Mr Michael Discombe

Yew Tree House Residential Care Home for the Elderly

Inspection report

9 Station Road
Headcorn
Ashford
Kent
TN27 9SB

Tel: 01622890112
Website: www.yewtree-carehome.co.uk

Date of inspection visit:
03 February 2016
05 February 2016

Date of publication:
13 April 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Say when the inspection took place and whether the inspection was announced or unannounced. Where relevant, describe any breaches of legal requirements at your last inspection, and if so whether improvements have been made to meet the relevant requirement(s).

Provide a brief overview of the service (e.g. Type of care provided, size, facilities, number of people using it, whether there is or should be a registered manager etc).

N.B. If there is or should be a registered manager include this statement to describe what a registered manager is:

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

Give a summary of your findings for the service, highlighting what the service does well and drawing attention to areas where improvements could be made. Where a breach of regulation has been identified, summarise, in plain English, how the provider was not meeting the requirements of the law and state 'You can see what action we told the provider to take at the back of the full version of the report.' Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work at there.

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

Improvements were needed to recruitment procedures to ensure documentation about staff met legal requirements. Confirmation was required that outstanding works to the electrical installation had been completed. Fire procedures were sometimes compromised by the use of door stops.

Medicines were managed safely but boxed medicines needed to also be dated upon opening. There were enough staff to support people.

Staff understood how to protect people from harm and emergency procedures were in place. Risks were appropriately managed.

Is the service effective?

Good

The service was effective

Staff received suitable induction and training to ensure they knew how to support people safely.

People made choices and decisions for themselves and staff ensured people were supported in line with the principles of the Mental capacity Act 2005.

Staff consulted people about what they ate and monitored their health and wellbeing.

Is the service caring?

Good

The service was caring.

Staff practices respected people's privacy and dignity. Staff were kind caring and thoughtful. People were given the opportunity to spend time on their own or with staff and others.

People were supported and encouraged to maintain their independence. People were supported to personalise their own space with their possessions.

Relatives said they were kept informed and always made to feel welcome at any time. Staff knowledge and experience enabled them to support people to the end of their life.

Is the service responsive?

Good

The service was responsive.

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

People were assessed prior to coming to stay in the service. They and their relatives said they were consulted about their care needs and care plans were developed to guide staff.

People enjoyed the relaxed and quiet atmosphere of the service and their ability to choose to participate in activities or not.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Some audits of service quality had been developed but were not effective to identify some shortfalls from inspection.

Improvements were needed to the recording of meetings for reference purposes and to the analysis and feedback of people and their relative's views about the service.

Policies and procedures were in place and kept under review. There was good partnership working with health professionals to ensure practice was updated and people received the right support they needed.

Yew Tree House Residential Care Home for the Elderly

Detailed findings

Background to this inspection

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

This inspection took place on 3 and 5 February 2016 and was unannounced The inspection was conducted by one inspector.

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

At inspection we met and spoke with seven of the people that lived in the service. We observed how they interacted with each other and with staff. We observed staff carrying out their duties and how they communicated and interacted with each other and the people they supported. We met two visitors at inspection who spoke positively about the service.

Not everyone could tell us about their experience of living at the service, so we used the strategic Short Observational Framework for Inspection (SOFI); SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with the registered manager, the provider, a shift leader two care staff and a cook. After the inspection we contacted and received feedback from eight relatives and two health professionals who have

regular contact with the service.

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

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and liked living in the service. They said staff were kind and caring. Comments from relatives were "Always clean and tidy". Another said "Good continuity of staff". A third commented "The garden could be better it has the potential to be nice". A fourth relative told us "It's just a little house really, a home from home".

Staff recruitment procedures did not ensure that all information required by legislation about new staff was in place. Important checks such as criminal record checks through the Disclosure and Barring Service (DBS), conduct in employment and character references, evidence of personal identity were all in place in accordance with legislation but health statements as to the fitness of new staff to undertake their role had not been completed and one record was also without a current photograph of the staff member.

