The Fremantle Trust

Cherry Garth

Inspection report

Orchard Way
Holmer Green
Buckinghamshire
HP15 6RF

Tel: 01494711681
Website: www.fremantletrust.org/cherry-garth

Date of inspection visit:
12 December 2022
13 December 2022
14 December 2022
15 December 2022

Date of publication:
23 January 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Cherry Garth is a residential care home providing accommodation and personal care for up to 60 people. The service provides support to older people, people living with mental health conditions, people with dementia, physical disabilities and sensory impairments. At the time of our inspection there were 28 people using the service.

The building layout is three floors, where people can live across five separate 'houses'. Each person has their own bedroom, and there are communal toilets, bathrooms, lounge and dining areas. There is a hairdresser and a coffee shop. At the rear of the building, there is a garden and entertainment areas. Various offices for staff are located throughout the building.

People's experience of using this service and what we found
Since the last inspection, numerous changes were made to ensure the safety of care people received. The service is now compliant with regulations, however further improvement is required.

People's risk assessments and care plans were replaced, updated and made more individualised. Sufficient staff were deployed to meet people's needs. An ongoing recruitment programme is in place as there are a high number of staff vacancies. Incidents and accidents were logged, there was consistent recording and follow up. Infection prevention and control remained satisfactory, with some deep cleaning required. People were protected against abuse and neglect. Medicines safety has improved. We made a recommendation about medicines policy.

People's care was more person-centred. The service had started to implement best practice guidance into everyday practice. People received nutritious, healthy meals and snacks. The service's premises were suitable for people receiving personal care; improvement to ensure a 'dementia friendly' environment is still required.

There was an active social life programme at the service. People commented on the wide range of activities and events. Complaints were investigated, most outcomes were communicated effectively. The provider had not ensured that complaints raised directly at head office were logged into the service's register.

There were improvements to systems and processes in place to ensure safe, compassionate, well-led care. The service's improvement plan was being used to track progress. The service had liaised with people, relatives, staff and the local authority more often than previously. There was evidence of a programme of audits, completed at different intervals, however more time is required to embed the governance system fully. There is evidence of meetings with people, relatives and staff. The oversight by the management team was better and they were more proactive at following up actions required. Staff reported some improvement in workplace culture, however felt morale still required improvement. We made a recommendation about the duty of candour requirement.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (published 1 March 2022).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

This service has been in Special Measures since 28 February 2022. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We carried out an unannounced focused inspection of this service on 19 January, 20 January and 24 January 2022. Breaches of legal requirements were found. We issued two warning notices and the provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective, Responsive and Well-led which contain those requirements.

For key question Caring, we used the rating awarded from the October 2019 inspection to calculate the overall rating. The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Cherry Garth on our website at www.cqc.org.uk

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Cherry Garth

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by an inspector, pharmacist specialist, specialist advisor and Expert 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.

Service and service type
Cherry Garth is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Cherry Garth is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we already held and had received about the service since the time of the last inspection. We sought feedback from the local authority, safeguarding team and other professionals who work with the service. We checked information held by the fire service, environmental health officer, Companies House, the Food Standards Agency and the Information Commissioner's Office. We checked for any online reviews and relevant social media, and we looked at the content of the provider's website. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with five people and nine relatives. We observed people's care and staff interaction with them. We spoke with the interim manager, quality manager, operations manager, care workers, activities coordinators and cleaners. We also spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We asked staff on shifts to provide their views. We reviewed a range of records. This included multiple people's care records, personnel files and medicines administration records. A variety of records relating to the management of the service, including policies and procedures were also reviewed. We took digital images of the premises and provided copies to the service. We wrote to the interim manager, quality manager and nominated individual after the site visit and requested some information. We received multiple additional documents and written explanations.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection in January 2022, we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

At our August 2018, October 2019 and January 2022 inspections, the provider failed to robustly ensure safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 12.

