Zinnia Healthcare Limited

Yew Tree Manor Nursing and Residential Care Home

Inspection report

Yew Tree Lane
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Manchester
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The first day of inspection took place on the night on 30 April 2018 and was unannounced. On 1 May 2018 an announced further day of inspection was completed. The inspection was prompted in part by notifications to us that raised concerns about people's care.

Yew Tree Manor Nursing and Residential Care Home (Yew Tree Manor) is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection. The home can accommodate up to 43 residents who require nursing or personal care and who are living with dementia. At the time of our inspection there were 35 people living in the home.

Since 2015, all comprehensive inspections of the service had found regulatory breaches. The last comprehensive inspection of this service was in September 2017 when two regulatory breaches were found for Regulation 12 Safe care and treatment and Regulation 19 Fit and proper persons employed. The service was rated as Requires Improvement overall, and rated good in caring.

At this inspection we found three breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

A serious incident had occurred at the home prior to our inspection. The Greater Manchester Police are investigating the incident. This matter is subject to an on-going investigation and as a result this inspection did not examine the specific circumstances of this incident.

The overall rating of the service is 'Inadequate' and the service is in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."

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

The management of medicines was not always safe and required improvement. Records indicated that medicines refrigerator storage temperatures were not always being monitored and recorded to ensure medicines remained effective and timely action had not been taken to rectify this. The competency of staff who had responsibility for the management and administration of medicines needed to be improved further. The provider did not have effective systems of assessing their staff team's ability to manage and administer people's medicines safely.

During a tour of the premises we found people who used the service were exposed to a risk of harm caused through the inappropriate storage of equipment, with the fire exit being blocked by a hoist and people's bedroom doors being propped open. We noted the sluice room and laundry room had been left unlocked, the contents of these room which included equipment and chemicals. This posed risk of injury or harm to people living at the home.

We found that safe and appropriate recruitment and selection practices had not been carried out by management to satisfy themselves that only suitable staff were employed to care for vulnerable people. This was also the finding at the last inspection.

Whilst staff were observed to be kind and caring towards people, further work was needed to embed a culture of caring throughout the service. One person was seen to have their head in their hands most of the morning, but there was very little interaction or reassurance from staff who walked past. We provided feedback to the manager who informed us that staff were challenged if poor practice was observed by management.

Care plans had improved and provided more person centred information about the current needs, wishes and preferences of people. Risk assessments had also been updated to provide clearer information about identified areas of risk and how these were to be managed so that staff could quickly respond to people's changing needs.

Throughout the inspection, we observed examples of positive and caring interactions between staff and people who used the service. However, opportunities for such interactions were limited as staff primarily focused on the delivery of task based care.

We received mixed views from relatives about the quality of care their family member had received. Some relatives were satisfied, but other relatives shared concerns about the care their family member had received.

The service was not well led. Systems in place to monitor and improve the quality and safety of the service were not effective and this placed people at risk of harm. Some areas of service provision were not robustly monitored and effective action was not always taken in response to issues identified. Staff felt motivated by

the new manager of the service and felt that improvements were being made.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People who used the service were exposed to a risk of harm through hazards associated with the building and premises.

People could not be assured that the management and storage of medicines was safe.

Required checks had not been undertaken to ensure suitable staff were employed to work with vulnerable people

Is the service effective?

Requires Improvement

The service was not always effective.

People's dietary needs were not always adhered to with their assessed needs.

Staff told us they considered there to be sufficient opportunities for training and on-going development. However, the provider was looking to review the training provided to staff in moving and handling.

Staff understood the need for and sought consent from people before providing care or support. The service was following the requirements of the Mental Capacity Act (MCA.)

Is the service caring?

Requires Improvement

The service was not always caring.

Due to some of the wider failings within the service people did not always benefit from a caring culture.

During the inspection we observed staff engage with people in a caring manner, but at times we did find interactions between staff and the people were limited.

People were treated with dignity and respect. Staff knocked on doors before entering people's rooms.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Despite previous assurances about the service's approach to engaging people in person-centred meaningful activities, this had not yet been embedded into the service.

Care records provided staff with the information needed to provide individualised care.

Staff reported any concerns or complaints raised with them to their manager. Complaints received had been acted on appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

The service has consistently failed to achieve compliance with legal requirements since 2015.

