Yew Tree Residential Care Home Limited

Yew Tree Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Yew Tree Residential Care Home is registered to provide accommodation for up to 18 people requiring nursing or personal care, including older people and people living with dementia. There were 17 people living in the home on the first day of our inspection.

People's experience of using this service and what we found
We identified numerous safety hazards in relation to premises and equipment which placed people at risk of harm.

Quality assurance systems were inadequate and placed people at risk of harm. The provider had failed to assess and mitigate a range of potential risks to people's safety in areas including infection prevention and control; medicines management; care planning and individual risk assessment; staff recruitment and organisational learning.

The provider had failed to provide staff with sufficient training and supervision for their roles. Senior staff lacked knowledge of important legal requirements and current best practice in some areas. Systems and processes to safeguard people from the risk of abuse were not consistently effective.

People did not support people in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Aspects of organisational culture were ineffective and the provider had failed to ensure adequate oversight of, and professional support for, the registered manager. The registered manager had not notified CQC of some significant events which had occurred in the home.

More positively, there were sufficient staff to meet people's needs. Food and drink provision met people's individual needs and preferences.

Staff worked closely with local healthcare professionals and had developed other positive links between the home and the local community. Relatives and friends felt involved in the running of the home and in their loved one's care.

Throughout our inspection, the registered manager maintained an open, responsive approach and took prompt action to address many of the concerns we identified.

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

Rating at last inspection
The last rating for this service was Good (published 17 July 2018).

Why we inspected
We initially conducted a targeted inspection prompted by information we received about a specific incident in which a person using the service sustained significant harm. This incident is subject to a criminal investigation and, as a result, this inspection report does not cover the specific circumstances of the incident.

On our targeted inspection, we identified concerns about the assessment and management of potential risks to people's safety; the protection of people's rights under the Mental Capacity Act (2005) (the 'MCA') and organisational governance. As a result, we widened the scope of the inspection to become a focused inspection to review the key questions of Safe, Effective and Well-Led.

We also looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Yew Tree Residential Care Home on our website at www.cqc.org.uk.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We identified six breaches of regulations relating to the assessment and management of risks; safety of premises and equipment; staff training; protection of people's rights under the MCA; safeguarding people from abuse and organisational governance.

Please see the action we have told the provider to take at the end of this report.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of Inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of 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 re-inspect it and is no longer rated as Inadequate for any of the five key questions, it will no longer be in special measures.

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.

Details are in our Safe findings below.

Is the service effective?

Inadequate

The service was not effective

Details are in our Effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Yew Tree Residential Care Home

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
Our inspection was conducted by three inspectors.

Service and service type
Yew Tree Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission (CQC). This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
In planning our inspection, we reviewed information we had received about the service. This included

information we had received from the registered provider and others about the specific incident which had prompted the inspection.

During the inspection
We conducted three site visits as part of this inspection; on 27 April and on 11 and 31 May 2022.

During the inspection we spoke with the registered manager; the director of the company registered to operate the care home ('the owner'); a cook and two members of the care team. We also spoke with three people about their experience of the care provided.

We reviewed a range of written records including four people's care file, three staff recruitment files and information relating to the auditing and monitoring of service provision.

After the inspection
We reviewed further information we had requested from the provider, including staff training records. We also contacted five relatives and friends to seek feedback on their experience of the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
• We identified numerous safety hazards in the building which placed people at risk of harm.
• Following an incident in which a person sustained an injury, a stairgate had been placed at the bottom of the main staircase to prevent people using it without staff support. However, the top of the staircase remained unguarded, enabling people to access it unsupervised and increasing the risk of injury. Acknowledging the hazard presented by the open stairwell, the registered manager said, "There are some independent walkers [who live upstairs] and I have thought about having a gate [but we haven't taken action to install one]."
• A ramp leading outside from the conservatory and another on an internal flight of stairs had no side protection, increasing the risk that people using either ramp might slip off and injure themselves.
• Portable electric radiators which generated a high surface temperature were in use in several bedrooms, including those of people living with dementia. The registered manager acknowledged staff had not assessed the risk that people might burn themselves on this type of radiator, prior to it being placed in their room.
• One person's bedroom door was wedged open in contravention of fire safety requirements, increasing risks to the person's safety in the event of a fire. An alarm cord in one communal toilet was broken and unusable, increasing the risk that someone might not be able to summon emergency assistance if required.
• A privacy screen in one of the home's shared bedrooms was in a poor state of repair and was liable to fall apart when it was moved, increasing the risk of injury to anyone nearby. Carpets in some areas of the home were frayed and rucked, increasing the likelihood that someone might trip and fall.