The failure to ensure that staff records comply with regulation is a breach of regulation 19 (3) (a) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The environment was small and intimate; people and relatives said they liked the homelike feel of the service. It was kept clean. Maintenance issues within the service were reported by staff and the maintenance book showed these were addressed within the premises itself within reasonable timescales. Checks and servicing of equipment including fire, gas and electrical installations were undertaken, however, the registered manager was unable to evidence that recommended remedial works for the electrical installation had been completed and this could place people at risk. Fire procedures and a fire risk assessment were in place but these could be compromised by the routine use of door stops on some bedroom doors, whilst this was in accordance with the wishes of the people in those rooms safer alternatives that comply with fire regulations and do not compromise fire safety are available and should be sourced and discussed with the fire service if necessary.

The failure to ensure outstanding recommended remedial works have been completed satisfactorily, and that fire procedures are adhered to could place people at risk and this is a breach of Regulation 15 of the Health and Social care Act 2008 (Regulated Activities) 2014.

In addition to regular servicing the registered manager ensured that weekly and monthly visual checks and tests of fire equipment were completed. Staff received fire training and attended fire drills; fire doors and fire escape routes were also routinely checked. Individual personal emergency evacuation procedures (PEEPS) were in place for each person and the registered manager was confident that at the present time all of the people on the first floor could use the staircase in an emergency, the staircase however, has only one handrail and people may be at risk in an emergency situation of not having adequate support on the stairs; this is an area for improvement.

At the time of inspection the registered manager's office had been moved to an external office in the garden and works for this were completed by the end of our inspection. The garden was currently off limits due to these building works but plans for landscaping the garden were to be implemented once the office move

was complete; relatives thought this would positively benefit the quality of life for their family members many of whom had previously enjoyed being outdoors in their own gardens.

Staff had received training to understand safeguarding and understood their responsibilities to protect the people in their care, in discussion they demonstrated confidence that they would be able to recognise abuse in all its forms and raise concerns with their senior carer, registered manager or the provider. They found the provider and registered manager approachable and felt they would be able to raise concerns about the conduct of other staff if necessary under the whistleblowing policy, they felt that they would be protected and their concerns acted upon. Staff understood and knew of the other agencies they could report concerns to if this became necessary.

There were enough staff on duty to meet people's needs. The registered manager completed a dependency tool for each person when they were admitted to the service; this was reviewed monthly with the care plan and risk information. At present people were mobile and relatively fit; no one required the support of two staff as many people were still independent with some of their personal care activities. People thought there were enough staff around and that it was not an issue to get support if they needed it; they had call bells to alert staff. Staff thought that staffing levels were enough for the dependency of people and size of the home. During those times when people needed more support, for example, getting up and going to bed, additional staff were rostered onto shift to help.

At night there was one waking night staff and the sleep in was provided by the provider who lived in an adjacent building and could be called by telephone to come over to the main house. We spoke with staff who had undertaken night shifts, they said there was little activity at night and the present arrangements worked well. At times when the provider was not available another member of staff covered this; a fold up bed was used for staff as the home was without the space to provide a sleep in area for staff.

Medicines were managed well. Only trained staff that had completed an intensive 14 week training course were able to administer. The registered manager took responsibility for ordering and booking in received medicines; they also ensured that unused medicines were returned to the pharmacy. The service did not maintain a large stock of medicines; medicines were provided in pre packed dosage system on a monthly basis. A medicine trolley was used and this was kept securely in a cupboard when not in use; when we checked this was clean and tidy. Medicines Administration Records (MAR) were well completed and contained photographs of each person so that the right medicines were given to the right person. Allergies were noted and a medicine profile was in place detailing what medicine each person took, what they were taken for and any possible side effects staff needed to be aware of. Some oral medicines were provided individually in boxed and bottled packaging and bottled medicines were dated upon opening, this had however, been extended to boxed medication; this is considered to be good practice and is an area for improvement.

