of a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The home did not have enough staff to meet people's needs.

The enforcement action we took:

Urgent imposition of a condition