Alysia Caring Limited

Cherry Blossom Care Home

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?	Requires Improvement

Summary of findings

Overall summary

Cherry Blossom Care Home provides accommodation, personal care and nursing care for up to 80 older people. The accommodation comprises of 80 single bedrooms located over three floors which can be accessed by stairs or lifts. All bedrooms have en suite facilities. There are communal lounges with kitchenettes and dining areas and a garden for people and their visitors to use. The ground floor has a bistro, hair salon, day centre and a cinema room.

This unannounced inspection took place on 11 March 2016. There were 42 people living at the home at the time of this visit as one floor was not yet occupied. This was the first inspection since the provider registered this service in March 2015.

There was a registered manager in place during this inspection. 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 Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and report on what we find. Where people had been assessed as lacking capacity, decisions were made in their best interest. Applications had been made to the local authorising agencies to lawfully restrict people's liberty where appropriate. Staff demonstrated to us that they respected people's choices about how they wished to be supported.

Records were in place for staff to monitor people's assessed risks, support and care needs. Plans were put in place to minimise people's identified risks and to assist people to live as safe a life as possible whilst supporting their independence. These records were not always completed in full by staff. This meant that there was an increased risk that risks to people's health and wellbeing would not be identified promptly.

Arrangements were in place to ensure that people's medicines were managed and administered safely. People's nutritional and hydration needs were met. Infection control processes were in place to help reduce the risk of cross contamination.

When needed, people were able to access a range of internal and external health care professionals. People were supported to maintain their health and well-being. Staff supported people with their interests and hobbies and to maintain their links with the local community to promote social inclusion. People's friends and families were encouraged to visit the home and staff made them feel welcome.

People were supported by staff in a compassionate and respectful manner. People's care and support plans gave guidance to staff on any individual assistance a person required. Records included how people wished to be supported, and what was important to them. These records and reviews of these records did not always document that people or their appropriate relatives had been involved in this process.

Staff understood their responsibility to report any poor care practice or suspicions of harm. There were pre-employment safety checks in place to ensure that all new staff were deemed suitable and safe to work with the people they supported. There was a sufficient number of staff to provide people with safe support and care.

Staff were trained to provide care and support which met people's individual needs. The standard of staff members' work performance was reviewed during supervisions, competency checks and appraisals. This was to ensure that staff were confident and competent to provide people's support and care.

The registered manager sought feedback about the quality of the home provided from people living at the home and their relatives. People and their relatives felt listened to and they were able to raise any suggestions or concerns that they had with the registered manager and staff.

Staff meetings took place and staff were encouraged to raise any concerns or suggestions that they may have had. Quality monitoring processes to identify areas of improvement required within the home were in place. However, not all quality monitoring was as effective as they could have been in identifying and driving improvements. Action plans from this monitoring were not always in place for documenting any required improvements to the service provided.

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 and administered as prescribed.

Staff were aware of their responsibility to report any concerns about poor care and suspicions of harm.

People's care and support needs were met by a sufficient number of staff. Checks were in place to ensure that new staff were deemed suitable to look after the people they supported.

Is the service effective?

Good

The service was effective.

The majority of staff were aware of the key requirements of the MCA and DoLS to ensure that people were not having their freedom restricted in an unlawful manner.

People's health, nutritional and hydration needs were met.

Staff were trained to support people to meet their needs.

Is the service caring?

Good

The service was caring.

Staff were compassionate and respectful in the way that they assisted and engaged with people.

Staff respected people's right to privacy and dignity.

Staff encouraged people to make their own choices about things that were important to them and encouraged people to maintain their independence.

Is the service responsive?

Good

The service was responsive.

Staff supported people to maintain their hobbies, interests and their links with the local community to promote social inclusion.

People's care and support needs were planned and appraised to make sure they met their current needs.

There was a system in place to receive and manage people's suggestions or complaints and people were aware of this.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a registered manager in place.

Audits were undertaken as part of the on-going quality monitoring process. These were not always as effective as they could have been in identifying and driving improvements.

