

# London And Manchester Healthcare (Romiley) Ltd Cherry Tree House

## 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

This inspection was carried out over three days on 23, 24 and 25 November 2016 and the first day was unannounced.

The service was last inspected in May 2016 following which the service was rated overall as 'Inadequate' and was therefore placed in 'special measures.' Services placed in special measures are kept under review and, following any immediate action taken, will be inspected again within six months. This inspection was carried out to check if sufficient improvements had been made to the service.

Cherry Tree House is a purpose built three-storey care home owned by London and Manchester Healthcare (Romiley) Ltd. It provides nursing care for up to 81 people. Accommodation is provided across three units. Bramhall Unit, situated on the ground floor, and Romiley Unit, on the third floor, catered for people who needed nursing care. Marple Unit, which predominately supported people living with dementia, was situated on the first floor. All bedrooms are single occupancy with ensuite toilet and shower facilities. The home has a secure garden and off road parking is provided. There were 51 people living in Cherry Tree House at the time of our visit.

The service had a registered manager in place. A registered manager is a person who has been 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.

Sufficient numbers of appropriately trained care staff and qualified nursing staff were available to support people and help meet their assessed needs. People who used the service, who we spoke with told us, "We seem to have more staff about now" and "Yes, I think there are enough staff."

Staff meetings and formal staff supervision had been taking place on a regular basis since the last inspection of the service and this was confirmed by staff we spoke with and records seen.

Medicines had been effectively managed since the last inspection of the service.

People told us they enjoyed the food on offer. We saw meals were fresh and looked and smelled appetising. People were offered choices of various alternative foods and beverages on each of the units.

Fluid and diet charts were being completed in enough detail to accurately monitor what people were eating and drinking. Any advice from healthcare professionals such as nutritionists was being recorded in relevant documentation.

Each person using the service had an up-to-date care plan, risk assessments and other associated documentation in place.

The service employed activity co-ordinators on each unit who actively engaged with people individually or in groups. There were activities on offer throughout the day to suit peoples tastes, including visiting performers.

The premises were kept secure, with keypad entry to each unit. Deprivation of Liberty Safeguard (DoLS) assessments had been completed and authorisation requested for those people with limited capacity and unable to use the keypad entry system. The communal areas and the bedrooms we looked at were clean. Policies and procedures to minimise the risk of infection were followed.

Where people who used the service lacked capacity to consent to care and treatment the appropriate steps were taken to protect their rights.

We observed some good interaction and communication between staff and people who used the service.

We saw that the service had a written complaints policy and a procedure which was visible at the entrance to each unit.

Systems were in place to monitor the quality of service and to identify where improvements to the quality of care could be made.

At the last inspection in May 2016 we rated the well-led domain as 'inadequate' as we found the management of the service was not, at that time, well-led and staff lacked clear management leadership. At this inspection we found the provider had taken action and was now meeting legal requirements. Although we saw improvement had been made, we have not rated this key question as 'good', to improve the rating to 'good' would require a longer term track record of sustainable good practice.

## 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.

Systems were in place to manage risks and for the safe handling of medicines.

There were sufficient numbers of appropriately skilled and qualified staff deployed throughout the home to ensure people had their needs met in a timely way.

There were clear lines of accountability within the staff team that helped keep people safe.

### Is the service effective?

Good ●

The service was effective.

People had access to external health and social care professionals that supported and provided people with appropriate treatments when required.

Staff had received appropriate, on-going training and had an understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Changes had and were being made to the environment to make it more dementia friendly.

### Is the service caring?

Good ●

The service was caring.

We observed staff delivering care in a kind, sensitive and caring manner. Staff were knowledgeable about supporting people with dementia, using approaches that were gentle and reassuring.

Visitors to the home confirmed they were kept informed and updated regarding the health and care of their relative.

### Is the service responsive?

The service was responsive.

People and their relatives confirmed they were involved in the development of care plans and reviews.

We observed all staff taking time to interact with people in a calm and unhurried manner.

A range of activities were offered to people on each unit. Activities were both individualised and planned with peoples likes, hobbies and interests in mind.

