Zinnia Healthcare Limited

Yew Tree Manor Nursing and Residential Care Home

Inspection report

Yew Tree Lane
Northern Moor
Manchester
Greater Manchester
M23 0EA

Tel: 01619452083

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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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place over two days on 3 and 4 May 2016. The first day was unannounced, which meant the service did not know we were coming. The second day was by arrangement.

The previous inspection took place on 20 and 24 August 2015. At that inspection we found breaches of seven regulations. The breaches related to staff numbers and support for staff, medicines management and the fire register, consent to care and treatment, dignity and respect, care planning, complaint handling, and governance.

We received an action plan on 26 January 2016 stating how the service had remedied or intended to remedy those breaches. We describe in this report whether and how improvements have been made to address those breaches. In our last report we gave the service the rating of Inadequate under the question "Is the service safe?" and Requires Improvement under the other questions, resulting in an overall rating of Requires Improvement. At this inspection two of the ratings have improved but the overall rating remains Requires Improvement.

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. At the date of our inspection there were 39 people living in the home of whom five were temporarily in hospital. 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. Bedrooms are on the ground and first floors. There are two lifts. Outside there are a garden and patio areas. The building is accessible to wheelchair users via a ramp and the home has disabled access facilities. Car parking spaces are available.

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'. 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.

People living in the home told us they felt safe. The physical environment was safer than at the last inspection. However, we had been contacted by two families who were unhappy about the level of safety in the home. In one case a vulnerable person had left the building unobserved due to a fire door alarm not working. We considered this was a breach of the Regulation relating to keeping people safe.

The other family had complained about many aspects of their loved one's care, including the hygiene of their bedroom. At inspection we found the home was clean, with some areas for improvement, and the latest infection control report had given the home a high rating.

There was a range of risk assessments. One person was known to be susceptible to pressure ulcers. The

relevant risk assessment was incomplete which meant that the risk had not been managed properly. This had contributed to a delay calling in the specialist nurses. This was a further breach of the Regulation concerning safety.

We saw some improvements in the storage and administration of medicines, compared with the previous inspection. Senior care workers were now involved in administering medicines, which gave the nurse on duty more time. We identified some areas for improvement in how medicines were given.

Some recording on the Medicine Administration Records was inaccurate. Since the last inspection some guidelines were in use for giving 'as required' medicines. However, we found several examples where these guidelines were not in use. We found this was a continuing breach of the Regulation relating to the safe management of medicines.

Staffing levels had improved and were now adequate. There had been a safeguarding incident when someone went to hospital over the Christmas period and there was no staff available to go with them. On a later occasion staff had accompanied the same person to hospital.

Recruitment processes were safe. Staff were trained in safeguarding and knew what to do if they witnessed or suspected abuse.

Some people told us they felt unsettled when objects went missing from their rooms, although in some cases they had been replaced by the home.

The building was well maintained. Problems with the fire register had been rectified.

We found that relatives had been allowed to sign consent forms on behalf of people who lacked capacity to consent to care and treatment. This was not in accordance with the Mental Capacity Act 2005. This was a continuing breach of the Regulation relating to consent. Mental capacity assessments were not being completed within the home. Applications under the Deprivation of Liberty Safeguards were being made.

Training and supervision of staff had improved since the last inspection.

The food was well liked and people's dietary needs were met. People's weight was monitored weekly or monthly. We found that one person's weight had not been recorded as often as recommended by the Nursing Home Team. This was a further breach of the Regulation relating to keeping people safe.

Health professionals visited the home regularly. Improvements had been made in the environment for people living with dementia, following a recommendation in our last report.

Most people living in the home and their relatives expressed satisfaction with the care provided. We saw some examples of a caring and thoughtful approach by staff. We also saw some staff being impatient.

We noted that some people were untidy and unkempt. This matched information we had received prior to the inspection from a number of sources. We found this to be a breach of the Regulation relating to personal care.

Records were mostly kept secure and confidential, but we saw examples where they were left in public view. Where people were able, they were encouraged to be independent, and involved in their care plans. They could also take part in residents' meetings.

We found that Yew Tree Manor was now more ready to care for people at the end of life instead of sending them to hospital. But there were examples where due to poor record keeping people had been sent to hospital despite an agreement that they would not be.

Care plans had improved and were thorough and well presented. There was a monthly review which enabled changes to be easily identified.

A new activities organiser had just been appointed. Some activities were offered but there was scope for the new activities organiser to engage more people in meaningful activities.

People knew how to make complaints. Recent complaints had been investigated and responded to appropriately.

We were aware of concerns that the home had not responded effectively to a serious allegation of abuse. The registered manager had not kept adequate records, although disciplinary measures had been taken. She minimised the seriousness of the allegation when talking with us. We found there had been a breach of the Regulation relating to safeguarding people.

The system of audits was more rigorous than it had been, including a new medication audit. Staff meetings and relatives' meetings took place.

There had been criticisms made of the leadership of the home, but a deputy manager had recently been appointed who was working well alongside the registered manager.

In relation to the breaches found at this inspection, you can see what action we told the provider to take at the end 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 building was a safe environment but on one occasion a fire door alarm had not operated. Risk assessments were in use but had not been used properly when a person was at risk of pressure sores.

The safety of medicines had improved except that guidelines for some medicines were insufficient.

Staffing levels were better than before. There was now a good system for providing information to the emergency services.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act 2005 were not always followed in relation to obtaining consent to care and treatment.

Training and support of staff had improved.

The food was good and enjoyed. People's weight was measured but in one case had not been recorded often enough, contrary to the instructions of an outside nursing team.

Is the service caring?

Requires Improvement

The service was not always caring.

There were examples of a caring attitude by staff. But there had been complaints of a poor approach to people's grooming and appearance, which were borne out by our observations.

Records were kept confidentially, except in some instances.

Yew Tree Manor was better prepared than it had been to care for people at the end of life.