People and their relatives were able to feedback on the quality of the home provided and felt listened to.

Cherry Blossom Care Home

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 11 March 2016, and was unannounced. The inspection was completed by three inspectors and an expert by experience. An expert by experience is a person who has personal experience of working with or caring for someone who uses this type of care service. Their area of expertise was older people and people living with dementia.

Before our inspection we looked at all the information we held about the home and used this information as part of our inspection planning. The information included notifications. Notifications are information on important events that happen in the home that the provider is required by law to notify us about.

We spoke with 12 people who lived in the home and 13 relatives. We spoke with the nominated individual, registered manager, three nurses, one senior carer, four care workers and the chef. We also spoke with three visiting health care professionals. Throughout this inspection we observed how the staff interacted with people who lived in the home and those people who had limited communication skills. We used this as a way of observing care to help us understand the experience of people who could not talk with us.

We looked at eight people's care records, three staff recruitment files and the systems for monitoring staff training and development. We looked at other documentation such as quality monitoring, relatives' and people's feedback questionnaires, staff meeting minutes, relatives meeting minutes, accidents and incidents, maintenance and safety records. We saw records of complaints, and medication administration records.

Good

Is the service safe?

Our findings

People said that they felt safe in the home. This was because of the care and support that was provided and how staff treated them. One person told us that, "I do feel safe here, the staff are lovely and very helpful….I worry about nothing in this place." Another person said, "I do feel safe here, I need a lot of moving [on a hoist] and I have no problems with how they treat me." A third person told us, "It's a general feeling but I do feel safe here."

Staff said that they had undertaken safeguarding training and records we looked at confirmed this. They demonstrated to us their knowledge on how to identify the different types of abuse and report any suspicions of harm or poor care practice. On person said, "Yes, they [staff] speak to us all kindly and politely. No-one shouts or gets upset with me. I like that." Staff told us what action they would take in protecting people and reporting such incidents. One staff member said, "Yes I have completed safeguarding training. If someone had a change in their behaviour, appetite or mood, had unexplained bruising or was not at ease around a person I would tell my team leader or the manager so that they could check that no abuse was occurring. If I saw a staff member speaking to a person disrespectfully or not respecting their dignity I would report them to my team leader. I have had to do this in the past in another home." We saw information on how to report suspicions of poor harm on notice boards within the communal notice board in the home. This was for people, visitors to the home and staff to refer to if needed. This demonstrated to us that there were protocols in place to reduce people's risk of harm.

During this inspection we saw that people had individual risk assessments undertaken and care plans in relation to identified support and health care needs. Individual risks identified included; people being at risk with their mobility; skin integrity; and malnutrition and dehydration risks. These risk assessments and care plans were in place to provide prompts and guidance for staff on how to support and monitor people safely.

Where people had experienced recent falls, records were not always complete. We saw that one person in February 2016 had a fall which resulted in an injury and appropriate external healthcare had been sought. However, in the persons care records we noted that the falls risk assessment in place had been updated to reflect the fall following the injury but had not documented both falls. This increased the risk of staff misinterpreting these records.

During this inspection staff said and records confirmed that pre-employment safety checks were carried out prior to them starting work at the home and providing care. One staff member said, "I am fairly new here. I answered an advert and completed an application form. The manager sent off for my references, one personal and one previous employer. My DBS [criminal record check], and identification were checked as well as my driver's license, utility bill and birth certificate. I did not start work before my DBS was back." Another staff member told us, "I had to give three references and have a DBS check before I started work here." These checks were in place to make sure that staff were of a good character and that they were suitable to work with people living at the home.

We found that people were supported by staff to take their prescribed medicines safely. We saw that there were suitable measures in place for the safe management of people's prescribed medicines such as guidance for 'as required' medicines and how medicines were stored and dispose of. People told us that they had no concerns about the management of their prescribed medicines. One person said, "I have high confidence the staff will look after me and that my medicines will be right."