Good 

### Is the service well-led?

The service was well-led.

The management and leadership of the service had greatly improved since the last inspection of the service.

Robust process had been put in place to regularly monitor the quality, safety and effectiveness of the service.

People using the service and their relatives were encouraged to participate in regular meetings with the registered manager and senior staff to share their views and opinions about the service and its further development.

Requires Improvement 

# Cherry Tree House

## 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 23, 24 and 25 November 2016 and was carried out by one adult social care inspector.

Cherry Tree House is a purpose built care home owned by London and Manchester Healthcare (Romiley) Limited. The service can provide nursing care for up to 81 people.

The service was last inspected in May 2016 and the overall rating for this service was found to be 'Inadequate' and the service was placed in 'special measures'. Services in special measures are kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will re-inspect again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. This inspection was carried out to see if significant improvements had been made.

Before our inspection we reviewed all the information we held about the service. On this occasion we did not ask the provider to complete 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.

During the inspection we observed how staff interacted with people using the service and how care and support was being provided in communal areas. We spoke with five people who used the service, three visitors and a visiting general practitioner (GP). We also spoke with the registered manager, the deputy manager (nurse), a member of the senior management team, all unit managers (nurses), the maintenance person, the administrative and reception staff, two activity organisers, all kitchen staff, one senior health care assistant and two health care assistants.

We looked at a range of records relating to how the service was managed; these included care records and records of medicines administered. We also reviewed training records, and examined the rotas for four weeks prior to our visit. Since June 2016, Stockport Clinical Commissioning Group (CCG) had carried out regular risk assessments of the service and we were provided with a copy of the full report, including details of the last assessment carried out in November 2016. Information in the report indicated that on-going improvement to the service had been made and sustained.

## Is the service safe?

### Our findings

There was evidence that people using the service had access to multiple external care agencies, including, District Nurse, Speech and Language Therapists (SALT), Physiotherapist, Consultant Psychiatrist and General Practitioners (GP). We found that any advice / guidance provided by health care professionals had been used to update individual care plans and we observed care staff following this updated information. For example, on Romiley Unit we looked at the care plan for one person who was identified as being at risk of falls. The advice was "Clear instructions to be given to [name] and time to take in the instructions." We observed a senior health care assistant supporting this person to transfer from the dining chair to wheelchair – this part of the care plan instructions were appropriately adhered to by the staff member who continued to interact with the person throughout the transfer, providing lots of reassurance to the person.

The registered manager held a daily meeting with all heads of departments at 11 o'clock each morning and we were invited to attend this meeting on the first day of inspection. Each head of department was asked to update on how people living on their units were and had been overnight. Staffing levels were checked for each unit, occupancy levels discussed, complaints/compliments discussed, safeguarding concerns checked/updated, expected health care visitors that day identified, maintenance issues and any other relevant matters were also discussed. At the end of the meeting all unit managers stayed behind to discuss any management issues/planned meetings. Staff spoken with told us that these meetings offered, "A great way to share information daily", "Consistency of information sharing" and "Keeps us [staff] up to speed with things." This meant that the health and wellbeing of people using the service was being reviewed on a day-to-day basis, enabling staff to be proactive in taking appropriate and timely action to minimise the risk to people and their health.

At the last inspection it was noted that there had been a high number of safeguarding alerts raised by the local authority about people who lived at Cherry Tree House. We saw evidence that all historical incidents and safeguarding's had been investigated and closed. At the time of this inspection no new safeguarding issues had occurred and no new referrals made to the local safeguarding authority. We saw that the registered manager had put in place 'Harms Logs' which were being completed on a monthly basis. These logs were being reviewed by the registered manager and unit managers to highlight any trends and lessons to be learned. At the time of our inspection we were aware that an historical safeguarding matter had been referred to the Crown Prosecution Service (CPS) for their consideration. The Care Quality Commission will also monitor this safeguarding matter and its outcome.