● There was a medicine policy in place for medicines management. At our last inspection we found that staff did not always follow it. At this inspection we found improvements had been made however, there remained areas where staff continued to not follow the medicines policy. For example, we saw staff drop a medicine on the floor and pick it up and administer it to the person. This was not in line with the service's policy.
● Staff monitored temperatures for medicine storage rooms and the medicines refrigerator. However, on the day of inspection we found that the documented temperatures for one of the fridges recorded by staff did not match the actual thermostat reading on the fridge. We observed staff recording the fridge temperatures were not able to reset the thermometer on the fridge and therefore we could not be assured that records were accurate. As a result, the temperature of one fridge holding people's medicines, was not within the recommended range on the day of inspection. The management team took immediate action once we informed them and moved the medicines from the fridge to another working fridge while they investigated. The fridge was replaced.
● Improvements were made around the ordering process of medicines. Stock holding had reduced and there were enough medicines for people for that cycle. Physical stock levels matched documented stock levels for people's medicines we reviewed.
● Some people were prescribed medicines to be given on an 'as required' basis (PRN). At our last inspection we found that not all medicines prescribed as PRN had associated protocols in place. At this inspection we found that people had PRN protocols in place with their medicines administration records (MARs) to guide staff when to administer PRN medicines.
● We saw one person administered their own medicine. A risk assessment for self-administration was in place to ensure that this was safe and appropriate for the person to do so.
● We found people's allergies to medicines were recorded on their MARs and their medicines care plans.
● Some people were prescribed topical medicines such as creams and emollients. We saw staff recorded administration on a separate MAR which had a diagram of a body map to inform staff where to apply the

topical application.

We recommend all staff who manage medicines review the policy to ensure it is satisfactorily and consistently followed.

Assessing risk, safety monitoring and management

At our August 2018, October 2019 and January 2022 inspections, the provider failed to ensure risk assessments were suitable and mitigated the risk of harm to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 12.

● There were improved risk assessments for people. Since the last inspection, all people's risk assessments were reviewed and rewritten.
● Risk assessments contained sufficient information that was more specific to the person. For example, people had different risks of falling, losing or gaining weight and choking. These were more accurate; however, some minor improvements were required, and we informed the management team.
● The number of falls had decreased with better intervention by care staff and the management team. There is further ongoing action to prevent people falling and sustaining injuries.
● Premises and equipment risk assessments remained in place and were up to date.
● People said, "I feel safe, I know the main door is always locked and no one can get in and it is locked at night too", "I do feel safe here" and "I feel safe here; they [staff] are nice people."
● Relatives told us, "(The person) is safe in her room…she is not under any threat…she is not in any danger", "I know (the person) is getting the care here, and she is being cared for. (Care worker A) is particularly good. (Care worker B) had made a good impact on her" and "(The person) uses a Zimmer frame to get around and as far as I'm aware they always check the Zimmer frame for issues. She doesn't have a pendant alarm around her neck, but she has one around the Zimmer frame."

Learning lessons when things go wrong

At our August 2018, October 2019 and January 2022 inspections, the provider failed to ensure accidents and incidents were appropriately managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 12.

● There was improvement in accidents and incident reporting.
● There were decreased delays by staff in reporting possible or actual harm to people. Staff were aware of the reporting procedures and, as far as possible, report without delay.
● Better investigation of incidents was in place. There was some missing information for a couple of incidents, but the management team accepted our feedback about this and provided assurances documents would be kept in the same location.
● Both paper-based and electronic systems were in place to log accidents and incidents. Actions to be taken were recorded in the computer system. They weren't always finished, followed up or marked as complete. The management team acknowledged this and stated the interim manager would ensure all outstanding

actions would be completed.
● Learning from incidents was being shared with staff via various methods, such as supervisions, daily handover meetings, staff meetings and written communications. Improvement is still required to ensure all relevant staff accesseding the lessons learned and implemented and followed them in practice.
● Better reporting of incidents and accidents was in place between the service and the local authority.
● A relative said, "Yes the care home does understand the responsibility towards record keeping any incidents or issues."

Systems and processes to safeguard people from the risk of abuse

At our January 2022 inspection, the provider failed to ensure people were safeguarded from abuse, neglect and omissions of care. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 13.