Where people had been accessed as being able to manage their own medicines we saw that there were risk assessments and monitoring by staff in place for this. This was to make sure the medicines were correctly taken. Records showed that any medicines errors or omissions were investigated and action taken to make sure the people involved were safe and that the staff member responsible was retrained. We were told and we saw that all staff who administered medicines had received appropriate training and competency checks.

During our inspection we saw that there were sufficient staff on duty to meet people's assessed needs. People's current dependency requirements were assessed and this determined how much care and support from staff would be needed. We saw that the staff skills mix was consistent with the needs of people living at the home. A staff member said, "Yes, there are mainly enough staff on duty if everyone is working who should be. We use agency staff and cover for each other but there have been times when cover has not been available and then the manager helps us. We can call on staff [from a different floor] for help if we are really short staffed. Much better now than it used to be." Our observations showed that people's requests for assistance were responded to and that staff whilst they were busy, people were not hurried. However, people and relatives had mixed opinions over the staffing levels within the home. One person said, "Yes my call bell works and is left near me so that I can ring it if I need help. No, I do not have to wait long for it to be answered." Another person told us, "I do have to wait a little while for help sometimes. Oh, about five to six minutes." A third person said, "It doesn't suit me here – there are not enough staff at any time of day. I am unable to move without assistance and this morning I had to wait over an hour for a second member of staff to enable me to get up and dressed as I need a hoist." This meant that for some people their needs were not responded to as quickly as they should have been.

During this visit we saw a poster on the communal notice board which detailed out of hours on-call contact information. One staff member confirmed, "Yes, we have an on-call system for use when the manager is not here, such as evening, night and weekend. We just have to ring whoever is on-call for advice or additional support." This meant that there was on-call information for staff to use when needed.

In the care records we looked at we saw that people had individual personal evacuation plans in place in case of an emergency. This showed us that there were plans in place to assist people to be evacuated safely in the event of a foreseeable emergency for example a fire.

We looked at the inspection checks and certificates for safety assessments on the home's utility systems and fire safety checks. This showed us that the management made checks to ensure people were, as far as practicable, safely cared for in a place that was safe to live, visit or work.

During the inspection we were informed by the registered manager that some people and staff had acquired diarrhoea and vomiting prior to the inspection. The registered manager assured that that affected staff and people at the home had been clear of symptoms for 24 hours. They told us that they had informed Public Health England, when the outbreak first occurred. They also told us that they had let relatives of people know via a telephone call. This was so that relatives could make the decision of whether to visit their family member during this time. A relative we spoke with said, "Yes, we were informed that there was [diarrhoea and vomiting] here and asked not to visit. Well, the manager said that we could if our family member did not

have any symptoms. I kept away. I did not want that. I spoke to my family member on the telephone each day." The home during our visit was visibly clean and tidy. A visiting health care provider told us that they felt that, "The place is spotless and people are spotless." Staff we spoke with confirmed to us that protective clothing was available in the home for staff to use. This showed us staff had access to this personal protective equipment to reduce the risk of spreading infection. Hand sanitizers were available around the home and hand washing instructions were displayed in communal toilets. Staff told us about the cleaning schedules that they followed to clean the home and records we looked at confirmed this. One person said, "This is a lovely clean home and they are always cleaning my room. I am a little untidy, I always have been. They do not seem to mind." This meant there were systems in place to reduce the risk of spreading infections.

Good

Is the service effective?

Our findings

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. We checked whether the service was working within the principles of the MCA. We spoke with the registered manager about the MCA and changes to guidance in the Deprivation of Liberty Safeguards (DoLS). We found that they were aware that they needed to safeguard the rights of people who were assessed as being unable to make their own decisions and choices. Where people had been assessed as lacking the mental capacity to make decisions, decisions were made in their best interest and these were documented. Applications had been made to the local authorising agencies to lawfully restrict people of their liberty where appropriate and authorisation had been received.