Is the service responsive?

Good

The service was responsive.

Care plans were improved since the last inspection and were thorough and reviewed regularly.

Some activities were offered and a new activities organiser had just been appointed.

The system for handling complaints had been improved.

Is the service well-led?

Requires Improvement

The service was not always well led.

A serious safeguarding incident had not been properly responded to by the registered manager.

More effective audits were now being carried out.

A deputy manager had been appointed who was sharing responsibility with the registered manager.

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 3 and 4 May 2016. 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. On this occasion the expert by experience had both personal and professional experience in supporting older people.

Prior to the inspection we reviewed all the information we had, including notifications from the service, and minutes of recent safeguarding meetings, some of which we had attended.

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 interaction 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 eleven people using the service, four sets of visiting relatives, five members of staff, and four visiting professionals. We spoke in detail with the registered manager and the deputy manager, a cook and three other members of staff.

We looked at five care records in detail, six medicine administration records, two staff files, and staff rotas. The registered manager sent us a number of documents at our request, including policies, training records, staff meeting and residents' meeting minutes.

Requires Improvement

Is the service safe?

Our findings

We asked people living in Yew Tree Manor whether they felt safe. We received positive answers from the ten people we spoke with, and no one expressed any concerns about their safety. People said, "I love it here", "I like being here", "I like the people", "I feel very safe and cared for", "very good staff", and "nice staff".

We asked visitors whether they were confident their relatives were safe. They told us that the staff were very approachable and kept them informed about their relatives' health and wellbeing. We observed that the environment was suitable for people with limited mobility. The floors were free of trip hazards and we noted an improvement since the last inspection, when the smaller lounge leading to the garden had been cluttered with equipment; this area was now much clearer. The garden itself was enclosed and a safe and enjoyable place for people to sit in the summer months.

However, we had also been contacted by two families in the months before this inspection, who were concerned about the level of safety within the home. In one case a person living with dementia had left the building at 7pm through a fire escape door but the alarm did not sound. Staff had previously noticed that the person was showing signs of wanting to leave. We were told at the inspection that the alarm had been deactivated, and had since been reinstated. The person was found by police after they attempted to board a bus on a nearby main road without any money.

The family member also complained to the service, emphasising that the person using the service had a history of falls. They also complained that they had not been informed immediately that their relative was missing from the home, which might have made a difference as the family member could have made suggestions about where the person might have gone to. They stated, "I am very worried, upset, and angry that my relative's dignity, comfort, wellbeing and safety have all been compromised whilst in the care of Yew Tree Manor." In response the deputy manager stated that staff discovered very quickly that the person had left the building and that they had returned within half an hour.

We had raised a safeguarding alert to the local authority, which substantiated the allegation. In this instance the person suffered no harm but had clearly been at risk because they had got out of the building unnoticed. This was a breach of Regulation 12(1) and 12(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The second case was where family members had complained about multiple issues relating to the care and safety of their relative. These included the cleanliness of their room, and a staff member not knowing the person had suffered an injury which could potentially have aggravated the injury. They also alleged that the call bell was often placed out of reach so that the person could not summon help if they needed it, which was a potential safety issue. These issues had been the subject of a safeguarding meeting which had not yet reached a conclusion by the date of this inspection. However we saw documents within the home which left no doubt that the room had not been cleaned to a satisfactory standard.

On the days we visited the home was mostly clean and there were no unpleasant smells. One visitor who

had been coming for three years told us they felt the care home used to have some issues with cleanliness, but that had been dealt with now. We saw the local authority infection control team had visited on 28 December 2015 and had given the home a high rating of 88%, which was a significant improvement on previous reports. However, we found dried faecal staining under two shower chairs. In one bathroom a pile of fresh towels and someone's toilet bag were lying on top of a clinical waste bin that did not have a bag in, but contained soiled continence pads. This created an infection control risk.

Two visitors expressed praise of the laundry service within the home, "They know our relative's clothes. They always come back to them. They take a real pride in the laundry."

Accidents and incidents were recorded. Many records stated "no injury found", in other cases staff had dealt with minor injuries. In cases where there had been a bang to the head or people were in pain, an ambulance was called.

When we looked at care files we saw a range of risk assessments used to ensure that risks were monitored. These included separate risk assessments relating to falls, nutrition, weight, mental health, dementia (when appropriate), moving and handling, bathing and showering, and Waterlow (which relates to the risk of pressure ulcers). There was also a risk assessment review form which recorded any changes in the risk assessments and was a useful aid to enable staff to identify quickly which risk assessments had changed.

We were concerned that one person's Waterlow risk assessment had not been correctly completed. The assessment works by adding in a score for a range of factors and then adding the scores together to produce an estimated risk for the development of a pressure sore. This assessment had two rows left blank and an incorrect score added in. The person's BMI (Body mass index) had also been estimated, which made the assessment unreliable. This particular person was at risk of pressure ulcers, and had developed three in mid April 2016. They had been referred to the tissue viability nurse (TVN) in April 2016. Daily records showed that care workers first alerted the nurse in Yew Tree Manor to the development of pressure ulcers on 14 April, but the referral to the TVN was not made until 19 April, and the referral incorrectly stated that all three pressure ulcers were "first seen on 18 April 2016." The registered manager told us that the person's relative had told her they had had pressure ulcers in the past which developed very quickly, making it more important to take prompt action. Positional charts which recorded how often the person had been turned in bed, to prevent the pressure ulcers deteriorating, had been used from 20 April following the TVN's visit. These charts were confusing because days were recorded on different sheets, and staff were using different ways to record the times. But they did show the TVN's instructions on repositioning were being followed.

