Mr Michael Discombe

Yew Tree House Residential Care Home for the Elderly

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was unannounced and took place on the 15 March 2017 with a further announced inspection day on 16 March 2017. Yew Tree House is a care home for up 13 older people some of whom may have the early onset of dementia type illnesses. Nine people were in residence on the days of inspection. There are 12 bedrooms one of which can be used as a shared room. Ten rooms are located in the main house over the ground and first floor with a shaft lift for people to access the first floor. Two semi-independent flats are located on the ground floor of an adjacent building on the site and one of these was occupied at the time of inspection.

At the last inspection on 3 February 2016, we asked the provider to take action to ensure outstanding remedial building and electrical works were completed. We also asked the provider to take action to improve staff recruitment checks, record staff meetings and ensure an adequate monitoring system was in place for assessing service quality. We also made some recommendations for the provider to consider.

At this inspection we saw that the provider and registered manager had made efforts to address previous shortfalls but breaches in recruitment and quality assurance had not been fully addressed.

Improvements to the recruitment records had not ensured health statements were in place. People and relatives were surveyed but a mechanism for analysing and aggregating their feedback was still to be implemented. Improvement to the quality assurance system gave the registered manager better oversight of service quality but the completion of checks was not robust to ensure it was effective.

Improvements to fire arrangements included increased fire drills for staff and door guards had been installed on some bedroom doors. Other bedroom doors however still remained propped open and continued to compromise fire safety. Recording of weekly fire checks and tests had not been sustained and could place people at risk if equipment was not in working order.

Outstanding remedial building and electrical works had been completed although a tidy up of the garden area was ongoing. Meetings between the registered manager and the provider were now recorded and opportunities for staff meetings had increased.

There was a registered manager in post. A registered manager is a person who is 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 premises were clean, homely in style and maintained to a satisfactory standard. There were ongoing small works here and there with a recent upgrading of carpeting having taken place and some improved seating in the garden. All necessary checks, tests and routine servicing of equipment and installations had been carried out.

People were treated with kindness and respect by staff and we observed and heard many examples of kind, and patient interactions between staff and people. People told us they felt safe and liked the staff that supported them. Many people came from the local area and the presence of the service in their own area was important to them; as was being part of the community of the village. People enjoyed the relaxed and quiet atmosphere of the service.

Activities were not structured. From our discussions with people this reflected their personal preferences and choices Relatives told us they had no concerns about the service and were satisfied with the overall standard of support provided. They felt confident in the quality of care and said they were kept informed by the Registered manager or staff of important changes;

Staff continuity was very good. New staff received an induction into the service tailored to their specific level of experience. Sixty per cent of the staff team held nationally recognised care qualifications. Staff said that they felt listened to and supported.

People said they enjoyed the food they ate and their preferences and choices were taken account of. People's health and wellbeing was monitored by staff who alerted health professionals and relatives appropriately. People were supported to maintain links with the important people in their lives; relatives told us they were always consulted and kept informed of important changes.

People were encouraged by staff to retain their independence and carried out tasks for themselves at a pace to suit them. People and their relatives were consulted about the care and support provided. Individualised plans of care guided staff in the support they delivered to people. Risks to people were appropriately assessed. Staff understood how to keep people safe from abuse and how to report their concerns. People told us they found staff approachable, they had no concerns but felt sufficiently comfortable with staff to be able to raise any issues with them if they had them.

Staff were observed to seek peoples consent and consult with them for everyday decisions; they worked to the guiding principles of the Mental Capacity Act 2005 (MCA). The MCA provides a framework for acting and making decisions on behalf of people who lack mental capacity to make particular decisions for their selves.

We have made one recommendation:

We further recommend that the provider seek assessment and guidance from occupational therapy professionals as to whether a second handrail on the opposite side of the staircase would provide better support for people using this means of escape in an emergency and for general safety in everyday use.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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

The health fitness of staff was not clearly stated in recruitment records. Some improvements to fire arrangements have been implemented but monthly/weekly checks and tests of equipment were not consistently recorded, and some bedroom doors were propped open with door stops.

The premises were clean and outstanding works had been addressed. Risks were managed appropriately. Medicines were managed safely.