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

We recommend that the provider seek assessment and guidance from occupational therapy professionals as to whether a second handrail on the opposite side of the staircase would provide better support for

people using this means of escape in an emergency and for general safety in everyday use.

We recommend that good practice in accordance with NICE guidance in regard to the dating of medicines upon opening be extended to boxed medicines.

Good

Is the service effective?

Our findings

People said they felt well support by staff. They said they enjoyed the food and were asked about what they would like to eat. They said staff called the doctor for them when they were unwell "I had a cough and they called the doctor in ". Relatives told us "They love the food its home cooked", She is always clean and well fed and they always ensure she goes to the GP if needed", "They worked well to overcome her depression and self-neglect". Health professionals commented that they found staff to be "active participants" at training, and "the manager and staff welcoming and responsive to suggestions and advice". Another health professional said of the registered manager and staff "they respond quickly to any unexpected deterioration in a patient, including identifying potential pressure sores, and respond to nursing instruction with regards to appropriate pressure relieving equipment and treatment."

At the previous inspection we raised concerns that staff were not receiving the training and supervision necessary to provide them with the skills and knowledge to support people appropriately. The provider and registered manager had made significant progress into the previous shortfalls and were able to evidence further training booked for the coming year. This remains an area for ongoing improvement and we would recommend that the current momentum around training continues so that shortfalls do not emerge again.

The service had been more successful in promoting the take up of nationally recognised care qualifications with sixty percent of the staff team qualified to level 2 or more in care. The service was also facilitating the completion of more intensive distance learning training courses that were marked by external assessors and covered the subjects in more depth than one day courses to provide staff with a broader understanding of these subjects. The registered manager also took up the offer of training offered by health professionals and the staff recently completed training in how to recognise and respond to changes in people's skin integrity.

There was a low turnover of staff and new staff employed were already experienced carers. The registered manager understood that future staff that may not be experienced or qualified in care would be required to complete a nationally recognised induction programme called the Care Certificate. The Care Certificate was introduced in April 2015 by Skills for Care. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life. The registered manager had researched what would be required and had workbooks in readiness for any new staff employed who met the criteria for completing this induction. Experienced staff who were employed were given an introduction and orientation to the service that enabled them to shadow other staff for a short period and to familiarise their selves to the routines of the service and peoples individual care needs.
Staff told us that they were supported through individual one to one meetings and annual appraisals of their work performance. These meetings provided opportunities for staff to discuss their performance, development and training needs. The registered manager or deputy were always available, and staff felt able to approach them at any time if there were issues they wished to discuss.

Eight out of 14 staff had received training in the Mental Capacity Act 2005 (MCA), and these same staff were now completing a more in depth distance learning course covering mental capacity and Deprivation of Liberty. The MCA provides a legal framework for acting and making decisions on behalf of people who lack

the mental capacity to make particular decisions for their selves. People told us that staff always asked them if they wanted support for their everyday care and support needs. In discussion staff showed that they understood that more complex decision making when people lacked capacity needed to be decided with the involvement of relatives and representatives; that any decision would be made in the persons best interest. The registered manager completed a mental capacity assessment and Deprivation of Liberty (DoLS) checklist for every person upon admission to the service and this was kept under review. At the present time the registered manager had not assessed anyone in the service as meeting the criteria for a DoLS authorisation; following discussion and reflection around this area the registered manager thought that one person might be moving towards requiring a DoLS, and would keep this under review.

The service had a no restraint policy. They operated an open door policy with no restrictions on people leaving the service if they chose to go out; those with failing mobility, however, were encouraged to leave in the company of staff for their own protection. Care plans made clear peoples individual emotional expressions of behaviour and this helped staff understand the behaviour and the simple strategies they should use to de-escalate this to keep everyone safe.