The incomplete Waterlow assessment meant that this person's risk had not been correctly identified, and the delay in referral to the TVN meant that the pressure ulcers had developed further than they should have before professional help was summoned. This was a breach of Regulation 12(1) and 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how medicines were managed in Yew Tree Manor. We noticed some improvements compared with our previous inspection in August 2015. The medicines room where medicines were stored was much tidier and better organised. We checked the records of controlled drugs. These are drugs which are required to be stored more securely than other medicines. We checked a sample of these drugs and found the balances in the records matched the amounts stored. Two staff had signed the record book on each occasion, as is required. There was an efficient procedure for ordering medicines from the pharmacy and returning them when necessary. We saw that the fridge temperature was being checked daily.

At the last inspection we had noted that nurses administered all medicines to people living at Yew Tree

Manor with the exception of those given by visiting district nurses. 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. On this inspection we were told and we saw that senior care workers were now responsible for administering medicines to people receiving residential care. This meant two staff were sharing the medicine round so it was quicker, and had the benefit of freeing up the nurse's time for other duties. The training record showed the three senior carers had received appropriate training.

We observed a senior care worker giving medicines to people. The senior care worker was polite and asked people if they would please take their medicines. Each person consented. They placed the tablets in people's hands and they took them. On most occasions the senior care worker stayed with the person while they consumed the medicines. In some cases the senior care worker held the tablets in their hand before popping them in the person's mouth and walking away. If it is not necessary touching people's medicines with hands is poor practice, as it carries hygiene risks, and by not watching people take their medicines the senior care worker could not be sure that they had consumed them. We considered there was scope for competency checking or further training of the senior care workers in medicines administration.

PRN or 'as required' medicines are prescribed to be given only when people need them. 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. At our last inspection we reported that at least five people were prescribed medicines 'as required' but did not have protocols for them. We found that this failing contributed to a breach regarding the safe administration of medicines.

At this inspection we found there was still an issue regarding PRN protocols. On five out of the six medicine administration records (MARs) we looked at, we saw people were receiving medicines 'as required', but there were no PRN protocols in place. Two people were each prescribed three different drugs 'as required' and had received them within the last two days, but there was no record of why or when these drugs should be given. This meant the service could not account for when medicines were being given. Another person was prescribed eye drops as required "2 drops into affected eye up to 4 times a day." There was no PRN protocol to instruct staff when to give the eye drops or into which eye. This meant an increased risk of the eye drops being given incorrectly.

We found there were some PRN protocols attached to the MARs, although in some cases the person was no longer receiving the medicine concerned. This showed that staff at Yew Tree Manor were aware of the need to create PRN protocols for 'as required' medicines, but they had not done so on at least five occasions. We saw one PRN protocol for an end of life painkilling drug. Next to the heading "Reason for administration" was written "PRN when required" which gave staff no indication of when it should be given.

A related concern was that MARs did not always accurately record how many tablets had been given for 'as required' medicines. For example one person was prescribed one or two tablets twice a day, as required. It was recorded that they had received the medicine twice each day but not how many tablets had been given. This would mean that the person's doctor would not know how many tablets had been taken, and would also make it more difficult to reconcile the stock count. We also saw that one MAR recording the application of creams had been ticked rather than initialled by the staff member. This was not good practice as it would make it difficult to identify which staff had applied the creams in the event of any query. A third issue about the completion of MARs related to a person who had received end of life care within the home. The MARs that recorded the specialised end of life care drugs were poorly written. Some of them were handwritten and barely comprehensible, with dates changed across the top and signatures added as if medicines had been administered, but then crossed out again.

In one person's room we found a pot of cream which had the person's name written on it, but no prescription label and no date of opening. This meant that staff would not know when it had reached its "use by" date. This was a similar problem to one identified at the last inspection.

We found the lack of adequate PRN protocols, alongside the inaccurate completion of MAR sheets and poor labelling of creams, was a continuing breach of Regulation 12(1) and 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, some aspects of the administration of medicines had improved. Everyone we spoke with told us they received their medicines on time. We did not find any examples on this inspection of delays in ordering medicines. Staff told us that deliveries were no longer left in an unlocked office but were placed in a locked room until they were distributed. Storage was much improved, although we observed the trolleys were not always chained to the wall despite notices telling staff to keep them chained to the wall at all times.

At the last inspection we found evidence that there were not always enough staff on duty, and found that this was a breach of the Regulation relating to staffing levels. On this occasion, we saw from the staff rota that the number of staff 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. Four staff started at 8am and two more at 9am. One member of staff confirmed that there were nearly always six staff on duty in the morning, unless someone had phoned in sick at the last moment and it had not been possible to obtain agency staff to cover. This member of staff stated that in their opinion there were enough staff to meet the needs of the people living in the home. There were five care workers in the afternoon and three at night. In addition there was a nurse on duty at all times, working a 12 hour shift.

We were aware of an incident which had been reported to the local authority as a safeguarding alert. During the Christmas period in 2015 someone had needed to go to hospital following a fall, late in the evening. The registered manager stated at a strategy meeting that it was their usual policy for staff to accompany someone to hospital, but on this occasion there were no staff available to do so. She added that staff had to balance the needs of the remaining people in the home against the needs of the person attending hospital. This particular person was vulnerable when unattended, and the safeguarding alert arose when they left the hospital on their own before being admitted. The registered manager stated that staff had informed the paramedics about the person's vulnerable state, but this information was not passed on to the hospital.

There is no obligation on providers to ensure that a member of staff accompanies someone to hospital, although it is often seen as good practice. If a member of staff had attended on this occasion it might have avoided the person leaving the hospital at risk to their safety. On a subsequent occasion the same person went to hospital again, this time accompanied by a member of staff from Yew Tree Manor, showing that the service had learnt from past experience.

Professionals who visited the home pointed out to us that domestic staff (including cleaners) wore the same uniform as care staff which might influence visitors into thinking that there were more than the actual number of care staff on duty. The deputy manager stated that there was a subtle difference in the uniforms; also that the domestic staff played an important role in the safe running of the home. Nevertheless people felt that this gave a misleading impression.