There were enough staff to support people. Staff understood how to protect people from harm and emergency procedures were in place.

Is the service effective?

Good

The service was effective

Staff received supervision but frequencies needed improvement. Staff consulted people about what they ate and monitored their health and wellbeing.

New staff received suitable induction. A programme of training was in place for staff to help them understand how to support people safely.

People had capacity to make everyday decisions for themselves and staff sought their consent. People were supported in line with the principles of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

Relatives said they were kept informed and always made to feel welcome at any time. People were asked for their views about the service and felt listened to.

People and relatives spoke about the service feeling like 'home'

and people referred to it as such. Staff were kind and patient, they treated people with dignity and respect, and people were considerate of each other's privacy.

People said they felt listened to and staff gave them the support they asked for. They were encouraged to do things for themselves but knew staff were there if they needed them.

Is the service responsive?

Good

The service was responsive.

People were supported to attend activities in the community. They enjoyed a relaxed routine that suited their particular needs.

People and their relatives knew there was a complaints procedure and felt confident of raising concerns if they had cause to.

New people had their needs assessed to ensure these could be met. People and their relatives were involved in the initial plans of care that guided staff support.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

An improved but simple system of monitoring and auditing had been introduced but this was still not being utilised effectively.

The pace of improvement remains slow, some requirements remain unmet. Previous improvements to recording have not been consistently sustained across all areas.

Policies and procedures in place were reviewed but this was not adequately robust to ensure staff were signposted to the most current guidance and reference material.

Yew Tree House Residential Care Home for the Elderly

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 15 March 2017 and was unannounced. In order to access some important documentation a further announced inspection day was undertaken on 16 March 2017. The inspection was conducted by one inspector.

The registered manager had not received a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We gathered this information during the inspection. Before our inspection we reviewed the records we held about the service, including the last inspection report and details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

During the inspection we met and spoke with eight of the people that lived in the service. We observed how they interacted with each other and with staff. We observed staff carrying out their duties and how they communicated and interacted with each other and the people they supported. We met three relative's at inspection who spoke positively about the service.

The majority of people had capacity to tell us about their experiences. One person was unable to do so we used the strategic Short Observational Framework for Inspection (SOFI); SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The registered manager was not present during the inspection but we spoke with the registered provider, a

shift leader, four care staff and both cooks. After the inspection we contacted a further four relatives and four health and social care professionals, no concerns were highlighted from this feedback.

We looked at three people's care and health plans and risk assessments, medicine records, three staff recruitment files, training and supervision records, staff rotas, accident and incident reports, servicing and maintenance records and quality assurance surveys and audits.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe and were well supported by staff. People said they liked that they had the same staff and this was reflected in relative comments; they commented on the good continuity within the staff team and that each staff member knew each person's needs well. Relatives spoke positively about the personalised service staff provided and how their particular relative thought of it as 'home'.

At the previous inspection we had identified that information about new staff required by legislation was incomplete; staff were without health declarations as to their fitness to undertake the role. Since then the registered manager had taken action to ensure staff files were well ordered and information easier to find. Important checks and information such as criminal record checks through the Disclosure and Barring Service (DBS), a full employment history, conduct in employment, character references, and evidence of personal identity including a photograph were in place. Actions taken to address information about new applicant's health status had not been implemented adequately; we have therefore issued a further requirement specifically to address this omission.

The failure to ensure that a declaration of health fitness to undertake the role in accordance with legislation is a continued breach of regulation 19 (3) (a) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Annual checks and servicing of equipment including fire, gas and electrical installations was routinely organised and completed. A previous recommendation regarding the implementation of door guards where door stops had been used had been progressed. Five bedrooms now had door guards fitted. Door stops were still in use on other bedrooms but there was no service development plan to state the programme of door guards installation would be extended to all bedrooms. We acknowledge the use of door stops was in accordance with the wishes of the people in those rooms but the safer alternative of a door guard that did not compromise the present fire risk assessment or safety of people in those rooms must be a safety consideration of the provider. The failure to ensure a door guard had been installed on all bedroom doors to prevent the need for door stops thereby compromising the safety of people in the event of a fire is a breach of Regulation 12(2) (b) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Weekly and monthly visual checks and tests of fire equipment, fire doors and fire escape routes had been routinely completed, but recording had lapsed in February 2017 and at the time of inspection had not been completed for over one month. These checks are important to ensure that equipment is in safe working order in the event of a fire occurring. We have addressed this recording lapse elsewhere in the report as it had not been picked up within quality checks undertaken by the registered manager.

