Zinnia Healthcare Limited

Yew Tree Manor Nursing and Residential Care Home

Inspection report

Yew Tree Lane
Northern Moor
Manchester
Greater Manchester
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

This inspection took place over two days on 24 and 26 January 2017. The first day was unannounced, which meant the service did not know we were coming. The second day was by arrangement.

Yew Tree Manor Nursing and Residential Care Home ('Yew Tree Manor') is located in Northern Moor, south of Manchester. The home can accommodate up to 43 residents who require nursing or personal care and who are living with dementia. At the date of our inspection there were 42 people living in the home. The building is a large house which has been extended several times. Downstairs there are two large lounges and a smaller lounge which leads into the garden. There is a further lounge upstairs primarily for the use of families when visiting.

At the comprehensive inspection of Yew Tree Manor on 3 and 4 May 2016 we identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA). The breaches related to the care and treatment of service users that did not always meet their needs, consent to care and treatment, premises safety, risk assessments not being completed accurately and systems and processes to investigate allegations of abuse were not always effective. We issued the provider with seven requirements stating they must take action to address these breaches. We shared our concerns with the local authority safeguarding team.

Following that inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to these breaches. This inspection was undertaken to check that they had followed their plan, and to confirm that they now met all of the legal requirements.

Additionally 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 we brought this inspection forward.

During this inspection we found that some improvements had been made. However, they were not sufficient enough to meet the requirements of the regulations.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'.

At this inspection we found people were not always protected from risks associated with their care because risk assessments were not always robust enough to provide guidance and direction to staff about how to keep people safe. People did not always have sufficient detail in their care plans to provide guidance and direction to staff about how to meet their needs.

We received mixed feedback regarding the leadership of the service. Visiting health care professionals felt the communication at the home was not always effective. However, the staff we spoke with felt supported

by the management team.

The service had audit systems in place; however they had not been robust enough to identify the shortfalls found during this inspection.

The provider had made some improvements in regard to medicines. However, we found one person did not have PRN protocols in place. Furthermore, on the first day of our inspection we noted the morning administering medicines round took a number of hours to complete.

Potential safety hazards were identified by the inspection team as we walked around the building. We brought these concerns to the management team's attention and found these had been resolved on the second day of our inspection.

Policies were in place to ensure people's rights under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were protected. Although policies and procedures were in place it was clear that they were not always put into practice. Staff and management did not have clear working knowledge of the current changes in legislation to protect people's rights and freedom. The provider was not following the principles of the MCA. It was not consistently and effectively followed to ensure people who lacked capacity to consent were provided with care that was in their best interests and in the least restrictive way. This meant the provider and the registered manager did not understand their responsibilities associated with the Act.

We found staff were recruited safely. Suitable checks were made to ensure people recruited were of good character and had appropriate experience and qualifications.

We reviewed the information and support available to ensure people received adequate nutrition and hydration. We found records were held as required to support people at risk of not receiving enough nutrition and hydration. We found advice given by specialist teams including GPs and dieticians was followed. Records in relation to monitoring people's intake of food and fluids were completed when required.

Staff had received appropriate training, supervision, and appraisals to support them in their roles. Staff, with the support of their line manager, identified their professional needs and development and took action to achieve them.

Procedures were in place to support people to access advocacy services should the need arise. However, we noted the provider had not supported one person who should have been referred to this service.

There was a system in place for reporting and responding to any complaints brought to the attention of the registered manager. However, we found one complaint could have been responded to better.

People were supported to maintain a healthy diet, and people's dietary needs and preferences were catered for. People told us they had a choice of food at the service, and that they enjoyed it.

Activities at the home were much improved since our last inspection. The service was looking to recruit a second activities coordinator.

The environment had some adaptations for people living with dementia.

Staff maintained people's dignity, and respected their privacy. Care records were kept confidentially.

We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered 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 risks to people were not always assessed properly and some risks that had been identified had not been mitigated.

We noted a number of potential safety hazards on the first day of our inspection.

The safety of medicines had improved. People's medicines were managed safely and audited regularly.