Quality assurance systems had not identified where quality and safety had been compromised. This placed people at risk of harm.

There had been a failure to learn from previous failings and drive improvement within the service.

Yew Tree Manor Nursing and Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 April and 1 May 2018 and was unannounced. The inspection team consisted of three inspectors and a specialist advisor who was a pharmacist.

Prior to the inspection the Commission had received a number of concerns. These related to recent safeguarding incidents at the home. Due to the seriousness of these safeguarding allegations the inspection was scheduled earlier than originally planned and the first day of inspection commenced at 8.50pm on 30 April 2018.

Before the inspection, we reviewed information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. The inspection was prompted in part by the receipt of a number of concerns. This information shared with CQC related to potential concerns about the management of risk in relation to staffing levels, the delivery of poor care, and the impact of this in managing identified risks safely. These concerns were also reported to the local authority and this inspection examined those risks.

Before the inspection, the provider had not been asked to complete a Provider Information Return (PIR) due to the rescheduling of the inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with nine people living at the home; other people were unable to have a coherent conversation due to living with a dementia. However during our inspection we used a method called Short Observational

Framework for Inspection (SOFI). This involved observing staff interactions with people in their care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spoke with two relatives and with members of the management team, including the new manager, and eight care staff. We looked at care plans and associated records for three people, records relating to staff recruitment, training and support, records of accidents and incidents, policies and procedures and quality assurance. We observed care, support and activities being delivered in communal areas.

Inadequate

Is the service safe?

Our findings

At our last inspection in September 2017 this key question was rated 'Requires Improvement' as we concluded that the provider needed more time to embed systems and processes to ensure people were safe. During this inspection we found that safe systems and processes were not followed which left people at risk of unnecessary harm.

On the first day of our inspection we arrived at the home at 8.50pm to establish whether the environment was safe and whether people were comfortable. We found the majority of people were relaxed and sitting in communal areas of the home, while others were in their bedrooms.

During our tour of the home we noted several potential safety hazards. We found the ground floor fire exit was blocked due to a hoist being stored inappropriately, which potentially compromised the safety of people in the event of an emergency. We found five bedroom doors were propped open by chairs or stools as door closure mechanisms were not in place for some of the bedrooms. On the second day of our inspection we discussed our concerns with the provider who immediately contacted an external company to fit the appropriate door closures. Shortly after the inspection we reported our concerns to the Greater Manchester Fire and Rescue Service. They visited the home on 2 May 2018 and found at the time of their visit the fire exits and routes were clear, a specialist contractor was also at the home fitting magnetic retainers to the bedroom doors affected, which meant they no longer needed to be propped open. The Care Quality Commission (CQC) will continue to work closely with the fire service to monitor that adequate progress is made in relation to fire safety improvements at the home.

During our tour of the premises we were able to access an unlocked laundry room on the ground floor and access an unlocked sluice room on the first floor. This placed people at a risk of harm through unintentional touching of electrical equipment and the washing machines posed as a potential trip hazard. The premises had not been made secure to minimise the risk of people unintentionally coming in to contact with electrical equipment. We discussed this further with a staff member on duty, who ensured the rooms were made secure by locking them.

The provider had not taken reasonable practicable steps to mitigate risks to the health and safety of service users. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in September 2017 we found the provider had not ensured prospective staff fully documented their employment history, as is required by the Regulations. We found this to be a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found no improvements had been made in this area.

People could not always be assured that safe recruitment practices were followed. The provider had a recruitment and selection policy. This established what the required checks are, to satisfy the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulation 2014). The policy made reference that a

minimum of two references should be obtained; one which must be from their current or last employer and a full employment history to be provided. Although this policy was clear and detailed we found the management team of Yew Tree Manor was not adhering to this policy.

For example, we checked the records for three newly recruited members of staff. We found all that all three staff had not been recruited correctly. One staff member's recruitment file contained two references, however we found these references did not clearly capture the dates of their previous employment. Both references, dated 22/03/2018 and 25/03/2018, were not on letter headed paper, contained no details of either organisation supplying the references and were not officially signed.