Staff spoken with were confident that if they had any concerns they would access the whistle blowing policy and report any issues of poor practice to their line manager. One member of staff told us, "Our new home manager is very open and supportive and welcomes staff to ask questions or report concerns so they can be dealt with."

Evidence was available to demonstrate that people who chose to stay in their rooms for the majority of the day, for example, if they were on bed rest, or wanted time to themselves, were checked by staff on a regular basis. People who were physically able, were free to move around the home unimpeded. Where a person's

physical mobility was difficult, we observed staff sensitively supporting the person to move around the home at their own pace, using relevant aids and adaptations. This meant that people using the service were all treated with dignity and respect regardless of their individual abilities.

Each of the three units within the service was staffed individually and each had a unit manager that was a trained nurse who worked in both a supervisory and management role. A registered nurse was rostered to work each shift, and there were four care assistants deployed on each unit, and rotas seen confirmed this. Each unit had the services of an activity co-ordinator, which at the time of this inspection, were supporting people to make Christmas decorations. Reception, domestic, laundry, maintenance and kitchen staff were employed throughout the service. Nursing, care and ancillary staff who we spoke with told us that the staffing levels in the home had much improved since our last visit to the service.

Rotas seen indicated that the reliance on using agency staff had greatly reduced since our last visit to the service. Where agency staff were still in use, a consistent approach had been taken to ensure the same agency staff were used wherever possible. On the days of our inspection there were sufficient numbers of nursing and care staff to safely meet people's assessed needs.

Two people who used the service told us, "We seem to have more staff about now – you don't wait half as long if you press your call bell" and "I think staff in this home are wonderful and do a good job. Yes, I think there are enough staff, but like other places I have been in, some [staff] are better than others."

The registered manager confirmed that only the trained nurses were responsible for dispensing medicines in the home, but, in the near future, all senior health care assistants would also be trained to support the nursing staff in this area. This would mean nurses could spend more time providing direct nursing care. Senior health care assistants we spoke with confirmed they had been told about this training and that they were looking forward to having more responsibility.

Medicines were kept in a locked clinic on each unit when not in use. We looked at the management of medicines on Marple Unit. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These are called 'controlled drugs'. We saw that controlled drugs were stored securely in a locked metal cupboard bolted to a wall. All controlled drugs were checked and counted, and we checked that the number of tablets and medicine patches tallied with the number recorded in the records, which they did.

The medicines trolley was locked when not in use and was attached by a security wire to the wall in the clinic room for added security. Both medicine fridge and room temperatures were checked and logged on a daily basis. There was hand washing facilities in the clinic, including hand wash soap dispenser and paper towels, which were both adequately stocked. This meant that staff with the responsibility for administering medicines could maintain appropriate hygiene practice before and after administering medicines to people.

We saw that there was a 'Destroyed & Returned medication book' in place. This is used to record any medicines which are no longer viable and can be returned to the pharmacy or approved contractor for appropriate safe disposal.

Liquid medicines and medicines to be instilled, such as eye drops had been labelled with the date they were opened. This meant that medicines with a limited shelf life were not being used out of date and no longer effective.

Information was available in the clinic room to provide staff with approved guidelines and approved

procedures to administer PRN medicines (medicines required on an ad hoc basis or 'as needed') such as paracetamol. There was also a BNF (British National Formulary) available. The BNF lists all medicines and includes their effects and any side effects and warnings.

We looked at the medication administration records (MAR's) for three people. MAR's are a formal record of medicines prescribed by a registered health clinician and record when they are given. They provide all information about the person's current prescription, including dose, formulation (i.e. whether in tablet or liquid form) and time of administration. Each record reviewed contained a current photograph of the person to aid identification, records of any allergies and protocols for people who needed medicines 'as required', all of which provide positive supports to safe medicines management records. Each record had been fully completed, with staff signatures denoting that the prescribed medicines had been administered to the person.