We checked the personnel files of two recently recruited staff. In each case we found that the staff member's identity had been established and two references from previous employers had been requested. The application form requested a full employment history and an explanation for any gaps in that history. There was a record of the questions asked and the answers given at interview. There was a record of the

employee's Disclosure and Barring Service (DBS) check. The DBS keeps a record of criminal convictions and cautions, which helps employers make safer recruitment decisions and is intended to prevent unsuitable people from working with vulnerable groups. One person was a national of a European country and there was a record confirming no criminal convictions in their home country, accompanied by an authenticated translation. These measures meant that the provider was following all the required steps to employ only suitable people to support the people living in the home.

The provider had several policies relating to safeguarding including "Safeguarding service users from abuse or harm" and "Safeguarding service users from significant risk of harm". The latter related to "particularly vulnerable" people living in the home. The policies were thorough and up to date in that they referred to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant that the service had appropriate policies to protect people from abuse and to deal with any allegations of abuse. Apart from the two new staff and one other, all staff were up to date with training in safeguarding. This meant that six out of seven staff who had not yet done the training at the time of our last inspection had now completed it. We spoke with one staff member who confirmed this. They said they were always looking out for any signs of abuse, and gave good examples of what signs to look out for. They were able to clearly explain the action they would take if they witnessed or suspected any abuse was taking place. They told us that they would inform the nurse on duty or the registered manager and were confident that appropriate action would be taken. This should help ensure that the people who used the service were protected from abuse.

During the inspection several people told us about items that had gone missing, which made them feel unsettled. One visitor told us that their relative's glasses had gone missing one day but staff had found them by the next day. A complaint had been received about a lost lady shaver, and the home had responded by purchasing a replacement.

We looked at certificates relating to the maintenance of the building and essential equipment, and found these were all in order and up to date. At our last visit one lift had been out of order, but both lifts were working and had been recently checked.

All staff apart from one recent recruit had received fire awareness training, although seven out of 37 staff were overdue to receive it again as it was due to be renewed annually. In addition 14 staff had received training as fire marshals in October 2015. There was an up to date fire risk assessment and an action plan which had been completed. In our previous report we found a breach in relation to the fire register which was inaccurate and out of date. Action had been taken to remedy this. A folder was kept by the front door with an accurate list of all the people living in the home and their Personal Emergency Evacuation Plan (PEEP) describing the assistance needed in the event of an emergency. This list was updated on a daily basis whenever someone went to hospital or went out for the day. This meant that measures had been taken to keep people safe in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

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 so that they can 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 (DoLS). We checked whether the service was working within the principles of the MCA.

At our previous inspection 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. The provider submitted an action plan stating how they intended to remedy this breach of regulation. They stated that they would continue to ask relatives or other representatives to give their signatures if a person was not able to give consent themselves. We informed the provider and registered manager by email in January 2016 that this was not the correct procedure. 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 Lasting Power of Attorney (LPA) for health and wellbeing. In the absence of that, there must be a best interests 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. The family member may well be involved and consulted, as they are form part of the decision.

At this inspection we found that relatives were still being asked to sign consent forms on behalf of people who lacked capacity. For example we saw a form for consent to the use of photographs, dated 21 March 2016. The form was printed "Signed (service user)…" but the relative had signed instead, indicating what relation they were to the person concerned.

There was a note at the bottom of the form which stated "Note: where service user cannot give their informed consent, the form may be signed by a legal guardian." That statement is not quite accurate, in that a person granted an LPA can sign to give consent, without necessarily being a legal guardian. That aside, there is no authority for a relative to give consent unless they have the relevant LPA. In view of the previous report and advice given following receipt of the action plan, the failure to obtain consent according to the requirements of the MCA was a continuing breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In other care files we saw some correct practice, for example where a person deemed to have mental capacity had signed their own consent forms, and another example where a person had granted LPA to a friend, and the friend had signed the care plan and a consent to be weighed form. However, we also found an absence of mental capacity assessments. There were statements that people 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 each decision has to have a separate mental capacity assessment.

We asked the registered manager about the absence of mental capacity assessments, and she stated that staff did not do them although they had in the past; they now expected social workers to do them. On one application for a DoLS authorisation the registered manager had written, "[name] has no capacity assessment in place." But such an assessment should be done before the application is made, because DoLS only applies to people who lack mental capacity. This meant that in this respect the service was not acting in accordance with the requirements of the MCA.

Completed DoLS applications were kept on their own file for ease of reference. Fifteen applications had been made since December 2014, although six of those related to people no longer living in Yew Tree Manor. Only one application had been authorised, by Cheshire East Council (the authority which was funding that person) and the rest were still awaiting authorisation by Manchester City Council. We saw that the applications had been completed fully, and in particular the most recent applications gave detailed reasons for why the authorisation was being sought. The individual detail given was an improvement on the wording of DoLS applications seen at our last inspection.

We looked at whether the staff received the training they needed to carry out their roles. We obtained the staff training record. There was a mix of face to face classroom training and online training. We found a high uptake of mandatory training in safeguarding vulnerable adults, health and safety, food hygiene, first aid, moving and handling, fire awareness and infection control. The intervals at which these training topics needed to be repeated were stated on the record. Health and safety, moving and handling, and fire awareness were annual, the rest every three years. All staff apart from the two newest recruits had completed all the mandatory training, but there were a few staff whose refresher training in one or two topics was overdue. A member of staff told us that they received reminders from the administrator about when training was due. They added, "We get loads of training. It is really good."

There was also a wide range of training topics which were studied online. A member of staff told us this involved watching a film then answering multiple choice questions. Nearly all the care staff had done the training sessions on dementia and on challenging behaviour, which were very relevant in Yew Tree Manor. Most of the staff had done training on the MCA and DoLS. We saw a record that three staff, namely the registered manager, deputy manager and a nurse, had received training on end of life care delivered by a specialist from the local hospital, and we were told this had been cascaded to the rest of the staff. A nurse from the Nursing Home Team told us they were concerned that staff lacked sufficient training in de-escalation techniques, needed to deal with behaviour described as 'challenging'.