Is the service effective?

Requires Improvement

The service was not always effective.

The home required improvement to ensure staff adhered to the principles of the Mental Capacity Act 2005.

Staff did undertake training relevant to their role and the needs of people they supported.

Records showed people had access to healthcare professionals, such as GPs, opticians, district nurses and chiropodists.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not consistently supported to be involved in their care planning.

People were not given information about or referred to advocates.

People we spoke with told us the staff were very nice and were trusted by the people who lived in the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were complete and were regularly reviewed. However, they lacked detail in areas such as how to effectively support people who behaviours challenges others.

Although there was a complaints system, we noted one complaint had not been investigated thoroughly, or consider ways to improve practice.

People had access to activities that were important and relevant to them.

Is the service well-led?

Inadequate

The service was not always well-led.

Although some auditing systems were in place they were not robust enough to identify the issues seen during the inspection.

There were a wide range of systems in place for assessing and monitoring the quality of service provided. However, we found these were not always thorough enough to identify and address potential risks to the health, safety and welfare of those who lived at Yew Tree Manor.

Staff we spoke with told us the manager was approachable and they felt supported in their role.

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.

The inspection took place over two days on 24 and 26 January 2017. The first day was unannounced which means we gave no notice of when we were coming. The second day was by arrangement.

Two adult social care Inspectors and an expert by experience carried out this inspection. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of care service.

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 we brought this inspection forward.

We contacted the contract officer of Manchester City Council for information about the council's recent monitoring visits. We also contacted local safeguarding teams regarding their involvement with Yew Tree Manor, and received information from the Nursing Home team. We contacted Manchester Healthwatch but they held no information about the home.

During the inspection we looked around the building and observed mealtimes and interactions between staff and people living in the home. We carried out an observation known as a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who cannot easily express their views to us.

We talked with 14 people using the service, six visiting relatives, six members of staff, and three visiting professionals. We spoke in detail with the registered manager and the deputy manager.

We reviewed four people's care files and looked at care monitoring records for personal care, body maps used to monitor injuries and accident records. We reviewed medication records, risk assessments and management information used to monitor and improve service provision. We also looked at meeting minutes and four personnel files.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and secure at the home and with the staff who provided care and support. A person told us, "I do feel safe in this home", "It is a safe home in my opinion" and "Yes I am safe here."

When we inspected the service in May 2016, we found that the provider was not managing people's needs safely. We judged that this meant people were at risk of harm, and assessed the location as "Requires Improvement" in relation to safety. We told the provider that they were required to take steps to ensure this was addressed. At this inspection we found that the provider had made some improvements in relation to risk assessments for falls, nutrition, weight, dementia (when appropriate), moving and handling, bathing and showering, and Waterlow (which relates to the risk of pressure ulcers), but risks relating to the management of people's behaviours were not robust to keep people safe.

For example, we looked at four people's care plans to check that risk were managed safely, but found that the provider was failing to take appropriate steps to protect people from harm. One person living at the home had a history of inappropriate behaviours that presented a risk of harm to other people. There was a risk management plan in their file, however this plan was not detailed enough to provide guidance for staff in relation to how to manage this behaviour to prevent the risk of harm. Subsequently, this person's inappropriate behaviours have continued and a number of safeguarding referrals had been raised as a result.

We viewed another person's risk assessment that recorded they will sometimes lower themselves to the floor and go to sleep in communal areas of the home. We noted this person's mobility risk assessment did not take in to consideration the risks this posed to other people potentially tripping over the person on the floor causing injuries to both. We brought this to the deputy manager's attention who acknowledged the risk assessment and care plan needed to include what measures the home had put in place to keep everyone safe.

This was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff undertook safeguarding training, and a safeguarding policy and procedure was in place. The registered manager maintained an electronic record of any safeguarding incidents that had occurred at Yew Tree Manor. We viewed the safeguarding log record which indicated that there had been a high number of incidents in the last 12 months.

We were aware of recent safeguarding issues at the home that were currently still being investigated by the safeguarding team. However, early indications have identified a number of areas the home needed to improve on.