The provider's failure to properly assess and maintain the safety of premises and equipment placed people at risk of avoidable harm and was a breach of Regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and owner responded proactively to the issues of concern we identified and took action to address them.

• We identified shortfalls in the care planning system which meant individual risks to people's safety had not been properly assessed and reviewed. For example, the provider had not assessed the risks associated with people who were living with dementia sharing a bedroom with others; increasing risks to people's safety and welfare.
• In February 2020, one person had been assessed at being at risk of 'becoming lost or injured' as a result of exiting the home without staff supervision and a range of control measures had been put in place. Between that assessment in February 2020 and our inspection in April 2022, the person had exited the home without

supervision on many occasions but staff had failed to review the baseline risk assessment to identify alternative means of mitigating this risk.
• Staff did not always use people's individual care plans to guide them in the provision of care and support. For example, one staff member openly acknowledged, "I don't read care plans." Commenting on this further risk to people's safety and welfare, the registered manager told us, "I have no system to ensure [staff] read the care plans."

Preventing and controlling infection
• Despite a relatively recent outbreak of COVID-19 in the home, we witnessed several occasions when staff did not wear facemasks or did not wear them correctly in accordance with the provider's policy requirements and national guidance. This increased the risk of COVID-19 infection.
• Confirming that these were not isolated incidents, the registered manager told us, "I come back at all times of day and night to do spot checks [and find] staff with their mask underneath their nose. And if I go to Tesco I come back and find [staff] with their masks at half-mast." One member of the care team did not wear a facemask due to a medical exemption. However, the provider had failed to assess the risks associated with them continuing to deliver care unmasked; or identify other types of face-covering they could have worn.
• The provider had failed in other ways to take adequate steps to control and prevent the spread of infection. For example, in one communal toilet there were no paper towels and in another there was no hand gel. This meant people could not wash their hands effectively, increasing the risks from poor hygiene practice.
• The sluice room and laundry were in very poor decorative condition which made it impossible for staff to clean them effectively, creating a further risk of cross-contamination and infection. Carpets in some areas of the home were heavily stained; and in other areas there were gaps between the vinyl floor-covering and the skirting board which had created traps for dirt and infection. One staff member described the carpets as "revolting".
• The poor condition of some equipment also increased the risk of infection. For example, a human weighing machine which was in regular use was encrusted with dirt; and the paintwork on a portable hoist had rusted through, making it impossible to clean effectively.

Using medicines safely
• We identified shortfalls in the management of people's medicines. For example, senior staff had signed some people's medicine administration records (MARs) to indicate they had personally administered a particular prescription cream. In fact, the cream was routinely applied by care staff and the senior staff member signing the MAR could not have known with certainty whether it had been administered or not. This poor practice increased the risk that some people may not have received their medicine as prescribed.
• One person who was living with dementia received some of their prescription medicines covertly from staff acting in their best interests. The person's 'medication risk assessment' stated staff should crush the medicines in water but there was no evidence that staff had checked with a GP or pharmacist to ensure it was safe or effective to administer these medicines as a dissolved substance.
• Some people had been prescribed mood-altering psychoactive medicines for occasional use if necessary. However, there were no protocols in place to guide staff in the use of these and other 'as required' medicines, increasing the risk of inappropriate or unsafe administration.
• The cabinet used to store 'controlled drugs' (medicines subject to special legal restrictions) had a faulty lock which made it difficult to secure. This meant controlled drugs were not always stored correctly in line with legal requirements.
• Some liquid medicines had not been marked with the date of opening, increasing the risk that people might receive medicines beyond their safe use-by date.

Learning lessons when things go wrong;
• The provider's approach to organisational learning was unsafe. For example, the specific incident that

triggered our inspection occurred on 15 April 2022. However, when we inspected the home 12 days later on 27 April 2022, the provider had still not taken effective action to prevent something similar happening again, increasing the risk of harm to other people living in the home.