Staff demonstrated to us that they respected people's choice about how they wished to be assisted. Records showed that staff had received training in MCA. On speaking to staff we noted that their knowledge about MCA 2005 and DoLS was variable. One staff member told us, "We treat everyone as if they have capacity and if we need to, make a least restrictive decision in their best interests." However, not all staff we spoke with were able to tell us who had a current and authorised DoLS in place. In addition, people's capacity had been assessed and documented but their records did not always specify the person's ability to make certain day-to-day decisions. This put people at risk of not being cared for in accordance with MCA and DoLS code of practice.

People told us that they were happy with the food served in the home. They said that the quality of the food was good and there was a good choice to choose from. During our observations we saw that staff confirmed people's choice of main meal and pudding. This was done either by using pictures or examples of the menu choice plated up as visual prompts. The chef talked us through any special dietary needs that people had and how these were catered for; this included food prepared for people with a specific health care condition or people who required their food to be in a softened form due to identified risks of poor swallowing. We saw that food charts were in place for people assessed to be at risk of malnutrition. Records we looked at showed that for people at risk, a dietician had been involved to give advice. Staff told us that they would contact the dietician again if they had further concerns of weight loss.

Within the communal dining rooms on the residential and nursing floor we saw kitchenettes in place. These were areas where people and their visitors could make themselves hot or cold drinks or make snacks. One person said, "The food is excellent – I can't fault it. Another person told us, "I love the food here, there is always enough and I can have more if I want."

People were provided with a selection of hot and cold drinks throughout the day. A staff member said,

"Special and soft diets are catered for here. People can have their breakfasts when they like. Some wake up early and the night staff do their breakfast and some get up later. No, breakfast does not stop at 09:00am. This manager is very clear with us that we all have to be flexible and encourage people to eat and drink when they choose throughout the day. Yes, at night snacks such as sandwiches, cakes, fruit, biscuits, crisps are always available. Some people like to eat a little and often and they can do this. We fortify food for some people." Our observations during the meal time showed that people could choose where they wanted to eat their meals. We saw that some people ate their lunch in the dining area, but some people had chosen to have their meals in their room. We saw that staff circulated amongst people whilst they ate to check that everything was satisfactory and to spend moments in conversation. This was done in a chatty and engaging manner which people appreciated and reciprocated. Where people needed some support we saw that staff encouraged people to eat at their own pace. This assisted the person to eat their meal with limited support while maintaining their independence.

Staff said that when they first joined the team they had an induction period which included mandatory training and shadowing a more experienced member of staff. This was until they were deemed confident and competent to deliver safe and effective care and support. One staff member said, "My induction was really good. It lasted a week and covered moving and handling, safeguarding, MCA and dementia. I showed for about three days. I got a certificate and had a workbook." Staff told us about the training they had completed to make sure that they had the skills to provide the individual support and care people needed. This was confirmed by the record of staff training undertaken to date. Training included, but was not limited to; safeguarding adults; infections control, DoLS, moving and handling, MCA 2005, fire safety, and dementia awareness. Another staff member explained to us how they were being supported to develop their skills and knowledge. They told us," I have and NVQ [national vocational qualification] level two and I am going to do the health and social care diploma soon. This demonstrated to us that staff were supported to develop and maintain their knowledge and skills.

Staff members told us they enjoyed their work and were well supported. Staff said they attended staff meetings and received formal supervision, competency checks and an annual appraisal of their work. One staff member said, "Yes, we have a supervision every two or three months and are due an appraisal soon. If we need to discuss anything with the manager we can do this at any time." This demonstrated to us that staff were supported within their roles.

External health care professionals were involved by staff if there were any concerns about people living in the home. These referrals for guidance included, referrals to the falls and continuing care team and GP's for people assessed as at risk. A staff member confirmed to us, "We ask the community mental health team, the falls team or a physio to visit if someone keeps falling over and they often visit here." A visiting healthcare professional told us that, "Staff listen to advice given, they know who [we] are coming to see and staff have up to date information [for us]."

Good

Is the service caring?