Staff supported people with their health appointments. People were given a choice of where they received their optical, dental and chiropody care as this could be provided at the service by visiting professionals. People were referred to health care professionals based on their individual needs. Staff were vigilant in checking people's wellbeing and whether there was an emerging health related need. People's weights were taken on a regular basis and any weight loss was alerted to senior staff. Peoples at risk for example, of falls, or pressure ulcers were assessed and procedures and equipment implemented to reduce the risk of harm occurring. Relatives said they felt happy that their family members health needs were attended to.

No one required a specialised diet and nobody was identified at risk of poor nutrition. We spoke with the cook who had an understanding of people's individual dietary preferences, and incorporated people's preferences into the main menu. Menus were developed from an understanding of people's likes and dislikes gathered when they were admitted to the service and from changes requested by them directly to the cook who was accessible to them. The menus seen varied over a three week period but the cook said there was flexibility within the menu each week for meals to be moved around or altered slightly to take account of feedback from people on the day about what they wanted. People were provided with two choices of main meal and dessert, with a range of choices for the supper menu. Menus were not displayed as people were individually asked each morning what they wanted for lunch from the choice offered, alternatives could be provided if the choices were not to peoples liking.

People said they liked the food and there was plenty of it, they confirmed they had a choice of two different dishes each day, and also of where they chose to eat their meals; the registered manager and staff encouraged people to meet together in the dining room each day, to reduce isolation and foster friendships and conversation. Due to building works this was off limits at the time of inspection; people were eating in their rooms or in the main lounge with tray tables. No one was upset by this, and everyone understood what was going on and why this was happening.

We recommend that the provider in accordance with nationally recognised guidance in regard to the frequency of training staff continues and builds on the present programme of training updates.

Good

Is the service caring?

Our findings

People told us they found staff to be kind and helpful. Several explained why they liked living in the service one said "They (staff) always pop their head round the door at night to check I am alright", another said "I feel happy here it's not like home but like the peace and quiet here", a third told us "I used to come here for a bath for day care, I wasn't happy at home". A relative told us "The location suits her, she has always lived in the village, we are very lucky to have this service", another said "the manager discussed my relatives end of life care needs and support with me and we looked at the options together, they could not have done a better job, the manager went above and beyond the call of duty to come in and sit with him on her time off". Other relatives told us "Staff really care; it's not like their job." "We are kept informed of the important things, I have observed staff sitting and chatting to people", another said "I often find a staff member sitting in with my relative talking." "She is always well dressed with her jewellery on", "It's the only place she would ever be happy."

The premises was small and homelike with lots of ornaments, pictures, cushions and foot stools. People had been able to personalise their rooms with small items of furniture and possessions. People were well groomed and staff took pride in ensuring people looked how they would wish with co-ordinated clothes, make up for those who still wished to use this and jewellery and accessories. Some people told us that staff painted their nails for them when they wanted it.

People described staff as caring, friendly, thoughtful and kind. Some people referred to them as 'good girls' who were willing to do anything for you. One person said "they make mistakes like everyone else, they are not perfect, they are people not robots and they have families and pressures outside of work as well as doing a difficult job". Staff showed they had a good rapport with the people they supported and we saw and heard many examples of positive light hearted and affectionate interactions from staff towards people. We also observed some patient and gentle interactions between people.

The atmosphere in the service was relaxed and quiet; people respected each other's privacy even though people chose to have their room doors wide open. Support offered by staff was discreet to maintain people's privacy and dignity. Staff were always in evidence and although people had call bells to hand and these were heard on occasion, such was the small intimate nature of the service that these were not heard often throughout the inspection days, as people either chose to get up and seek out staff if they wanted something or got their attention whilst they were passing.

The registered manager told us that all the people in the service either came from the village or their relatives did, consequently there was a regular flow of visitors to the home from as early as 8.30 am and up to the evening. Some visitors brought their pet dogs to visit, and all were made welcome and offered refreshments. There was a real sense that this was very much a village resource, people spoke about coming here for day care when they were struggling to bathe at home, this gave them a taste of living in the home so when the time came they wanted to move here because it was still very much part of the village.