Medicines audits were being completed on a monthly basis, with weekly and daily checks being conducted to minimise the risk of errors occurring. Handovers were being carried out between each shift and nursing staff were confirming that all medicines management had been carried out safely and correctly during their shift. We saw the completed monthly audits for the three units during the month of November 2016. Each audit had been checked and 'signed off' by the registered manager. A full medicines audit had also been carried out by the supplying pharmacy on 2 November 2016. We were provided with a copy of the findings from this pharmacy audit and no concerns had been noted or raised by the visiting pharmacist.

We checked to see if any person with dementia had been prescribed or were taking any anti-psychotic medicine. Side effects of anti-psychotic medication include excessive sedation, dizziness and unsteadiness – which can lead to falls and injuries. Such medication can also reduce a person's wellbeing and cause social withdrawal and accelerate cognitive decline. It was confirmed that no person was prescribed or taking such medicine and the pharmacy audit report confirmed this.

At the time of this inspection, the registered manager confirmed that no person using the service was suffering pressure ulcers / sores. Where people were potentially at risk from skin 'breakdowns' we saw risk assessments had been put in place with action described to manage the risk. We saw that these risk assessments had been reviewed on a monthly basis and any concerns would also be discussed at the 11 o'clock head of department meeting each day. Such information sharing helps to minimise the risk of poor skin integrity developing.

During our tour of the building we saw that a high standard of hygiene and cleanliness was being maintained. Communal toilets and bathrooms contained anti-bacterial gel, soap dispensers and paper towels. Anti-bacterial gel was also available outside rooms in the corridors in dispensers, and we found these to be properly stocked. We observed staff washed their hands appropriately. All staff wore uniforms, and whilst attending to personal care needs we saw that they had access to disposable gloves and aprons and other protective measures. Wearing such clothing protects staff and people using the service from the risk of cross infection during the delivery of care.

We spoke with the maintenance manager for the service who showed us documentation to confirm that regular safety checks were made and recorded on safety equipment, such as the fire alarm system, smoke detectors, lifts, hoists and emergency lighting. The maintenance manager also attended the daily meeting with heads of departments where issues of concerns could be raised, for example, problems with faulty equipment.

We saw that the fire alarm was tested, that fire extinguishers had been appropriately serviced and a personal

evacuation escape plan (PEEP) had been written for each person using the service. These plans explain how a person is to be evacuated from a building in the event of an emergency and take into consideration a person's individual mobility and support needs.

## Is the service effective?

### Our findings

People who used the service spoke highly of all the staff that supported them. We asked people who used the service if they thought the staff had the skills to meet people's care needs. One person told us "I think so, I know they are having a lot more training, I hear them talking about it."

One visiting relative told us "I wouldn't want my mum to live anywhere else. The staff, especially [named staff] are really very good. I think staffing has improved a lot and the staff know the resident's really will and appear to have the rights skills and training for the job they do."

We asked the registered manager if they were confident that the nurses and care staff had the right attitude, skills and competence to support people with their care needs. They told us "We make sure that staff complete training as and when it is required, and the nurses have completed refresher training in medicines management to ensure they remain up to date with their skills and knowledge around this subject. Unit managers [nurses] have the responsibility for monitoring staffs attitude and competencies whilst working on their units. If needed, action would be taken through supervision to discuss any matters of concern."

New staff who have no previous experience of working in health and social care had been placed on the Care Certificate training course, which is a professional qualification to equip people with the knowledge and skills which they need to provide safe and compassionate care. One senior carer who had worked for the service for three years told us that they had also recently completed the Care Certificate.

We spoke with nurses and care staff who all confirmed they had access to regular training, were supported with regular supervision and able to attend team meetings on a regular basis. Comments from staff included, "Training has much improved and I am receiving more than enough appropriate training to support me do my job", "Training is better planned now" and "We are kept up to speed with refresher training and with any new training that becomes available."

Training records seen indicated that four senior carers had completed 'train the trainer' training enabling them to cascade training down to their colleagues in subjects such as moving and handling and safeguarding vulnerable adults. Nursing staff confirmed that they were supported to maintain their professional status and were provided with clinical supervision and records seen confirmed this.