● Reporting of alleged or actual abuse and neglect had improved. The service had increased the vigilance of when people were at risk of poor care.
● Investigations of abuse or neglect were better. They included more detail, associated documents and clearer outcomes than at the prior inspection.
● Where necessary, disciplinary processes were utilised in line with the provider's policies. HR advice was sought as needed.
● The local authority confirmed safeguarding referrals were made by the service. Our records showed we received notifications of abuse or neglect in a timely way.
● There was improved oversight of the safeguarding process by the management team, with a small number of missed opportunities for closing off safeguarding matters. We discussed the regulations with the management team, and they accepted our advice.
● Staff continued to receive training in safeguarding adults. The provider had whistle-blowing pathways for staff to follow if they wished to report perceived poor care.
● The provider's safeguarding panel continued to meet at regular intervals to review the service's safeguarding events, as well as those from their other services.
● A relative said, "[The person] is extremely safe there [Cherry Garth], they have very good security on the doors, when she rings the call bell, they respond very well and fast."

Staffing and recruitment

At our October 2019 inspection, we recommended the provider use a nationally recognised dependency tool to ensure enough staff were deployed to meet people's needs.

At our January 2022 inspection, the provider failed to ensure enough staff were deployed to safely support people. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 18.

● There were enough staff deployed on shifts to meet people's needs.

● The staff dependency tool continued to be used to guide the number of staff to be rostered on shift. There was a clear plan of the suggested staffing per house, per shift.
● There were periods in some houses where there was no staff visible presence, especially when people were in communal areas such as the dining room or lounge. This occurred when staff were performing personal care in people's bedrooms. No harm was observed to occur, however the service did not risk assess this aspect of staff deployment.
● There was a large number of staff vacancies for permanent roles. The service used agency workers to fill shifts. We observed agency workers sometimes arrive late to shift, meaning the provider's staff were temporarily left with less staff than rostered. The delays were ad hoc, and mitigation of any risk was in place.
● We provided this feedback to the management team. They explained there were mitigating circumstances and there was ongoing negotiation with the agency.
● A satisfactory recruitment process was in place. The annual provider's information return submitted to us explained the continued difficulties recruiting suitable staff within the adult social care industry.
● Personnel files contained all the required information to ensure only staff fit for roles were employed. These included criminal history checks. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● People said, "I feel safe with both male and female carers" and "I do think they have enough staff, but sometimes they could with some extra staff"
● A relative said, "Staffing levels have improved…there is always room for more. Staff do interact more now." Another commented, "(I am) not keen on the agency staff as they really don't know the resident and they do what they are told to do." A further relative stated, "It seems to be a lot more staff now. [The person] used to be in pyjamas all day, and not being dressed. Now she is getting dressed and ready for the day."

Preventing and controlling infection

At our January 2022 inspection, the provider failed to ensure proper infection prevention and control processes. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 12.

● We took digital images of the premises where infection control practices still required further improvement. Copies were provided to the management team, who acknowledged our findings. Deep cleaning of carpets and some furniture was required. We were provided assurances this was to be undertaken promptly after the site visit.
● Therefore, we were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

● Visiting was not restricted. The service followed the government guidance in place.

We have also signposted the provider to resources to develop their approach.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our inspection in October 2019, we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
At our October 2019 inspection, the provider failed to ensure person-centred care was delivered and the implementation of best practice principles for older adult care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 9.

- The quality of people's assessments had improved. The care documentation included better assessment of people's care risks and how to reduce them.
- Care planning training was provided to some senior care workers to enable them to assess people's needs, write care plans and review them. The quality team continued to work on improvements to the care assessments.
- Although everyone's care plans were rewritten since January 2022, a small number were overdue for review. We pointed this out to the management team so they could follow this up.
- There was better understanding and use of care best practice guidance, especially for the assessment and prevention of falls and pressure ulcers.
- The frequency of serious injuries had reduced since our January 2022 inspection.
- A relative said, "I feel her day to day needs are being met, she has clean clothes on, her nails are being done for her, her compliance is an issue but it is good now, she has a shower sometimes."