During our tour of the home on the first day we noted several potential safety hazards. On one occasion we found the domestic cleaning trolley left unattended in the corridor while the domestic worker was on their

break, this contained hazardous cleaning products. This is a risk for people who may be confused. We found the laundry room had been left open and unattended on two occasions. The laundry room contained electrical appliances that could potentially cause a risk to people living at the home.

On the first day of our inspection we noted on the ground floor corridor stored five wheelchairs along the corridor and two wheelchairs blocking a lift that was not in use. Furthermore, we noted another five wheelchairs stored in a person's bedroom while they were asleep. The inappropriate storage of these wheelchairs posed a potential safety hazard . We brought these concerns to the management team's attention; they ensured these wheelchairs were stored in a more appropriate location.

This was a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in May 2016 we found a breach of the Regulations because the home had a lack of adequate PRN protocols, alongside the inaccurate completion of MAR sheets and poor labelling of creams. PRN medicines are prescribed to be given only when people need them. At this inspection we found a number of improvements had been made, however we found a small number of PRN protocols had not been completed accurately for some people. For example, we found some PRN protocols did not accurately capture if the person could communicate to staff if they require their medications. The nurse on duty updated this while we were at the home. In a care home setting people may not always be able to express their needs for example for painkillers, so it is important to have 'PRN protocols'. These are a set of instructions to assist staff to identify when an 'as required' medicine should be given.

Prior to our inspection we were informed by the home and local safeguarding team of a medication discrepancy in September 2016, resulting in a person not receiving pain relief over a two week period because the home had not ordered the required pain relief in a timely manner. This matter was fully investigated and the safeguarding was substantiated, and the home accepted responsibility. Since this incident the home has reviewed their ordering of medicines and introduced a new medicines ordering system called 'person centred software' that is checked daily by management. Since this incident, the home has not had any other discrepancies in this area.

During the first day of our inspection we noted that the nurse on duty administered all medicines to people living at Yew Tree Manor. This meant that the medicine round tended to take two to three hours, and some people did not receive medicines prescribed to be taken in the morning until nearly midday. At the last inspection we were told that senior care workers were now responsible for administering medicines to people receiving residential care. On the day of our inspection we found this was not the case, due to one member of staff turning in for work approximately two hours late. The management team explained that the senior care workers do administer medicines to residential people, but today was difficult due to the staff member turning up for work late and this had an impact on people requiring support with their personal care. On the second day of our inspection we found the morning medicines round was completed in a timely manner, due to the second nurse of duty. We noted from the rotas an additional nurse worked twice a week during the day shifts.

We viewed people's medicines against the Medicine Administration Record (MAR) to establish if the delayed administering of medicines had an impact on people. We found this was difficult to determine due to no times being recorded on people's MAR. The nurse on duty explained this delay did not have an impact, because some of the people who required their medicines earlier would have them administered between 7am and 8am by the night nurse, depending if that person was awake.

A list of staff responsible for administering medicines, together with sample signatures was available for reference and photographs of the people using the service had been attached to medication administration records to help staff correctly identify people who required medication. We checked that there were appropriate and up-to-date policies and procedures in place around the administration of medicines and found that the provider had developed a suitable policy for staff to reference.

We checked the arrangements for the storage, recording and administration of medication / controlled drugs and found that this was satisfactory. We saw that a record of administration was completed following the administration of any medication on the relevant medication administration record. Systems were also in place to record fridge temperature checks; medication returns and any medication errors. A monthly audit of medication was undertaken as part of the home's quality assurance system.

At the last inspection we found staffing levels had been increased from five care workers to six in the mornings. The registered manager explained that this was based on her assessment of the needs of people living in the home. At this inspection we found the staffing levels had increased further by one extra care worker to provide a constant one to one supervision for 24 hours due to a person being a high risk of falls.