The registered manager provided us with the training timetable for the winter period 2016 / 2017. Training in November included, moving and handling, pain and symptom control and fire safety. December's training included, choice and dignity, and documentation / record keeping. Further training in various appropriate subjects had planned dates throughout January and February 2017. The training matrix (record) was reviewed on a weekly basis by the home manager to review all training completed and actions to be taken to address any identified needs.

We saw that the service had a supervision policy and supervision with the staff had become more consistent since the new registered manager had taken up post. At the time of this inspection, the registered manager

was carrying out clinical supervision with the nursing staff. This was confirmed by those nurses we spoke with. One nurse told us, "I have completed train the trainer training and in the New Year will then be responsible for providing clinical training support to all nursing staff."

Evidence was available to demonstrate that all staff supervision was taking place on a consistent basis and staff we spoke with confirmed this. Regular staff meetings were also taking place that sometimes included a group supervision session and we saw evidence of this in the minutes of meetings provided to us. Supervision provides both staff and their manager the opportunity to discuss staff development and performance and any other issues that staff may want to bring to the attention of their manager or vice versa.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the 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.

Capacity assessments had been carried out on all people who used the service and the decision recorded in care files. Where appropriate, applications for DoLS had been made and a central log of applications was kept, detailing the date of application, when the authorisation was granted and when it was due to expire. The registered and unit managers were able to demonstrate a good understanding of the legislation to ensure that people's rights were protected, and staff we talked with were able to demonstrate a reasonable understanding of matters around capacity, gaining consent and best interests.

Where people required support and assistance to eat and drink sufficient amounts to provide them with a balanced diet we saw that appropriate care records were maintained, including food and fluid intake charts.

People told us that they enjoyed the food served at Cherry Tree House and staff asked them after breakfast what they would like for lunch on the following day. One person told us, "The food is really nice most days. I can't remember what I asked for by the time it comes but I always get something I like or can ask for something else."

Menus were displayed outside each dining area and matched the food being served on that particular day. On our second day of inspection we observed the provision of meals at lunch time on Marple Unit. The meal for the lunchtime was Chicken or Lancashire hotpot but we found that the tables were bare of place settings, cutlery, napkins and condiments. This did not provide people with dementia the impression that a meal was about to be served and also looked institutional.

We observed people being assisted into the dining room by staff and being encouraged to sit down ready for their meal. On one particular table four people were sat along with the activities organiser who was providing them with support and encouragement before their meal was served. One particular person was becoming more agitated the longer they waited and the member of staff spoke sensitively and kindly to them and offered them a cup of tea. Another person on the same table became worried about her 'baby' (doll) and the same member of staff brought the 'baby' to her and sat it on a chair next to the person which immediately pacified the person.

A member of the catering staff brought in the meals in a heated trolley and began to serve meals so staff could hand them out. The meals looked and smelled appetising. We heard the staff asking people for their

choice of meal and everyone was provided with a hot drink. Staff supported people throughout the meal time but found it difficult to assist everyone at the same time. Although people were provided with plate guards and specialised cutlery which supported people to eat independently, some people preferred to use their fingers and may have benefited from a choice of 'finger foods' being made available. This would help to make sure people were eating and also maintaining some degree of independence at meal times. We later discussed this with the registered manager and the next day saw that changes had been made to provide people on Maple Unit with finger foods and appropriate table settings, including condiments.

Information recorded in care files demonstrated that people had access to a number of external health care professionals, including speech and language therapist, physiotherapist and occupational therapists. We saw that people who were living with dementia had regular specialist mental health reviews, and we saw that a chiropodist visited on a regular basis. We checked care planning records and found these had been updated where advice or guidance had been provided by the visiting health care professionals.

We had the opportunity to speak with one general practitioner (GP) who visited the home every week to review health and medication needs of all their patients. They also worked closely with the service when new admissions took place, checking the status of information provided by the discharging hospital, especially around relevant information being supplied to the home. They also told us that "Staff followed any advice and guidance I give them."