Staffing and recruitment
• The provider's approach to staff recruitment was also unsafe. We reviewed recent recruitment decisions and found that Disclosure and Barring Service (DBS) checks had not been requested until the new staff members had started working, increasing the risk that unsuitable people might have contact with the vulnerable adults living in the home. Additionally, the provider had failed to request evidence of a valid DBS check from two external contractors who had regular and unsupervised access to residents.

The provider's failure to assess and manage a wide range of risks to people's safety placed people at risk of avoidable harm and was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager responded proactively to the many issues of concern we identified and took action to address them.

• The registered manager told us the COVID-19 pandemic and other workforce pressures in the care sector presented significant challenges to staff recruitment. As a result, at the time of our inspection, there were some vacancies in the staff team.
• However, the combination of overtime working and senior staff 'acting down' to cover shifts meant there were sufficient staff to meet people's care and support needs. One staff member told us, "There are enough staff, definitely. If someone phones in sick, there is always someone to cover the shift. We're not rushing [and] spend [quality] time with the residents. Reminiscing and listening to them."

Systems and processes to safeguard people from the risk of abuse
• The provider had a range of measures in place to help safeguard people from the risk of abuse. However, these were not consistently effective in providing staff with the all the skills and knowledge they required. For example, the registered manager had failed to report to the local safeguarding team the specific incident which had triggered our inspection.
• Training records showed over half the staff team (including the registered manager) had not completed the provider's Safeguarding Adults Awareness course. Reflecting this lack of training, the registered manager told us, "I didn't have knowledge of the local authority safeguarding procedure."

The provider's failure to maintain effective systems to safeguard people from the risk of abuse was a breach of Regulation 13 (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• More positively, most people we spoke with told us they believed the home was a safe place to live. For example, a relative said, "I think [name] receives very good care. I wouldn't leave her here if I didn't think she was safe."

Inadequate

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 the last inspection this key question was rated as Good. At this inspection this key question has now changed to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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 and found some staff had little understanding of the importance of obtaining consent before providing care or support.
• One member of staff described a technique they used with a person who had lost mental capacity and was sometimes resistant to showering. The technique involved deceiving the person into having a shower. The staff member acknowledged their approach was one they had developed themself and was not reflective of the guidance in the person's care plan. When we reviewed training records, we found this member of staff had not received the provider's Mental Capacity Act And Deprivation of Liberties Awareness training, despite having been in post for almost two years.
• When we raised our concerns about this practice with the registered manager she agreed the approach was "unacceptable and wrong in any context" and told us she would follow it up formally with the individual staff member concerned and the staff team as a whole.
• We found staff had taken other decisions they viewed as being in people's best interests without following a proper, legally compliant best interests decision-making process. For example, there was no record of a formal best-interests decision having been made in respect of one person who shared a bedroom with another person, but who lacked capacity to consent to room sharing. Similarly, staff gave one person their medicines covertly and used bedrails to stop them getting out of bed; without any formal best interests decisions have been made. The registered manager told us, "I don't think we have any [properly documented] best interest decisions."
• When we reviewed DoLS applications and authorisations, we found several people had been deprived of

their liberty for extended periods without the necessary legal authority having been obtained. Some people's DoLS had expired in 2020 but the provider had not requested a renewal.
• Similarly, no DoLS requests had been submitted for people admitted to the home since 2020, despite the registered manager acknowledging there were some new residents who had "definitely needed" a DoLS to enable the provider to legally provide care and treatment within a closed care home environment. Following the first day of our inspection, the registered manager submitted 11 new DoLS applications.

The provider's failure to protect people's rights under the MCA was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and owner responded proactively to the issues of concern we identified and took action to address them.