We noted from the rota during the week an additional nurse was on duty for at least two days to provide support to the nurse on duty and complete pre-admission assessments for people potentially moving to Yew Tree Manor. On the first day of our inspection we noted there was one nurse on duty, she was extremely busy throughout the day, administering medicines, providing clinical support and dealing with health professionals. On the second day of our inspection we noted there were two nurses on duty, who shared equal responsibilities and we observed the home ran much smoother on this day. One nurse was available to provide direction and leadership to the care staff, while the second nurse concentrated on updating care plans and administering medicines. We discussed the benefits of introducing a second nurse on duty seven days a week with the registered and deputy managers who confirmed they would discuss this further with the director of Yew Tree Manor.

We asked the registered manager how staff sickness and holidays were covered; they said that management approached other staff and asked them to work the shifts. However, the home had access to a care agency that would provide agency care workers that were familiar with the home.

During the inspection we looked at the records of four newly recruited staff to check that the recruitment procedure was effective and safe. Recruitment procedures were in place and being followed to ensure only suitable staff were employed by the service. Prospective staff completed application forms and the information provided included a full employment history. Pre-employment checks had been carried out. These included Disclosure and Barring Scheme checks, health clearance, proof of identity documents, including the right to work in the UK, and two references, including one from the previous employer.

Records showed that the registration of the nurses was checked regularly with the Nursing and Midwifery Council (NMC) to ensure they remained authorised to work as a registered nurse.

Staff members we spoke with told us they had received fire safety training. Each person living at Yew Tree Manor had a Personal Emergency Evacuation Plan or PEEP in the evacuation folder; it listed their name, age, any mobility issues and room number. PEEPs also outlined the level of
support each person would need to leave the building in the event that evacuation was necessary. This meant that people could be safely evacuated in the event of an emergency.

We looked at the records for gas safety and for fire and manual handling equipment checks. All the

necessary inspections and checks were up to date. We checked the windows and those that we could reach had restrictors that meant they wouldn't open more than 10cm, which was within the recommended range outlined in Health and Safety Executive guidance.

Requires Improvement

Is the service effective?

Our findings

We looked at records in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards.

At our previous inspections we found that insufficient care was taken to ensure that consent was obtained for care and treatment and to ensure that when a person lacked capacity to consent the correct procedure was followed.

At this inspection we found a continuing lack of understanding from the management team in relation to consent for care and of the requirements of the MCA. For example, we viewed four care plans. We noted two people who lacked capacity to make decisions on their care and treatment had signed consent to agree to having their photograph taken and being weighed regularly. We also noted a relative had signed a consent form on behalf of their family member who lacked capacity, however this relative did not hold Lasting Power of Attorney (LPA) for health and wellbeing to sign this consent form. Under the MCA a relative cannot give consent on behalf of a person who lacks capacity to consent themselves. The only exception is if the relative or representative has been granted a LPA for health and wellbeing. In the absence of that, there must be a best interest's decision. The MCA Code of Practice gives advice about how to reach such a decision. Depending on the situation, it does not have to be too formal. We discussed this issue with the management team during the inspection and they confirmed they would be reviewing all consent forms in people's care plans as they accept they misunderstood the requirements of the MCA.

This was a continuing breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we noted a number of statements in people's care plans stating the person lacked capacity for example "[name] does not have capacity to make decisions in their best interests." But there were no assessments to support this judgement. In fact mental capacity assessment should be decision specific and not generic . At this inspection we found this area had improved slightly as the home were now completing mental capacity assessments when the home suspected a person lacked capacity. We brought one mental capacity assessment to the deputy manager's attention as this assessment did not accurately record how the deputy manager assessed the person's capacity. A capacity assessment assesses whether a person can made decisions for themselves; sometimes a person's capacity to make decisions can fluctuate so a capacity assessment should determine which decisions a person can make, which they need help to make and which decisions must be made on the person's behalf. The deputy manager confirmed the process she followed and acknowledged this information needed to be recorded going forward.