Staff received fire training and the frequency and attendance at fire drills had improved, Individual personal emergency evacuation procedures (PEEPS) were in place for each person and the registered manager was confident that at the present time all of the people on the first floor could use the staircase in an emergency. Previously we had recommended that the provider seek advice from an occupational therapist as to

whether a second handrail would be appropriate for the staircase as people may be at risk from not having enough support if evacuating the building in a hurry, this has not as yet occurred and we would again recommend that a professional view is sought.

We further recommend that the provider seek assessment and guidance from occupational therapy professionals as to whether a second handrail on the opposite side of the staircase would provide better support for people using this means of escape in an emergency and for general safety in everyday use.

The environment was small; people, relatives and staff described it as being 'homelike'. Staff kept the service clean, there were no unpleasant odours. Maintenance and repairs were handled by the provider and staff reported any works in a maintenance book; there were no outstanding repairs at the time of inspection. Recent improvements in carpeting on the stairs and in the hallways had been undertaken. At the previous inspection we had highlighted that some building works in the garden had not been progressed; these were now complete and provided two paved seating areas for people in the rear and front gardens. During the inspection people were seen to be making good use of the garden seating. Relatives said they thought their relatives really enjoyed being able to sit outside in the sunshine and chat to other people, relatives and staff.

Medicines were managed well. Only trained staff that had completed an intensive 14 week training course were able to administer, from time to time their competency was assessed by the registered manager. The registered manager took responsibility for ordering and booking in received medicines; they also ensured that unused medicines were returned to the pharmacy. Medicines were provided in pre packed dosage system on a monthly basis. A medicine trolley was used and this was kept securely in a cupboard when not in use. Medicines Administration Records (MAR) were well completed and contained photographs of each person so that the right medicines were given to the right person. Allergies were made a note of. A medicine profile was in place for each person detailing what medicine they took, what they were taking it for and any possible side effects staff needed to be aware of. Some oral medicines were provided individually in boxed and bottled packaging and these were dated upon opening to aid medicine auditing.

There were enough staff on duty to meet people's needs. The registered manager completed a dependency tool for each person when they were admitted to the service; this was reviewed monthly with the care plan and risk information. At present people were mobile and relatively fit; only one person required the support of two staff and a hoist was available to help staff transfer the person between bed to chair. Many people were still independent with some of their personal care activities. People thought there were enough staff around and that it was not an issue to get support if they needed it; they had call bells to alert staff. Staff thought that staffing levels were enough for the dependency of people and size of the service. During those times when people needed more support perhaps through health deterioration or illness additional staff were rostered onto shift to help. At night there was one waking night staff and a sleep in staff member. Staff felt this arrangement worked well and provided them with the support they needed although they felt that most nights were relatively quiet.

People were kept safe because risks they individually may be subject to from their environment or as a result of their own care or treatment needs were assessed and managed. Risk reduction measures were implemented and staff were provided with guidance on how to support people safely. Risk information was kept updated, the measures in place worked well without being overly restrictive. There was a low level of accidents and incidents within the service which were insufficiently frequent in number to require the registered manager to analyse for patterns or trends. The registered manager was aware of the need to do so should the frequency in accidents or incidents increase.

Staff had received training to understand safeguarding; they understood that they had a responsibility to

protect the people in their care and to report any concerns they had. They understood their reporting responsibilities. Staff were confident of raising concerns if they needed to with the registered manager or the provider and if it was about the conduct of another staff member their anonymity would be protected. Staff were confident any concerns raised would be acted upon by the registered manager.

Good

Is the service effective?

Our findings

Relatives told us that staff were good at communicating with them if their relative was unwell or the GP was being called. One relative said "They keep a close eye on them, she had lost a lot of weight recently and they were monitoring this and mentioned this to us and to the GP."