Therefore, we were not confident these references were official and connected to the staff member's previous employment. The second staff file did not contain any references. We were told by the manager these references had been requested, but never received. However, we found this staff member was already working at the home. The third staff file had two references that had been received. The first reference was satisfactory, as this indicated who the company was. However, we found this staff member's application form contained gaps in respect of their previous employment history. The gaps of the employment history had not been explored by the provider during their checks.

This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The safety of people who used the service was placed at risk as the recruitment system was not robust enough to protect them from being cared for by unsuitable staff.

Prior to our inspection the Commission had been made aware of a number of issues relating to the management of medicines. These included medicines being left out on tables and on the floor in one person's bedroom. We found the provider had attempted to remedy these issues by implementing monthly checks of the medicines. However, we found these audits had not been effective and medicines discrepancies were still happening.

We looked at the systems in place for managing medicines in the home. This included the storage, handling and stock of medicines and how the administration of medicines were recorded.

We saw the refrigerator stored in the clinic room was working intermittently. We found the refrigerator was storing people's prescribed medicines for the management of conditions connected to diabetes and glaucoma. The medicine refrigerator temperature showed a minimum / maximum range of 1.8 to 16.5 degrees Celsius over the month of April 2018. Medicines that require refrigeration should be stored at a consistent temperature of between two and eight degrees Celsius. Where the temperature had fallen below two or gone above eight degrees Celsius there was no evidence of action taken, such as replacing the refrigerator or having it repaired. Where medicines are not stored correctly it may make them not work as they were intended. The temperature of storage is one of the most important factors that can affect the stability of medicines. Furthermore, we found that no monitoring of the refrigerator temperatures according to the refrigerator record on the 01/04/2018, 02/04/2018, 18/04/2018 and 30/08/2018. We found further gaps in the recording systems for December 2017, January, February and March 2018. These records also indicated the medicines refrigerator was working intermittently during December 2017 to May 2018, with no evidence of any action taken by the provider.

During the inspection we found the medicines stored in the refrigerator were all wet due to the refrigerator malfunctioning during the night of the 30/04/2018. The manager commented that the refrigerator was working again and they would monitor this, however considering the fluctuating temperatures of the refrigerator we raised concerns that the refrigerator needed to be replaced immediately. Furthermore, we

advised the manager that the current refrigerated medicines needed to be replaced due to concerns about their efficiency; a new refrigerator was ordered during the inspection.

We asked the manager for records of medication competency checks completed for all the staff who had responsibility for the management and administration of medicines. The manager told us that they had not started to undertake competency assessments of staff. NICE guidelines (March 2014) states that care home providers must ensure that designated staff administer medicines only when they have had the necessary training and are assessed as competent. In addition, care home providers should ensure that all care home staff have an annual review of their knowledge, skills and competencies relating to managing and administering medicines. Shortly after the inspection the Commission was provided with additional evidence which confirmed four medication competency assessments had been undertaken. However, we found just one of these medication competency assessments had been completed before the inspection. We found one medication competency assessment was completed on the first day of our inspection, with the other two completed on the 31/05/2018, 30 days after this inspection. Furthermore, we found the medication competency assessments were generic and consisted of a tick box form with no explanation of how the staff member in question undertook this role safely. This meant the provider did not have effective systems of assessing their staff team's ability to manage and administer service users medicines safely and did not have assurances that staff were competent.

During the inspection we viewed 28 Medication Administration Records (MARs). During our checks we noted the following areas of concern. One person had been prescribed medication that needed to be administered at specific times (two tablets to be taken three times a day at 7am, 1pm, and 7pm) to improve the symptoms of Parkinson's disease. It is extremely important that people with Parkinson's take their medication at the right time, every time. If someone is unable to do so, their Parkinson's can become uncontrolled and can cause patients to experience worsening tremors, increased rigidity, loss of balance, confusion, agitation, and difficulty communicating, increasing their care needs considerably. During the second day of our inspection we noted at 10:30am this person had not received their 7am medication. We found the agency nurse on duty was still administrating people their morning medicines, and was not aware this time specific medication had not been administered at 7am by the agency night nurse, who had finished their shift at 9am. This meant the person was placed at an increased risk because their medicines were not administered as prescribed.