Staff support: induction, training, skills and experience

At our October 2019 inspection, we recommended the provider reviewed staff training needs to ensure staff were supported to attain and maintain the skills and knowledge required to meet people's needs effectively.

- The service had taken action to act on our prior inspection recommendation.
- Staff training needs were identified by the management team, and appropriate training sessions were completed and planned. These included falls prevention and management, safeguarding and medicines administration.
- The majority of staff had participated in 'one-to-one' supervision sessions since our January 2022 inspection. The frequency of supervisions had decreased in the last quarter of 2022.
- The service used another approach of 'group' supervision sessions, where staff attended together. These

were used for key learning and distribution of important information.
● Staff training percentages across statutory and mandatory topics was satisfactory.
● The interim manager understood that staff should be offered opportunities for annual performance appraisals and acknowledged that these were not completed prior to his appointment.
● A small number of staff had completed additional qualifications in health and social care, for example diplomas. The service did not hold a tally of the number of staff who completed these courses, however when we asked, they provided further details about which staff were completed or had finished additional qualifications.
● A relative told us, "There has never been a situation that I thought there was a training issue."

Supporting people to eat and drink enough to maintain a balanced diet
● People received enough food and drinks to ensure they remained healthy.
● People's preferences were listed in their care documentation. Drinks preferences were listed discretely in the kitchenettes.
● Most people's weights were regularly recorded, and changes in weight were escalated to the GP or community dietitian.
● Appropriate risk assessments were in place for preventing malnutrition, dehydration and choking.
● The recording of people's fluid intakes had improved, however there were some gaps in recording offers of fluid at night and accurate amounts of fluid offered compared with consumed.
● Although some people enjoyed tea and coffee, this was not always recorded as tea or coffee on the fluid intake charts. The management team was informed and explained they would investigate why this was happening.
● There was a variety of meals and drinks. People were offered choices. Alternatives were available for people who did not like the set menu.
● Small snacks such as crisps and fruit were available, but not always openly displayed for people to select and take by themselves.
● Menus were available, however some improvement in presentation and use of pictures and symbols was required to ensure a better dining experience for people living with dementia.
● People stated, "We do have a choice for our meals, we can pick and choose what we want to eat" and "I get a choice of what I can eat, they give me anything [I want]."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People's health was assessed, maintained and promoted because the service worked well with community health and social care professionals.
● There were detailed notes in people's care documentation when in person or telephone advice was provided by visiting professionals.
● Care staff knew how to contact healthcare professionals if needed.
● Healthcare professionals included community nurses, GPs, remote medical support, physiotherapy, occupational therapy and podiatry.
● People's oral health was maintained well by care workers; access to routine and emergency dental care was available.

Adapting service, design, decoration to meet people's needs
● The premises and environment are suitable for people who require personal care.
● The activities coordinators tried to ensure decoration that provided enjoyment and memories for people.
● In one house, the mementos and items or objects to promote reminiscence required replacement. This

house cared for people with more complex needs and some behaviours that challenge. We advised the management team further items of interest could be used to promote meaningful moments for people living with dementia. Our advice was accepted.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- People's consent was obtained in the correct way.
- Prior improvements made by the service for correct implementation of the MCA and DoLS were sustained since our last inspection.
- DoLS applications were made and authorisations received to legally restrict people's liberty.
- The service failed to notify us of several DoLS outcomes; once we advised the management team the notifications were sent to us immediately. The failure to send the notifications to us posed no harm or risk to people. We use notifications to monitor services between inspections. The management team acknowledged our finding and provided assurances all future notifications required would be sent without delay.
- No form of restraint was used at the service.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our inspection in October 2019, we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our October 2019 inspection, the provider failed to ensure person-centred care plans and accurate keeping of care records. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 17.