Staff told us that they felt supported because the registered manager was onsite or contactable most days and they could speak to her if they were concerned about anything. The registered manager was always available; staff felt able to approach her at any time. A system for individual one to one meetings, observations of practice and annual appraisals of staff work performance was in place. The registered manager had implemented a system of direct observations to make the frequency of supervisions less onerous and this enabled her to monitor staff practice and also support the supervision process. In the last 12 months out of 13 care staff, six had received between four or five observations, 1-1 meetings and appraisal. Seven staff had received three or less. One care staff member who worked only one shift per week was not shown as having received any supervision since 2014.

The purpose of supervision, observations and appraisal is to highlight training and development needs in staff practice, to future plan for staff aspiration and development; where necessary to implement performance improvement plans. Although there was a failure to evidence that some staff performance was being adequately monitored, there were training opportunities for staff to complete additional qualifications and staff were supported through these courses by the registered manager. The close working of the registered manager and staff in such a small intimate environment ensured that the registered manager had a very good understanding of the strengths and weaknesses of all her team but supervision frequency for all staff remains an area of ongoing improvement.

Staff were an experienced team with at least 60% having achieved nationally recognised care qualifications. Staff familiarity with the service and peoples individual needs meant they were able to meet people's needs well. The registered manager has been a driving force in encouraging and prompting staff to update their training by completing on line training and attending face to face training courses for some subjects. She has sourced distance learning courses for specialist areas that some staff wished to learn more about and supported staff with their studies. There had been improvement in attendance and completion of training but this was an area of ongoing improvement that required the registered manager to maintain the current momentum to ensure gaps in training updates did not recur.

The registered manager understood that new staff appointed in future may not be experienced or qualified in care and would therefore be required to complete a nationally recognised induction programme called The Care Certificate; she had prepared a training pack for this eventuality which could be implemented. The Care Certificate was introduced in April 2015 by Skills for Care. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life. All new staff employed were provided with an introduction and orientation to the service that enabled them to shadow other experienced staff for a short period and to familiarise themselves with the routines of the service and peoples individual care needs.

People were complimentary about the quality and quantity of the meals they received and relatives joked about their relative's likely comments, "I suppose they've already told you how much they like the food have they?" Meals were in the traditional style, the cooks said they consulted people initially about what they liked and adapted menus to accommodate choices for everyone. They said people were not that adventurous in what they liked to eat and had their regular favourites and preferred puddings. People told us that they could have what they wanted for breakfast including cereal, toast, prunes, yoghourt or a cooked breakfast. There were two cooks who covered the week between them, menus were planned a week in advance, staff asked people each morning what they wanted for lunch and tea, choices were always offered but "they are quite settled in their ways although we have tried to introduce changes". One person had a soft diet, no one was considered nutritionally at risk or required food or fluid monitoring. The service achieved a 5 star rating from their environmental kitchen inspection.

People said that staff ensured they called the doctor if they were unwell. The registered manager had built up a good relationship with the local GP surgery. She had shared with staff recent praise received by her from local GP's regarding the quality of care people received at the home. People's weights were taken on a regular basis and any weight loss was alerted to senior staff. People considered at risk from falls, pressure ulcers or poor nutrition were assessed and procedures and equipment implemented to reduce the risk of harm occurring. Relatives said they were always kept informed of any deterioration or health issue and supported people to appointments if the service could not spare the staff. There was good partnership working between the home staff and relatives to ensure peoples appointments were facilitated.

There had been an improvement to the number of staff that had now completed Mental Capacity Act 2005 (MCA) training, with some staff having undertaken a more in depth distance learning course covering mental capacity and Deprivation of Liberty. The MCA provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for their selves. Staff were working to the principles of the MCA and our observations showed them to be seeking consent for any tasks or support they needed to provide. People were satisfied that staff consulted with them about their everyday care and support needs.