We found another person's MAR indicated that they had been refusing to have their prescribed eye drops for the month of April 2018. This prescribed medication is used to treat high pressure inside the eye due to glaucoma or other eye diseases (e.g., ocular hypertension). We discussed with the manager what actions they had taken, due to this person refusing support from the nursing staff with their eye drops. We found no action had been taken by manager or the provider. Once we brought this to the manager's attention they contacted the nursing home team for advice. This meant the provider had not reported this person's refusal to their GP or named social worker in a timely manner, to ensure the person's condition of glaucoma was being managed effectively.

We found a third person's MAR indicated they had not been administered their prescribed oral drops SF 40mg/1ml on 30/04/2018 and 01/5/2018. We discussed this with the manager, who was not sure if this had been administered or not. The MAR had not been completed at the administration time; therefore we were not certain this had been given. We found there was no formal escalation process for medication errors. We flagged this missed medication to the manager, who confirmed they would check why this had not been administered. Shortly after the inspection we were provided with a medicines error and near misses form the manager was implementing at the home. We will review the effectiveness of this form at our next inspection.

Some people were prescribed topical medicines such as creams, to apply to skin. We found these were not appropriately stored. We found in one person's bedroom they had two types of creams stored on their bedside table. We noted the home stored people's topical creams in the lockable clinic room, however some staff did not return these prescribed topical medicines in line with the homes policy. This meant people's topical medicines such as creams were not secure and could be used by people they were not prescribed for.

During this inspection we found concerns relating to the proper and safe management of medicines which was a breach of regulation 12, the proper and safe management of medicines, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse); they were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely by nursing or senior staff. Staff regularly carried out balance checks of controlled drugs in accordance with the home's policy.

People living at the home told us they felt there were sufficient staff on duty to meet their needs. They told us they would not have to wait for extended periods to receive support when they required it. During the inspection, we observed there were always staff located in or close to communal areas, and people received support promptly when they required it. Comments received from people included, "I think there are enough staff" and "The staff are okay, some new ones have started."

Staff told us there were sufficient staff available to allow them to complete their duties. Rotas showed, and staff confirmed that shifts were always covered either by existing staff, or if required, agency staff. The manager told us they had not used a dependency tool to help them determine staffing requirements, but that they would alter staffing levels based on consideration of people's needs and feedback from staff. Comments received from staff included, "I feel the staffing levels have improved, we are now getting more permanent staff" and "Yes the (number of) staff at the moment is fine."

We were aware of recent safeguarding issues at the home that were currently still being investigated by the safeguarding team. At this inspection we did not review this information of concern due to this still being investigated by the local authority, however the Commission will be attending forthcoming meetings to discuss these matters.

Training records viewed confirmed that all staff had access to safeguarding training and that the majority of the team had completed this training. The manager and staff spoken with demonstrated a satisfactory understanding of the different types of abuse, their duty of care and the action they should take in response to suspicion or evidence of abuse. Staff spoken with also demonstrated a sound awareness of how to whistle blow, should the need arise. Whistleblowing takes place if a member of staff thinks there is something wrong at work but does not believe that the right action is being taken to put it right.

Where risks in the delivery of a person's care had been identified, staff had implemented plans of care to provide guidance as to how the risk should be managed and keep people safe. In the three care files we looked at we saw appropriate risk assessments in place, for example moving and handling.
A system to monitor accidents and incidents that occurred was in place. The manager analysed the accidents monthly to identify any patterns or trends and records showed action had been taken to prevent them from happening again.

Requires Improvement

Is the service effective?

Our findings

Records and observations made during the inspection evidenced that staff received guidance from dieticians and Speech and Language Therapists (SaLTs) in order to ensure people received the support they needed to eat and drink safely, and to meet their needs in relation to nutrition and hydration. However, when the manager informed us of the people identified as needing thickener; we found the documentation to indicate thickener consistency for one person was not being followed correctly. The modification of liquid thickness and food texture is common practice in dysphagia management to avoid aspiration of material into the airway whilst maintaining adequate hydration and nutrition. We viewed a Speech and Language Therapy (SaLT) assessment, which indicated the person required a soft diet and identified the need for their drinks to be prepared to a custard consistency by adding a prescribed amount of thickener. We found this person was being offered thickened fluids of a syrup consistency. We asked the manager and kitchen staff for clarification. We found this person's care plan also recorded that the person required thick and easy to be added in all of their drinks to a custard consistency. However, in practice the provider was not adhering to these guidelines, which meant this person's eating and drinking requirements had been compromised due to the provider preparing their fluids incorrectly. This compromised the person's safety, health and wellbeing as there was an increased risk of choking.