Our findings

People's care records showed that staff had taken time to gather people's personal and social histories and their preferences. These preferences were then taken into consideration when planning all aspects of their care. Care reviews took place to make sure that people's care and support plans were up-to-date and met people's current needs. However, records we looked at did not always demonstrate to us that people were involved in these reviews of their care. One person told us, "No, I am not involved in planning my care or reviews. I know they have records about me but the staff do that." A relative said," We are asked by the staff if we are happy but I am not involved in care planning or reviews. A staff member told us, "We do monthly reviews and write down any changes. We involve the relatives when we can." The registered manager had already identified this as an area that required improvement. We saw documented evidence in a recent relatives meeting that relatives had been encouraged to be involved in the planning and review of their family members care and support.

Staff told us that end of life care was provided for people. They told us that the person, their relative's, the GP and continuing care team were all involved in the decisions made about the care and support they provided. People who had documented their wish not to be resuscitated had the appropriate documents in place to record this.

People and their relatives had, in the main, positive comments about the service provided. One person said, "You couldn't find a better place anywhere. This is a hotel compared to other places. The staff are good and it's clean." Another person told us, "This is a very nice place that has lovely staff." A third person said, "I get lots of care and attention. They [staff] know how I like to be cared for because they ask me."

Staff took time to support people when needed. We saw staff supporting people and that this was all done at the person's preferred pace and without rushing them. Where people were becoming increasingly anxious and starting to display behaviour that could harm themselves or others, we saw staff deal with this sensitively. One relative said, "People do sometimes get [upset] with each other and staff and I have seen the staff expertly and quietly separate the people." Another relative told us, "I have been here when a person has become [confused]. Yes, the staff responded quickly and spoke to the person taking their mind off of what was upsetting them; they [staff] soon calmed the person." Our observations confirmed this as we noted staff use reassurance and distraction to calm people to good effect.

Staff talked us through how they made sure people's privacy and dignity was respected and promoted when they assisted them with their personal care. Staff were seen to knock on bedroom, toilet and bathroom doors before entering them. We noted that bathrooms, toilets and people's bedroom doors were closed when people were being assisted by staff with their personal care. We saw that staff were polite and addressed people in a respectful manner and by the name they preferred. We noted that staff asked people if they needed support with their personal care in a dignified way. People were cleanly dressed and appropriately for the temperature within the home. One relative confirmed to us that, "My [family member] always looks clean and tidy." This demonstrated to us that staff treated the people they were assisting in a respectful and dignified manner.

Staff told us how they encouraged people to make their own choices to promote and maintain people's autonomy. For example, what time they would like to get up, what people would like to eat, where they would like to take their meals or what they would like to wear. One staff member said, "We help people to make their own decisions and choices by treating each person as an individual and constantly asking them." People said that they could ask for help from staff when needed and talked us through how they were encouraged by staff to make their own choices. On person told us, "I am asked to make a choice all the time." Another person said, "I make my own decisions." This demonstrated to us that people were supported by staff to be involved in making their own decisions and that staff respected these choices.

People's friends and family were encouraged to visit the home by the registered manager and staff. One person said, "My visitors come to see me and the staff make them welcome." Relatives we spoke with told us that there was no limitation on visiting hours. One relative told us, "There are dedicated and friendly staff working here who make me feel welcome when I visit."

Advocacy services information was available in the reception area of the home for people and their relatives should they wish to use this information. Advocates are people who are independent of the home and who support people to make and communicate their wishes.

Good

Is the service responsive?

Our findings

On the day of our inspection we saw that there was external musical entertainment in the day centre and a film shown in the cinema room for people to attend should they choose to do so. However, people and their relatives we spoke with had mixed opinions on the activities on offer at the home. One person said, "I go to the day centre and we do things there like puzzles or colouring." Another person said, "We can do as we want here. I join in the activities downstairs sometimes but I like to be in my bedroom." A relative told us that there were, "Some activities, but need more I think. People get bored." Another relative said that there were activities for people to do on some days and that the activities provided could be more varied. A staff member told us, "Activities have not been so good in the past but are better now. We could do with more things for each person to do. I think this is being arranged." Another staff member said, "Activities could be a bit better with more things going on. It's becoming more established and developing. We do as much 'one to one' in rooms as we can. People do go out to [named supermarket] and town. There are trips out on a Thursday." A third staff member told us, "Activities are good at the moment. Staff do activities at the weekends."