The manager maintained a record of people subject to a DoLS. A number of DoLS applications had been made by the home and one DoLS had been approved. We noted from one person's care records that there had been a number of behavioural issues that required the home to carryout hourly observations on this person. The home installed a bedroom door sensor that monitored their movements when they left their bedroom, and introduced hourly observations completed by the care staff. This high level of supervision had been in place for a number of months; however we noted an application to apply for this person's DoLS had not been completed in a timely manner. During a recent safeguarding meeting we asked the registered manager if this person had a DoLS in place, the management team were not entirely sure. During this inspection we viewed this person's DoLS application dated 20/01/2017 confirming a DoLS had not been applied for in a timely manner. This meant that in this respect the service was not acting in accordance with the requirements of the MCA.

Furthermore, this person's file stated that they struggled to communicate and their family did not wish to be involved. We asked the registered manager about this. They told us that an external advocacy service was available, so it was unclear why this service had not been contacted to assist in decision making for the person. Since the inspection we have been informed by the management team that they have made a referral for this person to the Independent Mental Capacity Advocacy (IMCA) service on the 9 March 2017.

The provider and registered manager had failed to assess and plan people's care in accordance with the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

We found the majority of the staff had completed the MCA and DoLS e-learning training, but there was still a proportion of staff who had not yet completed this. The registered manager said all staff would complete this training in the near future and the service should assure themselves that staff are competent in this area.

We viewed the training records at Yew Tree Manor. There was a mix of face to face classroom training and online training. Examination of training records confirmed that staff had completed key training in subjects such as first aid; moving and handling; challenging behaviour; fire safety; food hygiene; safeguarding; infection control; dementia awareness; and health and safety.

Nursing staff had received training in catheter care, end of life, continence care, and cerebral vascular stroke management.

The Care Certificate was in place for new staff to complete as part of their induction, however we noted this area needed developing as the home had not been proactive ensuring new staff completed all standards in a timely manner and clearly identify who was responsible for assessing the staff competencies. The registered manager confirmed they would review their induction systems to make sure staff completed this training within the required timeframe of 12 weeks. The Care Certificate is a nationally recognised qualification for new staff working in care. We will review this area at our next inspection.

We found that care workers had received appraisals annually and also had regular supervision with the deputy manager. Two staff members informed us that they didn't receive a regular supervision, we brought this to the managers attention who provided evidence that the two staff in question had received a supervision recently. This showed that the registered provider was interested and committed to staff development.

There was a three-weekly menu and people were asked for feedback about the food at residents' meetings.

We spoke with the cook, who was aware of individual's specific dietary needs.

Dining tables were set nicely with cutlery and condiments, and people could eat in the living rooms or in their own rooms if they preferred. There was a menu board on the wall with the day's menu. A number of people were receiving support in eating lunch from the staff members. One of our inspection team ate the lunch meal with the people using the service. They observed that the quality of the food was good. People using the service were seen to be enjoying their food.

We asked people living at the home their thoughts on the standard of the food. Comments received included, "The foods not bad really" and "I look forward to the meals here, no complaints with me."

The most recent local authority food hygiene inspection was in October 2015 and Yew Tree Manor had been awarded a rating of 5 stars which is the highest award that can be given.

At the last inspection we found a breach of regulation 12 in relation to weight recording charts not being completed correctly for people who required to have their fluid and food intake recorded daily. At this inspection we found the home had made improvements. The home introduced a new electronic care planning system that staff recorded electronically what tasks they had completed. This electronic system also flagged up areas such as fluid and food intake charts when they needed to be completed and the amounts people required. The management team commented that they viewed this system throughout the day to ensure these records were being completed. The management team were in the process of carrying out recorded spot checks to ensure these tasks were taking place.

We saw that improvements had been made since our last inspection in making the home more dementia friendly. There was signage to the dining areas and on toilet and bathroom doors to assist people with dementia to orientate around the home. Corridors on the units contained activities for people with dementia. Different 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. 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 decision making.

Requires Improvement

Is the service caring?

Our findings

We asked people who lived in the home and their relatives about the relationships they had with staff. Comments received included, "I love it here, it makes me want to live", "Beautiful set-up and a lovely place" and "Some of the staff are lovely, others can be too busy to get to know them."