Staff support: induction, training, skills and experience
• Systems were in place to provide staff with the training the provider had identified as necessary to support the people living in the home. At first, the registered manager told us training compliance was, "Not too bad. There are just a few [staff members] who haven't done some [mandatory] training courses." However, when we reviewed the provider's training records we found there were significant gaps in the provision of some training courses. This increased the risk that staff might lack the skills and knowledge to support people safely and effectively.
• Of the seven senior staff who were responsible for administering medicines, only one was recorded as having completed the provider's Medication Awareness (Refresher) training. When we brought this to the registered manager's attention, she acknowledged it was "not good". Despite the recent COVID-19 pandemic, only 40% of staff had completed the provider's Coronavirus Awareness and Infection Control training; only 31% of care staff had completed Falls Prevention Awareness training and only 29% of senior care staff had completed Risk Assessment Awareness training.
• We also identified concerns about the safety and effectiveness of the provider's approach to the induction of new staff. For example, practical moving and handling training for new care staff was provided by longer-serving staff, none of whom had been assessed as competent to deliver this training. This increased the risk of poor or out-of-date practice being passed onto new staff.
• Care staff were required to administer some prescription creams but there was no system in place to ensure they had been trained to do this safely and effectively. Commenting on this issue, the registered manager said, "I expect [senior] staff to show them how to apply creams … but it is done on trust. I [need to] update the induction sheet."
• When we shared our concerns about some of the poor staff practices we had identified, the registered manager told us she was "not confident staff are putting their training into practice" and that she worried "what happens when I leave the building".
• However, despite these concerns, the registered manager acknowledged that there was a significant backlog in the provision of staff one-to-one supervision which could have proved effective in reducing the risk of unsafe or ineffective practice. The registered manager told us, "Supervision [is supposed] to be every six weeks. But [we] are not achieving that. We have no matrix [to help us track when supervision is due]."

The provider's failure to provide staff with sufficient training and supervision for their roles was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
• The provider maintained a rolling 'Refurbishment and Maintenance Plan'; and since our last inspection some capital investment had been made which had improved the quality of people's lives. For example, an attractive and secure patio area had been created which gave some people an opportunity to spend time

outside independently.
• However, as described in the Safe section of this report, many areas of the home were in poor repair, putting people at risk of harm. Whilst the refurbishment and maintenance plan covered issues such as 'cut flower garden' and 'thin … trees/bushes', some areas of significant concern including the sluice; the open stairwell and the unguarded internal ramps had not been included.
• Action was required to improve the provider's approach to the maintenance and refurbishment of premises and equipment, to give top priority to issues of greatest health and safety concern.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
• A care planning system was in place to assess and determine people's individual needs and preferences. However, senior staff lacked knowledge of legal requirements and current best practice in some areas. This meant people's care plans did not always promote the provision of safe, effective care. For example, placing an instruction in one person's care plan to crush medicines in water.
• Additionally, staff did not always follow the guidance set out in people's care plans and devised their own ways of supporting people which did not reflect legal requirements. For example, by deceiving a person without mental capacity into having a shower.
• The registered manager used a variety of external information sources to try to keep up with changes to good practice guidance and legislative requirements. However, reflecting on the many issues of concern we identified, she said our inspection had "opened her eyes to so much stuff I didn't know and all that I need to do."

Supporting people to eat and drink enough to maintain a balanced diet
• Food and drink provision in the home met people's individual needs and preferences. Both a cooked or continental breakfast were available every day and at least two main course options were on offer at lunchtime. The cook told us she updated the menu on a regular basis in response to people's feedback.
• Staff were aware of people's individual nutritional requirements and used this to guide them in their menu planning and meal preparation. For example, the cook was aware of people who followed a soft food diet and people who were living with diabetes.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• Staff worked with a range of local healthcare professionals including GPs, district nurses and therapists to ensure people had access to any additional support they required. Staff also liaised closely with family members to ensure people's healthcare and other needs were met. One relative told us, "[Staff] inform me all the time of any [health] issues. I am kept well-informed."

Inadequate

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 the last inspection this key question was rated as Good. At this inspection this key question has now changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;

• The registered manager was a caring person who was fully committed to her residents and staff. For example, a relative said, "I like her very much. She is usually the one who rings me. She very nice [and] always kind." A staff member commented, "[The registered manager] is lovely. I can go to her with anything. She works very hard, much longer hours than she is employed to do."

• However, the registered manager lacked some of the knowledge and experience necessary to manage the home effectively in line with regulatory requirements. She told us, "[Before this inspection] I didn't understand the responsibilities of a registered manager [and] sometimes I feel out my depth. [Your visit] has opened up so many issues for me. As I walk around [the home], I am now looking in the way you do. I [realise] I have made so many mistakes."