Recent recruits had started on the Care Certificate. There was a note on their file of the date they received their workbook. The Care Certificate is a nationally recognised qualification for new staff working in care. We saw induction checklists had been completed when staff started their employment.

The system of supervision of staff had improved since our last inspection. We saw the schedule showing that all staff had received supervision in February 2016 and were due to receive it again at three monthly intervals. One member of staff said their most recent supervision with the deputy manager involved an observation of them working, followed by feedback and then a discussion. They said they had found this style of supervision helpful. Annual appraisals had also taken place in December 2015 for staff who had been in post a year at that time. These developments showed the service had taken steps to remedy the problems identified last time and was now using supervisions and appraisals to support staff to carry out their duties.

We spoke with one of the cooks. They could describe which people needed food that was soft or blended, who needed fortified foods (and how to ensure food was properly fortified) and who was diabetic. The cook told us they made diabetic-friendly alternatives so that people with diabetes could eat the same things as other people, for example cakes with sweetener in. There was a three-weekly menu and people were asked for feedback about the food at residents' meetings. They said they also learned what people liked and did not like, by collecting plates after meals and by speaking with people. We saw the cook doing this.

The food was well liked by people living in the home. One person said, "They're not a bad cook either. They'll do anything I ask of them." One relative had described the catering as "of the highest standard." Two visitors told us they were very impressed with the standard of food. Their relative was only able to eat pureed food, which was brought up to their bedroom. The relatives brought us the plate to show us that even though each item had been separately liquidised, it was attractively presented on the plate. This showed that people's dignity was respected.

We asked people at lunchtime about the food. They said it was "home cooked" and "very nice". The only criticism was that there was little choice sometimes. We sampled lunch with the people living in the home. 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. The staff knew the names of all the people and appeared confident and competent. We sampled the food which was beef stew and mashed potato or jacket potato with cheese and salad. The food was very good and the beef very tender. It was rice pudding for dessert which again was very tasty and hot.

We also observed a tea time meal. People were served soup followed by a choice of sandwiches and/or scrambled egg on toast. The person we sat with said it was lovely.

The kitchen was clean and tidy and scored a 5* (the highest) hygiene rating at the last Local Authority inspection in October 2015.

People's weights were recorded monthly or weekly when needed. We saw in one person's care file that they had been weighed weekly in January, but then monthly thereafter. This was of concern because the person's weight had been dropping rapidly; they had lost nearly 10kg in the last three months. The registered manager told us that this person had an increasingly poor appetite due to being poorly and was refusing most foods. She said that she had already contacted the person's GP who was coming to review them that day (3 May 2016). However, we also saw a note of a review by the Nursing Home Team on 26 April 2016. This stated "[person's] weight not checked again since previous visit and food diary not kept despite this being documented in care plan." The care plan entry by the Nursing Home Team was "Record food and fluid intake in food diary; Record weight and check weekly; Encourage fortified diet and snacks between meals." The next entry was in capitals: "ALL ABOVE DISCUSSED WITH SENIOR CARER AND DEPUTY MANAGER AS WAS REQUESTED 3 WEEKS AGO AND HAS NOT BEEN DONE."

Following this intervention by the Nursing Home Team, food charts were being kept although most entries stated "refused". The only entries were at mealtimes, so there was no evidence the person was offered snacks between meals, as had been recommended.

The lax monitoring of this person's weight and the failure to follow the instructions of the Nursing Home Team had put this person at additional risk of adverse consequences to their health. This was a breach of Regulation 12(1) and 12(2)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which requires providers to do everything practicable to reduce risks.

We saw that people had regular appointments with health professionals. One person who had recently arrived in Yew Tree Manor told us the staff had been actively arranging physiotherapy and had contacted their GP surgery on their behalf. Care records indicated that healthcare professionals visited the home regularly including chiropodists, opticians, and district nurses. We saw that all visits by health professionals were recorded.

In our last report we recommended that the provider should research and apply the latest guidance on providing a suitable environment for people living with dementia. This was because we had not seen any specific items around the home which could help people living with dementia, and some of the signage was unhelpful. Different corridors within the home were painted in different colours which were intended to help people know where they were, but beyond that there were few dementia-friendly adaptations. On this visit we saw that some improvements had been made. 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. In the dining area bunting was hanging from the ceiling which gave a festive atmosphere. There were large menus with pictures of the food. Pots of herbs were arranged on the tables, which people were encouraged to rub and smell. In the lounge the chairs were rearranged from rows into groups, which allowed people to face each other and hold conversations if they wanted to.

At a relatives' meeting on 21 February 2016 a relative suggested that reminiscence cards should be bought for residents, to help stimulate memories, and enable conversations to take place. They also suggested more memory lane books for the home. We did not see evidence that these suggestions had yet been followed up.

We considered that the provider had made some progress in response to the recommendation to improve the environment for people living with dementia, but there was still scope for further improvements.

Requires Improvement

Is the service caring?

Our findings

We asked people living in the home about the care they received, and most people said that they did feel cared for and that all their needs were met. One person praised a particular member of staff for their caring attitude. Another person said that they did not really like being in the home and would prefer to be back at their own home, but they knew why they had to be there, and added "there are good people who look after me."

One relative had recently written a thank you card to Yew Tree Manor, "Thanks for the care you have been giving my mum and for making her happy." Another relative wrote, "(My) [relative] was happy and well cared for and I always felt confident that (their) needs were being met…It was nice to see two representatives from Yew Tree Manor at [relative's] funeral."