People told us that their privacy and dignity was respected by staff. Staff told us they would knock on people's doors before entering and would ensure people were covered up where possible when receiving personal care. However, prior to our inspection we attended a number of safeguarding meetings in relation to incidents that had occurred at the home. We noted from one of these safeguarding meetings a family member expressed their concerns with the level of care their family member received. One example they gave was that the care staff did not ensure their family members dignity was respected as the home did not ensure their family member was fully dressed when leaving Yew Tree Manor after their respite stay.

People's equality and diversity needs were respected and staff were aware of what was important to people. However due to contradictory information in some peoples records, there was a risk that people's needs may not always be identified. We also found concerns to obtaining consent in relation to the Mental Capacity Act which could mean that consent in relation to the care they received was not lawfully obtained. People told us they were able to maintain relationships with those who mattered to them. Visiting was not restricted; people were welcome at any time. Throughout the inspection we observed friends and family continually visiting and being welcomed by staff.

People had call bells in their rooms if they needed to call for staff to help them. We observed staff popping in and out of rooms throughout the day of our inspection checking whether people needed anything.

Staff had a good understanding of people's interests, likes and dislikes. This meant that staff could have conversations with people about things that were important and of interest to them.

Interactions between staff and people were respectful and involved the person in decisions. Throughout the inspection we observed staff explaining their actions to people, giving people time and listening to what they had to say.

We saw some evidence that some people were involved in planning their care. For example it was recorded on one care file that the person had been included in discussions about the care plan, along with a family member. However, it was not always clear how often people were involved in their care planning due to a lack of evidence recorded in peoples care plans. We discussed this with the management team who confirmed they would review this area.

We considered end of life care within the home. In our previous inspection report we referred to evidence that Yew Tree Manor tended to send people to hospital rather than enabling people to die within the home. 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. At this inspection

we found one person was currently being nursed on the end of life pathway. During the inspection we were notified by a family member who raised a complaint to the home. The family were not satisfied with the response they received from the home shortly after their family member passed away. We noted the home were in the process of investigating this person's complaint and were due to respond to them.

At the last two inspections we saw an inconsistency in end of life care plans. At this inspection we found this was still the case. We noted one care plan captured information recorded about their preferences for care at the end of their lives; however the other three end of life care plans had not been completed. We discussed this with the management team who commented that the end of life care plans tend to be reviewed with the person / representative, but they have struggled to arrange dates with many of the people's family members to take this forward. However, we found this had not been evidenced in the care plans.

Staff told us they were experienced in providing end of life care and this was supported by training records.

After the inspection we received a letter from a healthcare professional, who was positive about the approach of one of the nurses providing end of life care. There comments included, "Your calm and unhurried approach has been exemplary and has helped [person's name] end of life care to be holistic and caring at all times."

During the inspection we were informed by the deputy manager people using the service had access to independent advocates. However, as we have already mentioned in the effective domain of this report we found this was not always the case. An advocate is someone who supports a person so that their views are heard and their rights are upheld. There was information available for people if needed.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we saw improvements in the care plans compared with previous inspections. There was a clear index at the front which enabled parts of the care plan to be found. There was a page with a photograph of the person, and the name of their keyworker and named nurse (if they were receiving nursing care).

The home had recently purchased a new electronic care records system to replace the paper-based system and the home started migrating records across to it. At the time of this inspection this process was still not complete so we looked at three people's paper records and one person's electronic records.

At this inspection we found the care plans were easy to navigate and provided information about the full range of people's needs. These included food/fluid intake, mobility, personal care, elimination, moving and handling, medication and health, social contact and communication, skin, sleep, behaviour, safety, finance, and end of life care. Care plans were up to date, reviewed as needed and contained information about people and their preferences. However as we have already mentioned within the safe domain of this report, we looked at one person's care plan which we would have expected a robust positive behaviour support plan in place due to recent inappropriate behaviours concerning this person. The care plan had a small section on this person's behaviours and a risk management plan had been established. This plan did not provide a detailed strategy to help manage this persons behaviour which others may find challenging. The risk management plan did not provide the staff with step by step guidance on supporting the person to enjoy their life whilst enabling staff to understand when they needed to intervene to prevent an episode of challenging behaviour escalating. We brought this to the deputy manager's attention who began to update this risk management plan while we were at the home.