There was a flexible approach to dealing with issues, one person told us that when they originally came to

the home they had lived more independently in one of the flats on site, they recognised they were not utilising these facilities and wanted to move into the home, someone else in the home wanted to live a bit more independently so they agreed quite amicably to swop, but because the person required ground floor and not top floor accommodation this drove the move of the manager's office from the main house to a purpose built garden office. Another bed was freed up and enabled a new person to come into the home who had been waiting for some time. All parties were happy with this arrangement and felt satisfied that their particular needs had been met.

Some staff were undertaking an intensive training course on end of life care, the registered manager said they had been able to support several people up to their death with the support of health professionals and in line with peoples own wishes. The registered manager spoke about someone who passed away having had a 'good death' because the partnership between home staff and health staff worked seamlessly, with the right support always in place when the person needed it. The registered manager said that they had been advised of where to find an end of life plan template by health colleagues and would use this in future. They understood about the use of emergency medicines which were administered by health professionals. Staff felt confident of working with people at the end of their lives, and ensured that once they had passed their bodies were treated with respect and dignity until they left the premises.

Good

Is the service responsive?

Our findings

People told us that they felt staff understood their care and support needs and always asked them about the support they wanted. A health professional told us "Residents are encouraged to be as independent as they can be, but are well supported when assistance is required. It is a happy, friendly and caring home."

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

There was a pre-admission assessment process for people who had been referred to the service, a relative told us that they thought the home manager was very selective about who was admitted and told us that in the case of their relative that the registered manager had driven for several hours to meet and assess their relative before agreeing that their needs could be met by the service. Some people because of the emergency nature of their admission were without pre-admission assessments, but care plans were quickly developed to guide staff in the needs people had and how these were to be supported.

Care plans were personalised and looked at what people needed and wanted in the way of support to live their daily lives. Care plans addressed the individual support people needed around maintaining their personal care, social interaction, leisure interests, and night time support including continence management, Guidance was provided to staff around support needed in specialist areas for example a hearing aid plan, a sight plan, or what level of support a person required with the effects of early stage dementia. Care plans took account of what people thought they could do for themselves and what they needed assistance with. Staff told us that that any changes to a person's needs that they became aware of were discussed with the registered manager who amended the relevant parts of the care plans accordingly to ensure the right level of support was offered. The registered manager was very familiar with everyone's needs and took time each month to update their care plans consulting with the person and or their relatives as needed if significant changes in support had occurred. Each person had an annual review to which relatives and care managers were invited and this looked at whether the person's needs were continuing to be met at the service and whether additional support was needed to meet changing needs. Some relatives told us that they had seen the care plan for their family member and been consulted about it, other relatives said they felt informed about their relatives care and support and any changes made to this.

Some relatives worried that there was not enough for their relative to do but when we asked some of them what their relative had done prior to admission to the home they acknowledged this was similar to how they lived their life now, and knew also that their family member was likely to refuse to do activities. We met and spoke with most of the people living in the service and also spoke with a representative relative for nearly everyone. Concerns about activities and stimulation were not an issue raised by people in the service their selves, although a few admitted they were bored they did not hanker after structured activities but this was

more a sense of loss of independence and their home. Everyone enjoyed the relaxed and quiet atmosphere of the service. Several said they liked to sit in the garden seats at the front of the home because it faced the main road into the village and they liked to see people passing by. Three people went out each week to a day centre; other people had tried this but had decided not to continue. Other people with staff support were supported to go into the village and one or two took themselves to the village independently.

People said they liked being outdoors and looked forward to the updating of the rear garden so that in the summer they could spend time out there. When at home in the service staff played cards with people, or helped them with quizzes and crosswords, staff were able to spend time chatting to people, and a large puzzle was completed as a joint project by everyone who took turns adding one or two pieces when passing. There was a musical entertainment each month which most people enjoyed. Feedback from people currently living in the service indicated that a lack of structured entertainment was more an issue for relatives than for the people themselves. The registered manager acknowledged that this may well change as new people are admitted. Most people had regular contact with family, and visiting was flexible. People said they went out with relatives and enjoyed these times, people said they would prefer to be in their own homes but were realistic that this was no longer an option and for them this was the best alternative.