We also received some very positive feedback from relatives visiting the home. They described it as a "very very caring home. There are some lovely carers here." They added that the care staff coped well with their relative sometimes being resistant to care. They said, "The staff communicate with us all the time. They are superb." Another visitor also told us that staff were very patient and understanding with their relative as they were not an easy person to care for. Visitors could visit as and when they wished to. One visitor had brought the family dog in to see their relative, which gave obvious pleasure to both the relative and other people.

We saw some examples of a caring approach by staff. During our observations in the main lounge, we saw one member of staff taking someone back to their seat. The person was being rather challenging and obstructive, and swearing a lot, but the care worker was very patient and understanding and allowed the person to take their time, and was speaking to them in a very compassionate, respectful and understanding manner. The person eventually sat down on a chair of their own choice and settled down calmly.

Other people were less positive. One person who was being nursed in bed said that care workers did not come and spend time with them often, but did say that one care worker had painted their nails twice since they had been there, which they had appreciated.

We mentioned earlier that two sets of relatives had contacted the CQC prior to the inspection in regards to the safety and wellbeing of their loved ones in the home. They expressed dissatisfaction with the level of care provided. One example they gave was of a care worker not knowing that someone had broken their arm and so causing unnecessary pain.

During the inspection we observed some examples of a poor attitude towards people living in the home. A member of domestic staff was supervising at lunch time. We heard them speak sharply to a person who kept standing up at the table and had not eaten their food. They said "Sit down! Sit down [name] and eat your food," and then turned away shaking their head saying "I don't know..." as if speaking about someone being intentionally naughty. At another time a care worker leaned over a person who was eating their meal to get some aprons that were stored next to them. The person was annoyed and told us this happened a lot when they sat there, and when they complained the staff told them to sit somewhere else. Both of these incidents

displayed a lack of respect for people.

We saw that some people were smartly dressed, but not everyone was well dressed and tidy. Some people's clothes were messy and untidy, and their hair and general appearance were quite unkempt. A visiting professional said to us, "People look bedraggled. Not well looked after."

We received similar allegations from an anonymous source about three people living in the home in January 2016. They described one person's appearance as "Dirty face…sore eyes, so itchy and uncomfortable for her. Sadly she smells as if she has never been bathed for months or ever." They added, "Most are unclean, most not cared for at all." Following receipt of this information we raised a safeguarding alert with Manchester City Council. Another anonymous caller told us in January 2016 that "people are regularly unclean, they are never bathed or showered. Their hair always looks filthy." The Nursing Home Team also reported that people were often unkempt and their clothes stained. They also had reported that one person had had a problem with a catheter. They alleged that no attempt had been made for over twelve hours to change the person's catheter, even though staff were trained to do so. Instead the staff then called 999. We met a district nurse who stated a concern that people's care needs were not always being met. For example, they said that care workers recorded that creams were being applied as prescribed, but their own observation was that the expected improvements in people's skin condition did not occur. They admitted that it was impossible to prove this was due to the creams not being applied or due to other health-related factors.

These separate witnesses indicated that the lack of sufficient grooming and personal care for some people was a recurrent feature at Yew Tree Manor. Coupled with our own observations they amounted to evidence of a breach of Regulation 9(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records were kept in the nurses' room which was locked when empty, which meant these confidential records were secure. However, we observed that MAR folders were left on top of the medicine trolleys all day, which were in the dining area and not always attended by staff, which meant they were accessible to people living in the home or visitors. We also saw a clipboard with people's names and a record of where they were in the home was left on a table in the dining area all day. Staff were required to update this record at intervals, and the information was not particularly sensitive, but it should not have been left out in public view. Staff had been reminded at a staff meeting in February 2016 about the need for confidentiality when talking with people living in the home.

Where possible, independence was encouraged. We spoke with one person who had been in Yew Tree Manor for a short time. They said that they felt very safe and cared for. They said they had their own freedom and many things were left up to them, such as what time they got up and went to bed. They got themselves dressed (although with some assistance), and had a shower when they wanted. They added "the staff get things sorted for me to accommodate me."

We saw some evidence that 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. This person had signed the form for consent to use photographs, but had not signed the care plan itself.

Residents' meetings took place which gave people an opportunity to become involved in the running of the home. Seven people had attended the most recent meeting held on 6 February 2016. The topics discussed were: What would you like to do in the home? How is your life in the home? Do you like the food here? What improvements would you like to see? Would you like to go on any trips? We saw from the minutes that those

people who attended the meeting were able to make a variety of suggestions, some of them practical such as asking for help with shopping. This meant that if people could attend and wanted to attend such meetings, they could be involved in decisions about day to day life at Yew Tree Manor. There were also meetings for relatives to attend.

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. We discussed this with the registered manager and the deputy manager. They told us that since the last inspection a specialist in end of life care based in Wythenshawe Hospital had delivered end of life training to the management team and then to all care staff. They described a genuine dilemma that sometimes arose about whether a particular health condition meant that someone had to go to hospital. We saw that a doctor had written on one person's 'patient review proforma': "They are only for hospital admission should they deteriorate with an acutely reversible event, otherwise they are for end of life care at Yew Tree Manor nursing home." This instruction ought to assist the home to decide when people nearing the end of life should go to hospital.

Prior to the inspection we had received information about an event where a family's wishes were not carried out. There had been a family meeting some months earlier, where it was decided that the person, who was at end stage dementia, should not attend hospital. This was recorded on a proforma from the Nursing Home Team. In March 2016 paramedics were called but the proforma was not made available and the person was admitted to hospital. The closest family member was very upset and raised a complaint. In the event the person only stayed in hospital one day and returned to Yew Tree Manor where they were given palliative care and died eight days later. This was the result of poor communication, because the documentation was not made available at the right time. A nurse from the Nursing Home Team told us of a similar example where an advanced care plan had been written stating that the person should not go into hospital, but they had been sent in nine days later. In their opinion the person should not have gone into hospital.