The above constitutes a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed the lunchtime meal during our inspection in the dining room. The dining tables were laid with place mats and napkins. Condiments were not placed on the table until they were asked for. Knives and forks were placed on the table after meals had been put down. People received juice and we noted that no other option was given. We observed people were offered additional portions after they finished their meal. However, we found the levels of interactions between staff and people were inconsistent. For example, we observed one staff member speaking to people and asking did they require assistance, while other staff entered the room on occasions and provided little interactions with people.

The majority of staff we spoke with felt that the training they received at the service was of a sufficient quality for them to perform their roles effectively. We were provided with staff training records which showed that staff had received training or that training had been arranged in aspects of care delivery such as first aid, Mental capacity act, dementia awareness, moving and handling, fire evacuation and food hygiene. A member of staff told us that when further training needs had been identified, these were provided. For example, staff were supported to undertake competency based training qualifications such as diplomas in adult social care (formerly known as NVQ's).

At the last inspection in September 2017 we found the care certificate had not been fully implemented for new staff to complete as part of their induction. The care certificate is a nationally recognised qualification for new staff working in care. At this inspection we were informed by the manager that the home had now implemented a two week training programme that supported new staff to undertake the Care Certificate. We found new staff were currently being supported through this process.

During our night visit we observed the agency nurse intervening when they observed poor moving and handling skills from two permanent staff members. The agency nurse explained to both staff members the best practice for safely supporting a person from their chair. We provided this feedback to the manager who commented that the moving and handling training was being reviewed due to the previous trainer recently leaving the home. We will review the progress of this at our next inspection.

Supervision sessions were completed on a regular basis and appropriate records were maintained. We saw that discussions had taken place around training, professional development and day to day operational matters. Where particular issues had arisen within the home, records demonstrated that supervision sessions were being used to good effect in order to resolve matters in a timely manner. Annual appraisals were also completed and records maintained.

We saw that people's health care and support needs were assessed before they moved into the home and this assessment continued whilst the person lived at the home. These assessments covered areas including mental and physical health support needs, moving and handling, mobility, nutrition, communication, sleeping, emotional and spiritual needs, activities, medicines and continence. The manager told us that care plans were developed using the assessment information. For example, one person's care plan included information about how their susceptibility to falls had increased because of a hospital operation. Staff were alerted to the extra prevention measures that had been put in place to mitigate the risk of injury including the placing of sensor systems to alert staff so that support could be provided as they got up. This meant that the service provided individualised care that was up to date.

The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). During this inspection we reviewed the homes policy for MCA and DoLS and found it gave appropriate guidance on when to apply for a DoLS authorisation. A DoLS matrix was also in use to ensure key dates relating to all aspects of the DoLS process were tracked. The manager was aware of the need to apply for a DoLS authorisation if the home needed to deprive someone of their liberty in order to keep them safe.

At our last inspection of Yew Tree Manor, we found improvements were continuing in respect of providing a suitable environment for people living with dementia. At this inspection, through our direct observations around the home we found good progress had been made in respect of creating a more dementia friendly environment. Corridors within the home were painted in different colours which were intended to help people know where they were. Signs on doors with people's names on were easy to identify; these included photos that were important to people to provide a gentle reminder. Rails and doors were painted to be clearly visible. We saw rooms had lots of personal belongings, making them individual and personal. There were large menus with pictures of the food which would enable people living with dementia to have more choice and control over their daily lives and help with decision making.

People told us they could see a GP if they needed to and their relatives agreed. Records were kept of food and fluid intake levels when people were at risk nutritionally and we found that they were completed consistently. People were weighed monthly and appropriate action was taken if people lost weight, for

example a referral to the dietician or an appointment with a GP.

Requires Improvement

Is the service caring?

Our findings

We found that although people and most relatives made positive comments about staff, the staff were not supported by the provider organisation to deliver a wholly caring service. Due to the shortfalls we found at the service, the ability of staff to provide a holistic approach to people's care needs was constrained due to ineffective medicines systems, the environment not always being safely secured to minimise risk and ineffective governance and leadership. This meant that people were not always at the centre of the care they received.