Many of the people at Cherry Tree House are living with dementia, and at the last inspection, it was noted that the building was not dementia friendly. We found that a lot of work had been carried out and was on-going in order to rectify this. Distracting wallpapers had or were in the process of being replaced, corridors had been or were in the process of being made more dementia friendly with appropriate murals being placed at the end of corridors so they no longer appear to lead to 'dead ends' and tactile objects were put in place for people to touch and take comfort from. The registered manager told us that this work would be on-going until all areas of the building had been made dementia friendly.

## Is the service caring?

### Our findings

People we spoke with who used the service said they received good care and support from the nurses and care staff that supported them. One person told us, "I love living here, I am well looked after." Another said, "I have everything I need. The staff are very good and the night staff will bring me a drink if I can't sleep."

One regular visiting relative told us, "I am so happy the way mum is looked after – this home is now managed extremely well. I have never found her [mum] to be untidy or 'smelly' – clean bedclothes are provided every day and the staff know her really well. They [staff] keep me informed. I know all about mums care plan and I wouldn't want mum to live anywhere else."

We saw a recent letter from the relative of a person who had received end of life care whilst at Cherry Tree House and their comments included, "...Your staff were caring and compassionate and when we were staying with [relative] 24 hours a day we witnessed their care. They came to shave and dress [relative] before he died because they knew he never came out of his room unshaven or undressed. They knew him and were considerate of his needs..."

We looked at one particular persons care plan information as we knew their relatives would be visiting later in the day and wanted to speak with them if possible. The care plan was detailed, up to date and clearly identified the support and care needs of this person. It stated that their relatives were involved in developing their care plan and were involved in reviews and sharing of relevant information. We saw that the relative, who had Lasting Power of Attorney (LPA) had signed the care plan and associated documentation after each review.

The relatives of the person whose care plan information we had looked at arrived at the service and agreed to speak with the inspector. We asked their opinions about the service and the care and support their relative received. Their comments included, "We are very happy with the service, it has much improved over recent months with more and better skilled staff that keep us informed about [relative]. It certainly has been a lot better with the new manager. The laundry here is fantastic; all [relative] clothes are washed, dried and ironed. [Name] is a fantastic carer, really keeps us informed. We can only reiterate that everything about the service has much improved since the new manager has been here."

We observed staff delivering care in a kind, sensitive and caring manner. We saw staff using skills to guide people with dementia without causing them distress by using an approach that was gentle and reassuring. The way in which people with dementia responded to staff indicated that the staff knew them well and that people trusted them [staff].

During our time on Romiley unit we observed all staff on that unit interacting in a friendly way with people getting ready to enjoy the festive season. An activities coordinator was supporting four people to make 'glittery' Christmas decorations, others were enjoying singing to Christmas music and one gentleman was enjoying a chat with the maintenance person, who had made him a cup of tea.

A concern at the last inspection of the service was that a blanket decision had been made on the Marple Unit, to provide decaffeinated coffee, because it was believed that one person's challenging behaviour could be attributed to caffeine. This decision had been made without any consultation with people who used the service on the unit. During this inspection visit we checked on Marple Unit the type of beverages on offer to people and saw that people had various choices of drinks and a choice of coffee, not just decaffeinated.

We looked at a number of bedrooms on each unit and found they were personalised with objects and pictures displayed that were clearly highly personal and important to people who used the service. We did not witness any personal care being given inappropriately, and all people appeared cleanly dressed and well presented.

## Is the service responsive?

### Our findings

During our inspection we spent time on each of the three units and looked at a total of six care files. We noted that where any untoward incidents had occurred, all associated documentation had been completed, including details of the incident, completion of body maps to indicate a possible injury and action taken to minimise the recurrence of such an incident again. Following incidents, such as falls we saw that a full review of the persons care needs had taken place and, where necessary, referrals made to external professionals, for example, physiotherapist to review the support and care needed. Following such a referral we saw that any advice or guidance given had been added into the care records, including the care plan.