We saw an inconsistency in end of life care plans. One was purely related to clinical needs, specifying the end of life drugs that were available. It did not include any personalised information about where the person wanted to die, or visitors or any wishes. By contrast someone else's plan did include such information, including the name and phone number of the priest they wanted to officiate at their funeral.

We concluded that Yew Tree Manor had taken some steps, while there was further work to be done to improve its ability to meet the wishes of those people and their families who wanted to end their days within the home.

Good

Is the service responsive?

Our findings

At our last inspection we had found that care plans did not always include enough information about people. We found that some significant events had not been recorded which meant that the care plans were not up to date. There was also not enough personal information about people's history, and their likes and dislikes, to enable new staff or agency staff to gain a full picture of someone in order to deliver personalised care.

In their action plan following the breach at the last inspection the provider stated that all care plans were being reviewed and rewritten to reflect the individual needs of people living in the home. There would be monthly reviews which would record any changes in needs. Staff would receive refresher training in care plan writing. There would also be monthly audits to check the system was working.

At this 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). There was a form with essential details completed in case the person needed to go to hospital. A document entitled "All about me" gave detailed information about the person's history. On one care file this document was not present. The document enabled staff to have an idea about the person's background and potentially to engage them in conversation about their interests.

There was a full range of care plans completed on each file. 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. We saw that the plans were amended to include any changes in a person's needs. We saw there was a monthly care plan review form, as had been promised in the action plan, which summarised changes to the care plans. This was in a useful format because it enabled staff, or visiting professionals, to see at a glance which plans had been changed. The form included the date of the next monthly review which would help ensure the reviews were completed. There was a similar review form for the risk assessments on the file. These included a dementia risk assessment, although it was generalised and involved only tick boxes. In the file of one person this risk assessment had not been completed, even though the person was described as living with dementia.

We considered that sufficient improvements had been made to remedy the breach of regulation in respect of care plans at the last inspection, but that vigilance was required to maintain the standard.

We saw an example of staff responding thoughtfully to an individual's wishes. One person asked if the care worker could contact their relative to ask if they could take them to the local cemetery to visit their spouse's grave. The staff member came back after a while to say they had tried to contact the relative on the telephone but there was no answer and they would try again later. We saw the relative visited later in the day.

We learnt that Yew Tree Manor had previously recruited two activities organisers, but only one remained in

post, who worked only at weekends. However, a new full time activities organiser had just been appointed and was about to start their induction the day after our inspection finished. There was an activities calendar which listed different activities for each day of the week.

We saw there were a limited number of activities available. As on our previous visit the television was on in both lounges but people did not appear to be watching it. During our observation in the morning in the main lounge we saw care workers walking through and asking people "Are you okay?" but that was the extent of the interaction. There was little stimulation and lots of people were having naps. All the people we spoke with said there was little to do. We did observe some people playing dominoes with a staff member, and some other board games taking place in the afternoon. The person playing dominoes told us they enjoyed playing but could only play when the staff had time to play. They commented "the staff are often very busy and don't have the time." They added, "I hate just sitting around, nothing to do, bored." A few people said they read the books available but there was no library to choose from. One person wanted a specific newspaper a couple of times a week and had been asking, but said that no one came in to deliver newspapers and it had not happened. Another person who was in the home on respite had their laptop with them and told us the staff had supported them in trying to get the Wifi working. Another person told us that they had been out twice with the activities organiser who worked at weekends to the local shops.

We spoke with a member of staff who told us they understood the value of activities. They said they went out of their way to engage with everyone living in the home, even if it was just to stop for a minute of two for a conversation. They said this was especially important for people who stayed in their rooms. They added they thought people would benefit from more outdoors activities. There had been a couple of trips the previous year. Yew Tree Manor did have the benefit of an attractive garden which was used in the summer, with gazebos to protect people from the sun.

We met a Quality and Review Officer from Manchester City Council who was conducting a review of activities and other aspects of the home. They praised the work of the former activities organiser who had left, and expressed hope that the new one would be as good.

People we spoke with said that if they wanted to complain they would know who to complain to, but they had nothing to complain about. In our last report we found a breach relating to the failure to record and respond to all complaints received by the home. On this occasion 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. Since their appointment in February 2016 the deputy manager had replied to complaints in writing, and we considered that their letters showed that complaints were taken seriously, and apologies were made when appropriate. We asked whether lessons were learned from the complaints. In one example the complaint revolved around an extra charge made for 1:1 support. The registered manager told us this had been agreed orally, and the learning from the complaint was to ensure that all such agreements would in future be made in writing.

Requires Improvement

Is the service well-led?

Our findings

As was mentioned earlier, the service had appropriate policies to protect people from abuse and to deal with any allegations of abuse. However, a social worker had raised questions about whether the policies were readily available to staff. In the staff room they had been unable to locate any safeguarding information, such as posters, flow charts, useful telephone numbers or policy documents for staff to read.

Concerns had been raised with us by social workers and other officers within Manchester City Council that Yew Tree Manor was not always applying these policies or managing safeguarding allegations effectively. In particular, there had been an alleged assault by one person living in the home against another. The nurse in charge had not realised the seriousness of the allegation and had not immediately reported it to the police, a failure which the police stated had prevented them obtaining potentially significant evidence. The registered manager was criticised for failing to keep a complete record of actions she had taken following the incident. She had reported the nurse's actions in a phone call to the Nursing and Midwifery Council (NMC) but had not kept a record of the date of the phone call or of the information given to the NMC. She told us that she was advised on the phone that the matter could be dealt with internally, but there was no written record of that advice and it was unclear on what basis it had been given. A safeguarding lead nurse in Manchester City Council advised the registered manager to use the online written form to report future incidents to the NMC in order to preserve a record of the information provided. The registered manager told us she accepted this advice and would ensure she created written records in future.