The clinical lead nurse completed initial assessments before people moved to Yew Tree Manor. They visited the person and spoke to relevant people such as family members and nurses on the hospital ward. We saw one person who had recently moved to the home and the service was in the process of writing a new care plan on the new electronic care panning system.

At the last inspection we saw there were a limited number of activities available. At this inspection we found the activities had improved, but there was still room for further improvement. The home employed an activities coordinator who sometimes worked as a care worker at the home. The activities coordinator was very enthusiastic about their role. The activities coordinator informed us that they have recently subscribed to the magazine called 'The Daily Sparkle', this is designed to stimulate memories and cognitive functions for older people and those living with dementia. This was in its early stages, but the activities coordinator was positive about the resources for people to use. We looked at the records kept by the activities coordinator; they listed people's names, the activities they had done or had chosen not to participate in and the date. This information was then inputted onto the homes electronic system to provide a monthly overview on what people had taken part in. Keeping records helped to ensure that the activities coordinator spent time with every person at the home and could identify which activities each person liked and disliked.

On the first day of our inspection we noted very little stimulation being provided in the home and no activities had been arranged on this day. On the second day we noted a singer provided entertainment for the people, and this was well attended in the large lounge. The home had a designated wall along the corridor that provided photos of recent activities people had been involved in. We noted a weekly timetable had not been implemented to inform the people and their families what activities the home had arranged. We discussed this area with the registered manager who commented that they were in the process of recruiting a second activities coordinator and the current coordinator will be given time to implement an activities timetable. We will review this at our next inspection.

We asked the people for their opinion on the activities provided at the home. We received a mixed response. "The activities are okay, I tend to join in when there is something I like", "The singer is superb who visits the home, I wish she worked here" and "Very happy, 100%, apart from activities."

There was a complaints procedure in place which gave people advice on how to raise concerns and informed them of what they could expect if they did so. People we spoke with told us they knew how to raise concerns and said they felt able to do so. We noted since our last inspection in May 2016 the home had received four complaints from people's families. We found that the system for dealing with complaints had improved. Both written complaints and oral complaints were kept in the same file, together with notes of investigation and copies of the replies sent to the complainant. However, we noted one complaint raised concerns about the attitude of one of the staff working at Yew Tree Manor. We noted the response from the registered manager did not fully respond to the complainants concerns. We brought this to the attention of the registered manager who acknowledged our observations and commented they would be happy to investigate further if the complainant came back to her. We will continue to monitor how the home manages people's complaints.

During our two day inspection one person's family had a number of complaints about the care being provided at the home. We brought these concerns to the registered manager's attention who confirmed they would attempt to resolve these issues with the family shortly after the inspection.

Inadequate

Is the service well-led?

Our findings

Prior to our inspection concerns had been raised with us by social workers and Manchester commissioners that Yew Tree Manor was not always managing safeguarding allegations effectively. We found this had also been the case at our last inspection.

We attended a number of recent safeguarding strategy meetings to determine the seriousness of the allegations and observe how the home dealt with these issues. In particular, there had been an allegation of neglect, that the home had not supported a person who was on respite care to receive medical attention in a timely manner. Once this person returned home it was established a number of days later they had sustained a serious leg injury. Although it was difficult to determine if this person sustained the leg injury at the home the safeguarding team found a number of areas the home needed to improve on. For example, one of the staff statements was illegible to read and the home had been given guidance in the past on how to support staff in this area. We noted the home could not account for certain care records when the social worker requested them. When the person was admitted to the home for respite care a body map was completed by a staff member. Body maps are completed to identify and monitor any current pressure sores or new and pre-existing injuries. We found this body map had not been dated by the staff member who completed it, and a number of bruises had been identified. This had not been reported to the safeguarding team. Failure to report significant bruising had prevented the safeguarding team to make further enquires and meant the home were in breach of their own safeguarding policies and procedures.