Care and support plans were developed by staff and these provided guidance and prompt to staff on the care and support the person needed. Pre admission assessments had been completed by staff and this determined the individual support that people received from staff was in response to their assessed needs. One person said, "They [staff] know how I liked to be cared for because they ask me." Support included assistance with their prescribed medication, personal care assistance, attending health care appointments, rehabilitation goals, and meal time support. However, we noted that people's rooms were not identified by use of their names, pictorial prompts or personalised items to make them more homely for the person living there. They were not as person centred as they could have been and limited people's ability to be aware of their surroundings.

The majority of people and their relatives told us that that they knew how to raise a suggestion or complaint should they need to do so and they would be confident to that a suggestion or complaint would be listened to. We saw that this information was found displayed in the lifts for people and their visitors to refer to if needed. One person told us, "No complaints or concerns. I would tell the nurse or manager. Yes, they would listen to me and take action to put it right." A relative said, "No, I have no complaints. I would go straight to the manager if I did. Yes, I am confident that they would listen to me and sort the problem out." Another relative told us, "No complaints and my concerns are dealt with immediately." Staff said that they knew the process for reporting concerns. Records showed that the complaints received had been responded to and resolved to the complainant's satisfaction.

Requires Improvement

Is the service well-led?

Our findings

Quality monitoring systems were in place to monitor the quality of the service provided within the home. These checks included, but were not limited to; care audits, infection control, meal times, an external medicines audit completed by the pharmacy and maintenance. Audits were also carried out specifically at the weekend to make sure that the quality of the service provided did not reduce. We also noted that there was a manger walk around audit and an operations manager visit. However, we found that audits were not as effective as they should have been. Examples we saw and found included the incomplete records for people's food and fluid intake as well as incomplete records for people's risks. Four out of eight risk assessment records reviewed were either incomplete or did not provide staff detailed information in relation to the assessed risk. This included a lack of detail of the amount of fluid that a person should consume each day as guidance for staff. A further example was a staff recruitment file we looked at which had not followed the providers robust safety checks. This meant that audits were not as effective as they should have been and had not identified all areas that required improvement and as such limited the provider's ability to take appropriate and timely actions.

There was a registered manager in place and they were supported by nurses, care staff and non-care staff. People and their relatives told us that they knew who to speak with and spoke positively about the staff. One person said, "The staff are so nice and will help you with anything. You only have to ask." A relative told us, "Lovely home that seems to have settled down now. There were a few teething problems at first, but it is much better now the manager is getting on top of things." Another relative said, "Yes, the manager is very approachable and she takes action to put things right. I think things are better here now for my [family member] and everyone."

The registered manager had an understanding of their role and responsibilities. They were aware that they were legally obliged to notify the CQC of incidents that occurred while a service was being provided. Records we looked at showed that notifications had been submitted to the CQC in a timely manner.

All staff spoken with confirmed that their role was to give people the best care they could. Staff told us that they were free to make suggestions, raise concerns, and that the registered manager was supportive to them. One staff member said, "The [registered] manager often walks about the home and encourages us to let them know our views." Another staff member told us that, This is a lovely home that puts the people who live here first." Records we looked and staff confirmed that staff meetings happened. These meetings were also used as opportunities to update staff on the service.

The registered manager sought feedback about the quality of the service provided from people who lived at the home and their relatives by asking them to complete questionnaires. Questionnaires returned showed that the feedback were mainly positive with some areas of improvement to be worked on. Such as people and their relatives wish to be involved in the review of their or their family members care plans.

Staff demonstrated to us their knowledge and understanding of the whistle-blowing procedure. They knew the lines of management to follow if they had any concerns to raise and were confident to do so. This

showed us that they understood their roles and responsibilities to the people who used the service.