People who used the service we spoke with said, "The staff are okay, some of the newer ones don't speak much to me though", "Some of the staff are better than others", "The care is good from what I have experienced", "I am happy here, I tend to keep myself to myself, the staff are fine" and "I sleep well, like a log, I don't hear a thing, staff make me my supper about 9pm then I am off to sleep, they look after me, it's a good life."

We observed that staff were kind and caring when interacting with people, but did not always take the opportunity to interact outside of providing support with a task. For example, during the lunch time serving, staff walked through the dining area but did not engage with people. We observed several situations where staff could have interacted more readily where people were sitting alone, or looking bored. Instead we observed staff standing over people, or where they were in the same room as people, they did not take the opportunity to interact. One person was seen to have their head in their hands most of the morning, but there were very little interactions from staff who walked past. We provided feedback to the manager who informed us that staff were challenged if poor practice was observed by management.

People spoken with confirmed that they were given privacy and given respect and dignity. Staff were seen to provide appropriate care and support in a timely manner during the two days of our inspection and were observed to knock on people's doors and wait for a response before entering people's bedrooms. Likewise, when personal care was needed, this was given in privacy either in resident's own rooms or bathrooms.

People were able to personalise their bedrooms. For example, people had decorations in their bedroom which were important to them or showed their interests. For example, one person's room contained photos of their family and people who were important to them.

Personal and confidential information relating to people who used the service was kept secure. This included hard copy files being stored securely in lockable cupboards and information held electronically was password protected with only relevant people having authorisation.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found the activities on offer had improved and were well managed. However, at this inspection we found the level of activities provided was inconsistent and the previous improvements made had not been sustained. Given the specialist needs of some people living in the service, we did not consider this to be sufficient to meet individual needs. We also found missed opportunities for staff to interact with people. For example, we noted on a number of occasions people were sat in the large lounge; some people were asleep throughout and others looked disengaged. We observed that staff members did not interact with people whilst they were present. We saw there was an activities co-ordinator on duty, but they worked in the smaller lounge with four people who were willing to engage in hand massage therapy. There was a weekly programme of activities and the activities timetable for the morning session publicised 'men's salon'; however we found this was not being followed as hand massage therapy was being undertaken for the female clients at the home.

We observed that for the majority of the day most people were sat for long periods of time with no stimulation, and were disengaged with their surroundings. Most people spent their day in the main lounge with the television on and the volume very low. Staff were seen to be available in the lounge area, but did not take the initiative to ask people if they would like to take part in an activity other than watching the television.

We discussed the activities on offer with the manager and provider who both commented that the activities on offer were being reviewed and they were fully aware further improvements were needed in respect of planning activities and ensuring they were person centred to people's interests. We will continue to monitor the progress of this.

At our last inspection in September 2017 we found the provider did not have appropriate care systems in place to provide safe care and treatment for people living in the home. We found this to be a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found there had been improvements in this area, which meant the home was no longer in breach of this regulation.

The manager told us that they had focused on the development of people's care plans and we saw they were now up to date and reflected people's individual needs. The care plans reviewed included initial assessments, risk assessments and care plans. We saw that appropriate risk assessments had been undertaken and included areas such as falls, nutrition and pressure ulcer prevention. Reviews of care plans had been undertaken on a monthly basis. People told us that they had been involved in the development of their care plans and involved with reviews of their care.

We reviewed the policy in relation to complaints. We looked at how complaints were responded to and managed at the home. We saw that a complaints policy was on display in the main reception area of the home. Staff told us that any concerns or complaints raised by a person using the service would be taken directly to the manager. The complaints and complements log detailed any comment made and the actions

taken to address concerns appropriately.

Yew Tree Manor had enrolled on the Six Steps programme in 2013. The Six Steps is an end of life programme in the North West, designed to enable care homes to improve end of life care. We noted the care plans we viewed included a section about people's preferred priorities in respect of end of life care. Advanced care plans with updated 'do not attempt resuscitation orders' in place had been signed by an appropriate clinical lead such as the GP were in place.

Inadequate

Is the service well-led?

Our findings

In reaching our judgement about how well-led we considered Yew Tree Manor Nursing and Residential Care Home to be, in addition to the failures identified during this inspection, we took into account the inspection history of the home. In particular, the fact that the home has not been compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 since 2015.