We examined one particular care plan on Marple Unit that identified the person was at moderate risk of falls. Risk assessments had been completed for falls, staying safe, moving around and skin integrity. Reviews of these had been carried out on a monthly basis, the last review being conducted on 23 November 2016. We also noted that in the daily log and observational records for this person, staff were carrying out our regular observations of this person to minimise the risk of falls, for example, "[Name] was in the communal lounge area at the start of shift, appears much more settled, less walking about." This meant that actions identified to minimise the risk of falls were being followed up.

Since the last inspection of the service, an entirely new recording and care planning system had been introduced and all documentation used throughout the service had been updated to this new system. In those care files we looked at we saw that information about the person and their main needs had been written in a person centred way focussing on their abilities to maximise their independence as much as possible. Background information about the person provided a good pen picture that would enable any staff new to the service to quickly understand how to work with the person, and meet their basic requirements.

We saw that risk assessments were reflected in the care plan(s) and were reviewed on a monthly basis. For instance, to monitor the risks of people at a higher risk of developing pressure sores, Waterlow risk assessments had been carried out. This assessment measures the risk to skin integrity of the person. In those files where this assessment had been completed, and where a high risk of developing pressure sores had been identified, corresponding care plans had been developed to guide staff in monitoring and providing support to minimise the risk.

To ensure both day and night staff had quick access to information about each person on Marple Unit, handover charts were in place. These charts contained details of each person on the unit, their room number, Deprivation of Liberty Safeguard (DoLS) status, medical history, comments on background history, and a space for staff to write notes. They also identified people who required medicines to be administered to them early morning or at other specific times, those on thickened fluids and those with high risks of things such as weight loss and falls. This meant that staff were being supported to maintain good care practice and to support people in a timely way.

We saw that the service had a written complaints policy and a procedure which was visible at the entrance

to all units. We spoke with three visiting relatives who told us that, although they had not needed to raise a complaint, they knew the procedure to follow should they wish to. One relative told us, "I know I can speak with the any of the nurses or the home manager and any concerns I may have would be dealt with straight away." We tracked one complaint raised in September 2016 about a cracked wash hand basin in a bedroom. A response was provided to the complainant and the sink replaced to their satisfaction. The registered manager had the responsibility for electronically recording all complaints on a weekly / monthly basis. This information would then be processed at the head office of the organisation and the Quality and Compliance Manager would then review the information to ensure the complaint had been dealt with to the satisfaction of the complainant.

We saw people had made compliments about their experiences of the services they had received. Such information provided the management team with an insight into how effective and responsive the service was in meeting people's needs. One person had commented, 'To everyone at Cherry Tree House, a huge thank you from the bottom of our hearts for all the love, care and support you shared with [name]...' Another person commented, 'We really appreciate all your help and kindness shown to [name]' and 'Heartfelt thanks for all you did for my dad.'

## Is the service well-led?

### Our findings

At the time of this inspection a Registered Manager was in post and was available throughout the time of the inspection.

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

At the last inspection in May 2016, we rated this domain inadequate as we found the management of the service was not well-led and staff lacked clear management leadership and support in order to carry out their job roles effectively and safely, which, at times, placed people using the service at risk of their needs not being satisfactorily or safely met. At this inspection we found the provider had taken action and was now meeting legal requirements. Although we saw improvement had been made, we have not rated this key question as 'good', to improve the rating to 'good' would require a longer term track record of consistent and sustainable good practice.

The manager had been in post since May 2016 and was registered with CQC on 10 October 2016. We were aware that there had been a succession of managerial changes at Cherry Tree House since 2013 and out of six managers employed only two had been registered with the CQC. The successive changes of managers had led to a lack of consistency in managerial style and consequently any sense of responsibility or accountability.

People who used the service that we spoke with were aware of the new management arrangements. One person told us, "[name of manager] is lovely. She comes around every day to check on things, she knows us all by name and makes sure we are being looked after properly." Another person said they had seen 'great' improvements in the staff's attitude to their work and the numbers of staff on duty.

Without exception, all the staff in their various roles we spoke with were extremely complimentary of the new manager and their abilities to maintain consistency and continually improve the quality of the service provided. Comments included, "The change in culture of this service now means it is a nice place to work in. We now have structure, full support and strong leadership and I now understand what my role is. The atmosphere in Cherry Tree House is now wonderful", "We have waited a long time to get a proper manager in this home, but the wait has been worth it" and "I'm getting really good support from the manager, it is one of the best nursing homes I have worked in."