The failure to report unexplained bruising shows that the safeguarding incident had not been treated seriously enough. An effective response by the registered manager is needed in order to protect people living in the home from further risks. This was continued breach of Regulation 13(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As already mentioned in the safe domain of this report two other safeguarding's were still currently on-going and the outcomes of these meetings were still yet to be established. However, early indications have identified a number of areas the home needed to improve on.

We looked at how managers were monitoring the quality of the service provided. Information collected during the inspection showed that a range of audits were completed such as infection control, care planning, the environment, medicines, accidents and incidents, on-going staff training and development.

We noted audits covering care planning and health and safety had failed to address shortfalls found during our inspection. For example, we looked at the arrangements in place for auditing people's care plans. We found these audits did not accurately pick up on the required information people needed to keep them safe in their care plans.

Although policies and procedures were in place it was clear that they were not always put into practice. Staff and management did not have clear working knowledge of the current changes in legislation to protect people's rights and freedom. The provider was not following the principles of the MCA and it was not

consistently and effectively followed to ensure people who lacked capacity to consent were provided with care that was in their best interests and in the least restrictive way. This meant the provider and the registered manager did not understand their responsibilities associated with the Act.

Over the previous two inspections of this service since 2015 we have found several breaches of the regulations.

We found the same or similar breaches in regulations where the provider had failed to act on these to improve the care and support people received. We have not seen sustained improvements to the service due to the lack of reliable and effective governance systems in place.

We concluded this was a breach of Regulation 17, (Good governance); of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider continued to conduct a visit every two months or so to inspect the premises, and talk with people living in the home and with staff. We saw the report of their latest visit, when they had spent over 13 hours in the home over two days.

At our previous inspections we have been made aware of some criticisms of the registered manager's leadership of Yew Tree Manor. At this inspection we received a mixed response from health professionals visiting the home. One stated, "It's a nice home, but communication seems to be a constant issue. The management don't always keep us informed when people's needs are changing." Another person commented, "There has been some improvements, but we still have issues with the management keeping us informed." The third person stated. "Yes I have found improvements; the home will make referrals to Speech and Language Therapist Team (SALT) directly and not just wait for me to do it."

We received positive feedback from the staff about the management and leadership of the service. Positive comments included, "If I need to speak to the manager or deputy manager I can stay at the end of my shift as one of them is usually in at 8am", "I can say if I'm not happy about something", "I enjoy working here; my colleagues and the manager are friendly and always available. If there is an issue you can go and knock on the door. The deputy manager is wonderful" and "Managers will listen to staff."

We saw dates were scheduled for regular team meetings. We viewed minutes from the last team meeting in January 2017. Topics discussed included the development of the service, completion of records and actions for staff to follow from a recent safeguarding meeting.

People had an opportunity to attend residents meetings. The manager told us residents meetings took place at least every three months. The meetings discussed various subjects that included the quality of food, care and the service. Most comments were positive about the service. In addition, the service obtained feedback from people who used the service and relatives to identify areas that needed improvement and to assess the impact of the service on the people using it. The last survey was completed in December 2016 and four questionnaires were returned.

There was a system in place to monitor accidents, incidents or safeguarding concerns within the home. The manager maintained a monthly record about the incidents which had occurred and what had been done in response. Additionally, there was a record of what the outcome was and any 'lessons learned' to help prevent future re-occurrences.

We were kept informed of all incidents that occurred at the service. The manager ensured that CQC were

made aware of any issues or concerns that took place. The provider notified us promptly of any incidents as they are required to do so we could take appropriate actions.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Service users were not provided with care and treatment in a safe way as risks to their health and safety were not being accurately assessed or plans made to mitigate those risks. During our tour of the home on the first day we noted several potential safety hazards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The failure to report unexplained bruising shows that the safeguarding incident had not been treated seriously enough. An effective response by the registered manager is needed in order to protect people living in the home from further risks.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider failed to gain appropriate consent and make a DoLS referral in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

The enforcement action we took:

Warning notice against the registered provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not ensured that they assessed, monitored and improved the quality and safety of the services provided in the carrying on of the regulated activity.

The enforcement action we took:

Warning notice against the registered provider.