Staff were aware that more complex decision making when people lacked capacity needed to be decided with the involvement of relatives and representatives and in the person's best interest. A capacity assessment and Deprivation of Liberty (DoLS) checklist was completed for every person upon admission to the service and this was kept under review. Staff knew that one person was subject to a Lasting Power of Attorney (LPA) and that their relative needed to always be consulted. The relative's authority to do so however was not made clear in the persons care records. We have discussed with the registered manager how she can improve recording in this area.

The service operated an open door policy with no restrictions on people leaving the service if they chose to go out; those with failing mobility, however, were encouraged to leave in the company of staff for their own protection. Care plans helped staff understand any emotional behaviour that impacted on others. This was rare, but some people could express these on occasion and care plans guided staff in how to de-escalate such incidents if they occurred, to ensure no one was unduly affected.

Good

Is the service caring?

Our findings

People said they liked where they lived and many referred to it as their 'home' in discussions. One person said "I really like it here, everyone is really kind and caring", laughing they told us "I don't want to go anywhere and I want to die here but not yet". She went on to tell us, "I can get my hair done if I want to go out staff will take me down to the village in the wheelchair".

Staff were observed talking with people and providing discreet support to those who needed a little prompt in making some everyday decisions for example "Would you like to see what X and X have decided they want for dinner", seeking their involvement in everyday decisions. Another person said, "I keep myself occupied, its nice today so I might go and sit outside this afternoon. They (staff) do a good job I am very grateful to all of them."

A staff member said "It's what I would describe as a homely home; it's small and quite personal". Staff had time to sit with people and talk about things that interested the person, be it current news or past memories. Staff said that although the current group of people showed little interest in activities they sometimes participated in joint projects like the recent completion of a large jigsaw that had taken some time for them all to complete.

The service very much remains a village resource and people and relatives were grateful to have the option of a place in their local environment. Respite and day care were available dependent on need and availability if people required that service.

The atmosphere within the service was much like a large family home and routines were flexible, people were referred to by their preferred name. People, staff and relatives called each other by their first names and this fits very well with people's personal expectations and the casual nature of the service.

There were ornaments, pictures, cushions and foot stools. Furniture of a satisfactory quality was of different types and sizes and provided a homely appearance. People and their relatives had personalised bedrooms with small possessions including some items of furniture to help them to settle in.

People told us that they were encouraged to do things for themselves for as long as they could. In discussion, staff said they responded flexibly to whatever support people needed on a day to day basis. Whilst most people could do some of their own personal care and dressing, on some days when they felt less able to do so staff were there to provide more individualised support. People were happy to retain as much of their independence as they could in the knowledge if they needed help it would be provided.

One person needed support to eat their meals and a staff member was observed helping the person to eat their breakfast, the staff member chatted conversationally to the person throughout the time they gave support, and also chatted to other people in the room. We were told that the person spent much of their time in their room and this reflected how they had always spent their time prior to deterioration in their health. Staff brought the person out into the lounge each day for a few hours so they did not become

isolated, but ensured the person had time in their room also as they would have wished.

People had call bells but as staff were always available people chose to wait for them to go by or got up to seek out a staff member if they needed one. Call bells were not heard during the inspection although night records showed that people did use them if needed.

The days of inspection were sunny and we observed people sitting out enjoying the sunshine. Some people who smoked enjoyed their cigarette, sitting chatting to each other, staff and to visiting relatives. A staff member took hats out for those who were sitting in direct sunlight, and people and relatives were offered hot or cold drinks. The provider had recognised that sitting outside in the front courtyard area of the service in view of passers-by was something a number of the people liked to do. A view onto the main road and passers-by going to and from the village piqued their interest and so, increased seating in several areas in the courtyard had now been completed to accommodate peoples preference for this.

The routine of the service was very casual, the door was unlocked and in the afternoon was left open so people could come and go to the courtyard seating area. Relatives came and went freely from the service, some visited early and one visited before 9 am, others brought their dogs with them when they visited their relative. A relative told us "It's so relaxed there if we take her out it doesn't matter what time we take her back they never worry, It's a unique place and she is very comfortable there."

Staff respected people's privacy and dignity, any personal care support was undertaken discreetly. Staff took pride in helping people to maintain their personal appearance to a standard they were used to and wanted to be seen as especially when they were going out to meet friends or relatives. For some this meant ensuring hair and makeup were completed, clothes were smart and jewellery added the finishing touch. Some ladies requested to have their nails painted and staff supported them with this.