We saw records of the registered manager's investigation and disciplinary action which had been taken against the nurse in question. This included a final written warning which would stay in place for three months. The nurse was also to undergo a programme of training and supervision monitored by the clinical lead. We saw the records of the sessions that had taken place, which were designed to be supportive of the nurse.

We had been informed of concerns among officers of Manchester City Council that there had not been a full investigation of the event and the response to it. The initial notification to CQC had lacked detail of the allegation. The registered manager showed us the record of an 'investigatory meeting' between herself and the nurse a few days after the event. We considered that the investigation could have been more effective. For example, in the record of the meeting the nurse stated "As soon as I was informed by care staff", without apparently being asked what the care staff had actually said, which was critical to the investigation. Nevertheless, there had at least been an investigation by the registered manager and the sanction imposed on the nurse reflected the seriousness of the allegation.

When we discussed this with the registered manager, she attempted to minimise the seriousness of the events by stating that the victim of the assault had not made the precise allegation which formed the basis of the police investigation and safeguarding meetings. This claim by the registered manager was not supported by the police reports of their interview with the victim the day after the alleged assault, nor by the registered manager's own record of her investigatory meeting with the nurse. The registered manager appeared when talking with us not to acknowledge the significance of the alleged incident. The disciplinary

action taken against the nurse indicated that at that stage the incident had been taken seriously.

The failure of the nurse to report the incident immediately shows that its significance was not appreciated initially. The subsequent failure to keep a full record of the investigation indicated 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 a breach of Regulation 13(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that deficiencies in the internal audit systems constituted a breach of the relevant Regulation. This time we found some improvement in the audits. There was a range of audits in place. These included a monthly weight loss audit which checked recorded weights to identify any significant reductions. We saw this had been completed monthly although the April 2016 audit did not state which day of the month it had been done. Care plan audits were conducted on four care plans each month. These audits were a series of statements with space for comments, although in most places they had only been ticked. There was a social activities audit which included questions about the environment for people living with dementia.

A new detailed medication audit had been devised and we saw two completed audits carried out by the deputy manager. These were thorough and encompassed all aspects of medicines administration, including receipt, storage, record keeping, controlled drugs, training and communication. The deputy manager told us they were aware of the issue of inadequate PRN protocols, which we identified as continuing from the previous inspection, but it was not clear whether this had been picked up by their audit. A different medication audit had also been carried out by the registered manager in April 2016. We asked why they had conducted two audits a day apart, and they told us they were trying out the new one to compare it with the old.

There was also a kitchen audit, and an infection control audit in March 2016. A supervision audit checked on supervisions and spot checks conducted in the previous month. A pressure sore audit had been completed for a person in the home who was susceptible to pressure ulcers developing. We commented in our last inspection report that such audits should be conducted more widely as a preventative measure and not only for people already identified as vulnerable to pressure ulcers.

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 three days. The provider had commented on the use of agency staff, which they said the registered manager was trying to reduce. They also stated they wanted to improve the physical environment of the home. These comments showed that the visits were carried out with a critical eye which led to improvements being identified. The audit system had therefore improved but relied on the managers carrying out the audits effectively.

Prior to our inspection we were aware of some criticisms of the registered manager's leadership of Yew Tree Manor. We spoke with visiting professionals who also expressed some concerns. One stated, "Communication is a big issue. We often go over the same issues again and again." They expressed a concern that some people had been admitted to the home whose behaviour staff were not adequately trained to deal with. Another visiting professional said that some of the staff were very good, but "You don't feel like you have trust in the overseeing eye."

We saw that the introduction of a new deputy manager in February 2016 had made a difference. The responsibility was being shared. We saw evidence of good teamwork and sharing of ideas. Both managers

expressed confidence in the other person and said they worked well together. We perceived there was less pressure on the registered manager than there had been in previous inspections. We also saw that other changes introduced since the last inspection had improved staff morale, in particular the new role of senior care workers in administering medicines to people receiving residential care. This meant that nurses had more time available to manage their shift and deal with people's nursing needs.

Two visitors told us they had noticed a positive improvement since the arrival of the deputy manager and felt they were good at encouraging and supporting the staff. They added that they thought the teamwork among staff was a strong point, because when two staff came in to provide personal care to their relative they worked very well together. Their one criticism was that they had received some phone calls about their relative's health from a nurse whose spoken English was very difficult to understand. We ourselves heard several staff speaking whose accents were strong. At the staff meeting on 17 February 2016 staff had been instructed to speak only in English when with people living in the home, suggesting this had been an issue before then.

We saw minutes of the staff meeting held on 17 February 2016. They took place every three months. Ten care staff out of 27 had attended along with the provider, registered manager and deputy manager. We had commented in our last report that the meeting appeared to be a list of things staff should do or not do. This was still the case, although staff views on a number of items were recorded this time. There remained an opportunity for staff to contribute their ideas to the agenda about how the home could be improved. We also obtained minutes of meetings with nurses, which had discussed the changes to the medicines round which we saw had now been implemented.

Meetings were held with relatives of people living in the home. The record of the meeting held in February 2016 showed that relatives had the opportunity to raise questions about individuals. There had been a questionnaire to family members issued in January 2016 but only two questionnaires had been returned which was too small a sample to draw conclusions. More results had been obtained from a survey of people living in the home, where three out of seven people expressed the desire for more activities. The provider had responded with the plan to recruit a new activities organiser.

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 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not always meet their needs. Regulation 9(1)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that the premises were safe to use, because an alarm on a fire door had not been operative. Regulation 12(1) and 12(2)(d) Risks of developing pressure ulcers had not been correctly identified and professional help was not summoned in a timely way. Regulation 12(1) and 12(2)(b) Risks to people's health from rapid weight loss were not always assessed and mitigated. Regulation 12(1) and 12(2)(a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The systems and processes to investigate allegations of abuse were not always operating effectively. Regulation 13(3)