Since the last inspection a new Nominated Individual (NI) had taken on overall responsibility for the management of the home. A Nominated Individual is a person the provider (owner) has nominated to be registered with the CQC to take responsibility for the overall management of the service and to provide supervision and guidance to the registered manager. We met with the NI during this inspection and they provided us with some information about the support, guidance and further developments planned for the

service. The NI is also the Quality and Compliance Manager for the services provided by L & M Healthcare.

The registered manager showed they led by example. They provided us with lots of relevant information about the management structures they had put in place in order to closely monitor the service and to ensure people's wellbeing was maintained, enhanced and improved. The registered manager told us that they supported all staff to spend time with people throughout the day, not just when assisting people to get up or go to bed.

The registered manager had introduced various ways to support, manage and work in partnership with the team of staff employed at Cherry Tree House, external commissioners of services and other healthcare professionals. Each day at 11 o'clock the registered manager held a meeting for all the heads of each department and we were invited to attend one during our inspection. This meeting included discussing each unit, the handovers between staff on each unit, the care and wellbeing of each person living on the units, plans for the day, any matters of concern and other relevant information. At the end of the meeting each manager of the units stayed behind to discuss 'managerial' issues with the registered manager.

Effective quality checks had been introduced and undertaken to drive continuous improvements for the benefits of people who used the service and staff. All senior and managerial staff had their own particular responsibility for carrying out daily, weekly and monthly audits of service provision. We saw that any areas of concern identified had been recorded and where needed action taken so that the quality of care provision was not being compromised.

People using the service and their relatives were encouraged to participate in regular meetings with the registered manager and senior staff. We saw the minutes from a meeting held on 4 October 2016. The agenda items discussed included, recruitment of staff, home deep clean, replacement of hand wash basins, training (including 'React to Red') regarding prevention of pressure sore development, developing good Dementia care, management structure and availability of management at weekends, last CQC inspection and opportunity for general questions. Such meetings meant that both people using the service and their relatives were provided with opportunities to participate, share their views and opinions and discuss issues about the management and further development of the service.

Regular staff meetings were held which gave staff opportunities to participate in the development and running of the service. We saw minutes from meetings held over the last seven months and discussions included the care and welfare of people using the service, staffing, health and safety, and ways to improve the service.

Records and reports were available to demonstrate that the management team had been working closely with other healthcare services, for example, Stockport Clinical Commissioning Group (CCG). The CCG had been providing support since June 2016 by way of assessing risks to the quality of provision (of services) at a point in time. These updated assessments had been carried out in July, October, and November 2016. Evidence was available in the report to demonstrate continuous improvements were being made.

At our inspection of the service in May 2016 the local authority had suspended placements to the home due to a number of concerns raised about the service and subsequently the Local Authority (LA) and Clinical Commissioning Group (CCG) put in place a team of health and social care professionals to work with the management and staff of Cherry Tree House to try and identify and improve poor practice. We saw evidence that the LA and CCG had reviewed the quality of service provision a further four times since their initial assessment in June 2016. The last review took place on 20 November 2016 following which the suspension on placements had been lifted.

Since the new manager had been in post they had kept the Care Quality Commission (CQC) notified of certain events that involved the care and wellbeing of people using the service by way of sending CQC the required notifications. A notification is information provided in a document about important events which the service is required to send to the CQC in a timely manner.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	<p>At the last inspection in May 2016, we rated this domain inadequate as we found the management of the service was not well-led and staff lacked clear management leadership and support. At this inspection we found the provider had taken action and was now meeting legal requirements. Although we saw improvements had been made, we have rated this key question as 'good', to improve the rating to 'good' would require a longer term track record of consistent and sustainable good practice.</p> <p>A longer term track record of consistent and sustainable good practice and management of the service must be maintained.</p> <p>Regulation 17 (1)(2)(3)</p>