• The owner was the sole director of the company registered to operate the care home. The registered manager told us she believed the owner lacked knowledge and experience of the care sector and was therefore unable to provide her with the professional advice and support she needed. The registered manager said, "I am really, really willing to learn. But you can't learn if there is no one to teach you."

• As evidenced by the many shortfalls in service provision we identified, the owner had failed to exercise effective oversight of the registered manager. He had also failed to recognise her limitations and find a way of providing her with the professional support she required. Speaking candidly, the registered manager told us, "The owner needs to be more involved in the business. Or get someone [with greater knowledge of health and social care] to provide me with support."

• The provider's approach to quality assurance systems was inadequate and placed people at risk of harm. There was a range of audits in place to monitor service quality; including regular checks of medicines, health and safety and care plans. However, these had failed to identify and address the many issue of concern we identified on our inspection.

• We also identified concerns about aspects of organisational culture, in particular lines of internal communication and control. For example, one staff member told us they had raised concerns with senior staff before our inspection about the unsafe stairwell and internal ramps we describe in the Safe section of this report. However, no action had been taken. Similarly, the registered manager was unaware of some of the poor care practices we identified, including crushing medicines in water and giving someone a shower without valid consent.

• Even when she was aware of poor staff practice such as the non-compliance with face mask requirements, the registered manager was unable to assert her authority with some members of her team. She told us,

"[Some longer-serving staff] are so set in their ways. They can be a challenge. I need to be ... more firm with some … staff. [I wonder sometimes] if some of them do what they shouldn't do on purpose, to see if they can break me."

The provider's failure to implement systems and processes to oversee the safe and effective leadership and management of the service was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Notifications are events which happened in the service which the provider is required to tell us about. During our inspection we identified that an injury sustained by a person living in the home had not been notified to CQC as required. Additionally, we had not been notified of the local authority safeguarding investigation into the specific incident which triggered our inspection. The registered manager apologised for these lapses and told she would take action to ensure any future notifications were submitted as required.

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
• Throughout our inspection, the registered manager maintained an open, responsive approach and took prompt action to address many of the concerns we identified. She also displayed commendable candour in reflecting on the many shortfalls in service provision, including her own lack of experience and knowledge in some areas.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others
• Almost everyone we spoke with told us the registered manager maintained a very visible presence in the home and that they felt fully involved in the day-to-day life of the home and decisions about their care. A relative commented, "They treat [name] very well. They … phone and let me know if there are any issues. We worked together doing [name]'s care plan. It was really important to me that [name]'s needs were met according to her wishes. And I know they update it. That's fabulous."
• With COVID-19 restrictions beginning to ease, the registered manager had scheduled a series of residents' meetings to give people a further opportunity for involvement.
• Staff told us they enjoyed their work and were proud to work in the home. One staff member said, "It's a great home … staff and residents are so friendly. It's different from other care homes I have worked in. It's a lot smaller [and] is a real home from home."
• The registered manager and owner promoted the welfare and happiness of the staff team in a variety of ways. For example, one staff member told us, "We got a Christmas bonus and we have staff parties. They provide takeaway food of our choice."
• The provider conducted regular surveys of staff and professional visitors to seek their feedback on the running of the service. We reviewed the results from the most recent staff survey and noted 90% of staff were satisfied in their role and 95% would recommend the home to a friend or relative who needed care. Looking ahead, the registered manager told us she planned to extend the survey to people who lived in the home and relatives.
• As detailed elsewhere in this report, staff maintained contact with a range of external professionals including GP's and community nurses. Staff had also developed good links with local churches who visited the home regularly to help people maintain their faith. Looking ahead, the registered manager told us she planned to get involved in the local care providers' association which she hoped would be a beneficial opportunity for networking and information-sharing.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to protect people's rights under the Mental Capacity Act (2005).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess and manage a wide range of risks to people's safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to maintain effective systems to safeguard people from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to properly assess and maintain the safety of premises and equipment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement systems

and processes to oversee the safe and effective leadership and management of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to provide staff with sufficient training and supervision for their roles.