- Care plans had improved and reflected a more person-centred approach.
- Care staff knew people's needs well. They were observed to provide comfort and compassion to people they supported. When asked, care staff told us how they provided personal care that was individualised.
- Daily notes adequately reflected the personal care each person received. This included some examples of emotional and psychological well-being.
- Documentation of care by staff was better, however some instances of care required more detailed notes. For example, if a person's condition deteriorated or they became unwell, then daily notes did not always reflect this in a comprehensive way. Further training and supervisions are planned by the management team to address this.
- People said, "My day to day needs are being met. I usually have a…wash. Someone is there to help me with that", "I do get involved in my care plan, they do talk to me about it" and "Overall quality care is good… the staff do sit and talk to me."
- A relative stated, [The person's] core needs are being met. She is getting her food and her room is clean. She is getting assisted with the things she needs." Another said, "Things have improved a lot here now, not any issues like before."

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's disabilities and sensory impairments were assessed and clearly documented.
- Care workers demonstrated they could communicate in a meaningful way with most people they

supported, even if the person could not respond.
● Appropriate signage and symbols were in place throughout the building, to help with wayfinding and understanding where particular rooms were.
● Information provided in the event of an emergency, for example documents used for paramedics and hospitals, contained details of people's communication barriers.
● A relative stated, "[The person] has asked them [(staff)] for a shorthand book. I think someone must have prompted her, so that was super nice." A person told us, "I do have good communication with the care assistants."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People were encouraged to have an active social life at the service.
● The activities coordinators and most care workers provided interaction to prevent social isolation.
● The activities programme was excellent. It was varied, based on people's preferences, included both in-house and external activities and was well-resourced. People were observed to actively participate and appeared to enjoy their involvement.
● The activities coordinators fostered inclusivity in the events programme; events that covered a broad spectrum of faiths and beliefs were organised. Photographs captured memories for people and staff to reflect on and acknowledge enjoyable experiences.
● A relative commented, "Staff are always interacting with [the person] …they talk to her and do engage with her."
● A staff member said, "When a resident has a birthday, we put on a tea party for them and invite family members to come and join in. Last week [a person] had her birthday tea party. Her son came; he had a beautiful time. He made a donation to the care home to show how much he had appreciated it all." Another said, "We try to keep the residents busy, we get to know all the residents, the likes and dislikes. I love it here and it is rewarding."

Improving care quality in response to complaints or concerns
● A suitable complaints system was in place, but some improvement is required to ensure the processes are fully completed in every instance.
● People and relatives confirmed they knew of the complaints process. Some told us they had raised concerns or formal complaints.
● Information was clearly available at the service, in literature and in the provider's corporate publications about how to make a complaint.
● Most complaints were investigated appropriately, and outcomes provided. One complainant advised us they were not provided with an outcome. We asked the nominated individual to investigate what went wrong in the matter; they reached out to the complainant and later provided us evidence of the outcome. The complainant accepted the apology and explanation given by the nominated individual.
● Where complaints were made to us about the entire service or management, we contact the nominated individual. We contacted the nominated individual several times in 2022 to advise them of cconcerns we received, as well as raise concerns from whistle-blowers. When we checked the service's log of complaints, these were not recorded at local level. The nominated individual kept the record at the provider's office, to ensure confidentiality of information received.
● The nominated individual accepted our finding. They explained they would ensure in future that all complaints received, even via third parties such as CQC, were to be logged at the service level as well as head office. We are satisfied with this assurance from the provider.
● A relative stated, I haven't had to air concerns or complaint. [The person] seems to be well and looked after really good."

End of life care and support

- People's end of life preferences were documented.
- Satisfactory documentation was in care files for people who did not wish to be resuscitated in the event of a cardiac arrest.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection in January 2022 we rated this key question inadequate. The rating for this key question has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our August 2018, October 2019 and January 2022 inspections, the provider failed to ensure good governance of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 17.