Where possible the registered manager had end of life discussions with people and their relatives but acknowledged this was a sensitive area that not everyone wished to discuss. People were supported to the end of their life where possible and a number of staff had undertaken 'end of life' advanced training to ensure they understood how to support people's needs. No one with end of life needs had been supported recently. The registered manager understood the need for a separate end of life care plan to address the most important aspects of ensuring the person remained comfortable and well supported at all times, and that arrangements for the use of emergency medicines which would be administered by health professionals were in place.

Good

Is the service responsive?

Our findings

People told us how they spent their time. We spoke with eight of the nine people living in the main house. No one expressed interest in having more regular activities although most enjoyed the music person when they visited. People liked the flexibility to live their life as they would have if they were living at home, if they wanted to go to the village they could go with staff support. No one said they were bored and staff said that some people received a lot of visitors and that there were always people coming and going from the service. People liked the relaxed atmosphere and that they could do what they wanted.

We met one person who was going out, they told us that they went to Elder Care Centre in the village each week; several other people also attended this. One said "Elder Care is a social event I don't do much there but there are opportunities to chat". They told us that they also went out once per week to play cards at a local venue and had been able to retain their membership of the local Women's Institute group and was supported to attend monthly meetings. We observed that a new person who was staying on respite was a little restless so a staff member invited them to go along with the group going to the Elder Care Centre; they ended up staying there and having their lunch out.

A relative said "My mum doesn't want anything else to do, she likes to sit and think and staff take time to sit and talk with her." They said if she wanted to go down to the village they pop her in a wheelchair and take her down she gets 1-1 support, no one misses out.

"Other relatives commented positively about the way in which staff had discreetly expressed concerns that their relative was not coping in one of the independent flats and had been helpful in helping the person make an easy transition to the main house. Relatives felt this was working very well and the person now had staff around 24/7 and other people to talk with.

There was a pre-admission assessment process for people who had been referred to the service. The emergency nature of some people's admission meant the initial assessment process was overridden in the need to support the person into a place where they could be supported safely. At these times assessment was undertaken during the persons stay and informed the care plan.
Relatives and staff said they thought the registered manager was very careful about who was admitted to the service and she usually personally assessed people referred to ensure their needs could be met. This sometimes involved travelling some distances to undertake assessments.

People's care plans were personalised to reflect their identified needs and how they preferred to be supported. People and their relatives were consulted about the content of care plans by the registered manager. Care plans addressed each person's support needs in relation to maintaining personal care, social interaction, leisure interests, and night time support including continence management. These guided staff in the support they provided and highlighted any specialist support people required around some aspects of their care needs, for example support around sensory issues.

Care plans made clear what people needed assistance with and what they could do for themselves and

whether this varied. The registered manager in consultation with staff and people reviewed care plan content on a regular basis to ensure it provided the most updated account of each person's needs and required support. Staff felt able to contribute their views to these reviews. Each person had an annual review to which relatives and care managers were invited and this looked at whether the person's needs were continuing to be met at the service and whether additional support was needed to meet changing needs. Relatives felt they were kept well informed and consulted about their relatives needs by staff.

A complaints procedure was in place and this was displayed in the service. The complaints log was empty and people and relatives we spoke with said they had not had cause to raise any concerns. Professionals we contacted also raised no concerns about the service. People said if they did have a concern about anything they were more likely to discuss this with a relative first before approaching the registered manager. Relatives said they felt confident of raising concerns with the registered manager or staff who they found approachable, but to date had never had cause to do so.

Requires Improvement

Is the service well-led?

Our findings

People thought the registered manager ran the service well. Relatives and staff found the registered manager approachable. They spoke positively about the personalised nature of the service, and the great continuity of staff and how this positively impacted on the consistency in the quality of care. Many of the people in the service come from the village of Headcorn and surrounding area and it offers a niche service and is very much seen as a resource that other villages do not have; some relatives described the service as 'unique' in their experience.