We were clear in stating that significant improvements were expected and that compliance with these regulations was required within the given timescale. We were also clear that if the provider failed to achieve compliance with the relevant requirement within the given timescale, we would seek to take further action. Full information about the Care Quality Commission's (CQC) regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

At the time of this inspection Yew Tree Manor did not have a registered manager in post. A registered manager had not been in post since December 2017. A registered manager is a person who has registered with the 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. A new manager was appointed in February 2018 and confirmed they had applied to the CQC to be registered as a manager for the service.

Staff told us they felt well supported by the new manager. Comments included, "The manager appears approachable so far, but it will take her a while to get this home to the level it needs to be" and "[Manager's name] is very nice and I have confidence she will succeed here."

We reviewed what systems and processes had been implemented since our last inspection to demonstrate the home was safe, that people were receiving a good standard of care and quality monitoring was in place to demonstrate good governance and compliance with regulations. These included, a monthly audit tool, medicines audits, infection control audits, hand hygiene audits, staff file audits, pressure sore audits, care plan audits, weight audits and analyses audits of accidents and incidents. We saw that audits had been completed regularly, however these were ineffective in that action was not always taken even when the provider had identified areas that required improvement.

For example, we looked at how medicines were monitored and checked by the service to make sure they were being handled properly and that systems were safe. We found audits were completed by the manager and clinical nursing manager on a monthly basis, this included 29/04/2018, 29/03/2018 and 05/02/2018. However these audits did not record what action was taken when medicines discrepancies were found. The most recent medicines audit completed by the clinical nursing manager on 29/04/2018, indicated there were 9 medicine errors detected. However, this audit did not detail what measures were put in place when errors were found. Furthermore, this audit failed to identify the shortfalls we found during our latest inspection, such as; the medicines refrigerator not working correctly, the likelihood one person was not receiving their prescribed medication at the correct time and nor did the audits determine what action

needed to be taken when service users refused their medicines. The medicines audits completed on 29/03/2018 and 05/02/2018 also identified errors within the medicines systems at the home, but again failed to detail an action plan of how persistent medicines issues were going to be resolved. During the inspection the manager updated the audit form to include a section whereby actions taken could be recorded, having taken into consideration our comments. We will review the effectiveness of this audit at our next inspection.

Systems in place to monitor the safety and quality of the service had lapsed. We found the managers walk around checks that were introduced at our last inspection were not happening as frequently as once a week, which was what we noted at our last inspection. We were provided with just the one 'manager's walkabout spot checks' completed on 30/04/2018, this meant no evidence was provided of any walk around checks from December 2017 to March 2018. This audit looked specifically at people's bedrooms and communal areas of the home in terms of the maintenance of the environment. We found this audit was basic and did not pick up on the significance of service user's bedroom doors not having the appropriate door closure mechanisms in place.

This demonstrated a continued failure to complete regular audits of the service provided, which sought to assess, monitor and improve the quality and safety of the service and a failure to act on feedback. This was a continued breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to good governance.

During our inspection we pointed out that the service had out of date electrical installation conditions certificate and a re-inspection due in December 2017 had not been carried out. Shortly after the inspection the Commission was provided with the most recent electrical installation conditions report completed in January 2018. This inspection highlighted aspects of the premises electrics to be unsatisfactory. The provider ensured this work was completed in May 2018, and the Commission was provided with an electrical installation conditions certificate confirming the required works had taken place.

We noted that meetings with staff and people using the service or their representatives had been coordinated periodically to share and receive feedback on the service provided.

We saw a number of surveys and questionnaires were completed by people with an interest in the home. This included resident's surveys and surveys for people's representatives. We found the surveys were not monitored and action plans were not developed from them. Surveys are a tool for improvement and should be used as such. If actions are not identified from the feedback provided then the feedback has not served its purpose.

We saw dates were scheduled for team meetings. Meetings were arranged depending on the staff member's roles within the home. For example, we were provided with the most recent care staff meeting that took place in April 2018. The provider also arranged an additional meeting that was a general staff meeting for all staff connected to the home, which was again undertaken in April 2018. Topics discussed included; infection control, care plans, safeguarding and mental capacity.

We saw the last Care Quality Commission report that included the rating of the service was displayed in the main reception area of the home, where people could see it.