- Governance at the service was satisfactory. Further improvement of the leadership must be demonstrated over a sustained period.
- A manager was registered with us since our last inspection. An interim manager commenced in December 2022 as the registered manager started long-term leave. There was an effective handover process between the two managers.
- The interim manager is suitably knowledgeable, skilled and experienced in managing the service.
- The operations managers and quality managers appointed to oversee the service changed since our last inspection. A small number of quality management related documents from these prior managers were not available, as they were kept electronically, and those staff have left the organisation. The nominated individual was able to retrieve some of the missing documents for us to review. They demonstrated actions were taken to continue the improvement of safety and management of the service.
- Audits by the registered manager, deputy manager, quality manager, operations manager and nominated individual were completed. For example, this included medicines management, personnel files and care plans. The audit tools were satisfactory and provided areas for improvement.
- An ongoing action plan was in place. This included findings from the various audits.
- Care documentation had improved since the last inspection. There remained some gaps; these were demonstrated to the management team who agreed to continue working on improving notes recorded by care workers.
- A relative said, "Quality of care compared to before…it is good now" and "They [staff] do communicate if [the person] has an incident or she has fallen. We get a call for that."
- Staff said, "The new manager…he is very supportive and very hot on us doing the activities."

At our January 2022 inspection, the provider failed to ensure notifications required by law were sent to us without delay. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 18.

● Since the last inspection, the registered manager and provider sent us various notifications, as required by several regulations.
● The interim manager has a good knowledge of what matters which require reporting to us, and how to report them.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At our January 2022 inspection, the provider failed to ensure the service followed the duty of candour requirements. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 20.

● There was a limited number of serious injuries since our last inspection.
● For the serious injuries that occurred, the service was open and honest with the person and relatives (where appropriate) about what went wrong. This included what steps were taken to prevent recurrence of the matter.
● Investigations and documentation of them had improved. Associated documents were kept together to provide a clearer audit trail of steps taken with each serious injury.
● One notifiable safety incident was investigated appropriately, and relevant documentation was on file. However, the final step of the process involving providing a written apology, was not able to be located.
● The management team advised they were unable to locate the letter but offered to send a new version to the relevant person. This was completed and proof was provided to us. No risk of harm or actual harm occurred from this oversight.

We recommend the provider offers training to management team members to ensure the duty of candour requirement is consistently completed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

At our January 2022 inspection, the provider failed to ensure they effectively gathered and acted on feedback. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 17.

● The service demonstrated better engagement with people, relatives, staff and others.

● There were regular meetings with people and relatives. Minutes with actions were recorded; actions weren't always carried forward.
● More regular staff meetings occurred since our January 2022 inspection. They involved general staff and leadership team meetings.
● Staff were provided regular offers to talk and engage with the provider's HR staff, and evidence was provided of the number of interactions between the two parties.
● 'You said, we did' was displayed in the main reception. This showed items that the service had received feedback on, and what solution was put in place. One example was changes to people's menus, including more meals that they requested in the monthly menu.
● Relatives said, "My [relative] has been here a few years now. There have been improvements in the past six months", "I have met the new manager today. He introduced himself to me. He approached me" and "The care home has very good communication with us, I don't know who the new manager is, but they do provide excellent service and that is all down to the carers."
● One person said, "The new (interim) manager comes around every morning. He is approachable, comes up and talks to us."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Workplace culture was better, however further improvement is required.
● Staff morale had improved, however some staff still felt they were not always listened to or that their feedback was not always acted on.
● Staff explained workforce pressures but reiterated that they provided the best care they possibly could.
● People and relatives felt the service was inclusive and involved them in most of the decision making. They explained that sometimes information they may have found useful was not always communicated with them.
● Relatives said, "We have turned up whenever we like, there is no restrictions, the staff are friendly and they do make us feel welcome" and "They have been some changes since the new staff have come in, they look more committed to the care they provide and seem to take more of an interest of the residents' needs."

Working in partnership with others
● The service worked well with other agencies.
● The local authority confirmed that the service had taken their prior findings seriously and had worked to improve care at Cherry Garth.
● A relative said, "I think [the registered manager] turned it around when she came in…things changed for the better." Another stated, "Communication was a big thing, there was a lack of communication, now they do inform us a lot more, I don't know if it was [the pandemic] that made it all difficult."