Health and social care professionals we contacted raised no concerns about the service. One health professional commented that they often saw the registered manager at provider forums and had confidence that the registered manager would, if she was concerned about anything or needed advice; seek out relevant professionals to provide this.

At our last inspection we were concerned that audit processes put in place had not been sufficiently effective to identify shortfalls in service quality highlighted by the inspection. Since then further progress has been made in some areas whilst in others improvement had not been sustained. For example, improvements had been made to fire drill frequencies for all staff and door guards had been installed on some bedroom doors to avoid the use of door stops which could compromise fire safety. The weekly/monthly recording to evidence that access to fire doors was kept clear and checked regularly, or that visual checks and tests of the fire alarm and fire equipment had been conducted had not been maintained. These checks were overdue by one month when we inspected. The failure to evidence checks on fire equipment could compromise people's safety if equipment was not in working order.

The provider and registered manager were a visible presence around the service most days. To address a previous requirement regarding a lack of effective quality monitoring; the registered manager had developed the quality assurance system further with a small number of audits in respect of health and safety, fire checks, cleaning and medicines. She also reviewed much of the documentation within the service including policies and procedures. We found that reviewing was not undertaken thoroughly and some policies which should be used by staff to guide their practice sign posted staff to professional guidance that had long been superseded. These shortfalls were not being highlighted by the present quality assurance system.

We are aware that budgetary limitations mean that the registered manager had less time to spend on developing the service. We acknowledge that some progress has been made to improve recording for staff meetings and those between the provider and registered manager. Overall recording in most areas was being maintained. However, recording shortfalls around fire checks had not been highlighted by the existing quality monitoring processes and improvements made to address two previous requirements had not been fully met and we have issued new requirements to specifically address the outstanding areas. There was a failure to ensure quality checks of the service were implemented effectively and carried out robustly to highlight shortfalls in recording and documentation used to support staff practice to ensure peoples safety. This is a continued breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

The registered manager met with the provider each week, these meetings had been largely informal get togethers to discuss minor issues within the service. Regular formal meetings had now being established that provided opportunities for discussion of future planning for the service between the registered manager and the provider. Recordings of these meetings was brief but served as a reference for both the provider and the registered manager to know what areas had been discussed and any actions from these. The previous service development plan had been met but had not been updated to reflect new developments planned in the service, including the programme to install door guards on all bedrooms.

Staff meetings were held more frequently and these were recorded. Staff said there was a good team work spirit, they got on well as a team and could depend on each other. They thought it was good to have the opportunity to meet with other staff and this could be helpful for sharing and discussing specific information. Staff thought the frequency of meetings was enough and felt able to raise issues if they wanted to and could add items to the agenda. Minutes were available for those staff that were unable to attend.

People and relatives were routinely surveyed for their views. The registered manager reviewed all comments and suggestions and addressed anything raised directly with the person who had commented. Often there was very little feedback and people indicated a high level of satisfaction overall. People and relatives said they did not leave things and usually felt able to raise any issues immediately. A mechanism for aggregating information received from surveys and reporting back to people and relatives an overall analysis was still under development.

Significant events within the service were rare but the registered manager understood the reporting process and notified the Care Quality Commission (CQC) appropriately of significant events in the service that they were required by regulation to tell us about.

People, relatives and staff found the provider and registered manager approachable. In discussion the provider had a good understanding of people's individual circumstances and their needs. The registered manager worked alongside staff on some shifts and had a good oversight of the individual strengths and weaknesses within the team and how she needed to help improve some staff performance.

The registered manager continued to regularly attend the Care homes forum where she was able to hear about changes and developments within care home provision and also interact with other managers to share experiences and information and receive some peer support.

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 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to ensure a door guard had been installed on every bedroom door to prevent doors being propped open thereby compromising the fire safety of people in the event of a fire.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to ensure that audits which were in place were implemented effectively to highlight shortfalls. Regulation 17 (2) (a) There was a failure to ensure analysis of surveys and an aggregation of findings was provided as feedback to people and their relatives. Regulation 17 (2) (d) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The failure to ensure that staff records give a clear statement as to the health fitness of a prospective staff member to undertake their role. Regulation 19 (3) (a)