Requires Improvement

Is the service well-led?

Our findings

A relative told us "This is a very nice unique service, it's for the people in the village and there is a real sense of community." A health professional told us "The manager regularly attends the care home forum and will contact me if she needs to." Another told us "Yew Tree in Headcorn is a well-managed home where residents are well cared for, happy and stimulated."

At our last inspection we expressed concern at the lack of quality audits in place to provide assurance to the provider that the service was operating to a good standard. The provider is a visible presence around the service most days but there was a lack of evidence as to what the provider or registered manager checked to assure their selves that service quality was being maintained. Since then the registered manager has developed a small number of audits in respect of health and safety, fire checks, cleaning and medicines, but some of these had not been implemented effectively to identify the concerns highlighted in respect of fire procedures, whether an additional handrail was needed or recommended improvements needed to medicines. There were no other systems in place at present to effectively pick up operational shortfalls, for example the lack of required documentation in respect of staff recruitment files, or ensuring progress in training updates was being maintained. There was a failure to ensure that all aspects of the service could be audited and those audits which were in place were not implemented effectively to highlight shortfalls. This is a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager met with the provider each week, these meetings were largely informal get togethers to discuss minor issues within the service, and these were not always recorded. There was evidence that the provider and registered manager were now establishing regular formal meetings that would also provide opportunities for supervisory support for the registered manager and were recorded; recording of these meetings was still limited to bullet points and lacked sufficient detail of the level of discussion held and the decision making process to provide a reliable reference source for either the provider, registered manager or staff. A service development plan has been developed from these discussions but this would also benefit from the inclusion of clear timescales and reporting on progress to meet the identified development. Staff meetings were held but infrequently and not to any set pattern. Meetings were recorded and this showed that meetings were more often called in response to issues that had arisen or to pass on information to staff. Staff felt that the current frequency of staff meetings was enough; they said they were able to raise issues there if they wanted to. We discussed with the registered manager whether it would be of benefit to establish regular meeting dates and encourage staff to contribute to the agendas to increase their involvement and ownership of meetings and developments within the service and this is an area for improvement.

People were routinely surveyed for their views and although looked at by the registered manager for any comments or suggestions, no feedback was given back to people about what the surveys had told the provider and if as a result any suggested improvements had come out of this. Relatives were also surveyed, these also showed a high level of satisfaction about the delivery of service to their relatives, and their observations of staff practice. The registered manager was now analysing each individual survey and where

comments had been made was indicating the actions taken to address the comment made, again we discussed the importance of perhaps making relatives aware of how their feedback was used, and the manager agreed to look at how best to convey this information.

There was a failure to ensure that there was adequate recording of meetings between the provider and registered manager, at staff meetings and also in the analysis of surveys and the lack of feedback provided to people and relatives. This is a breach of Regulation 17 (2) (d) (e) of the health and Social care Act 2008 (Regulated Activities) 2014.

Policies and procedures were updated regularly by the registered manager; any significant changes were brought to the attention of staff who knew where policies were kept and could access these for reference if needed.

At our last inspection we were concerned that the provider and Registered manager had not notified the Care Quality Commission (CQC) appropriately of significant events in the service that they were required by regulation to tell us about and we had issued a requirement for them to take action to address this, which they have now done. They were now aware of what and when they needed to inform CQC of events that occurred and were doing so when the need arose.

The provider was a visible presence in the service and was on good terms with people and staff and familiar with their individual circumstances. The registered manager demonstrated knowledge and understanding of the needs of people living in the service and had a good grasp of dynamics within the staff team, working with some staff on an individual basis to get the best out of them.

The registered manager was a regular attender of the Care homes forum and health professionals spoke positively about her leadership and willingness to learn, and take advice from them to improve the quality of support they gave to people in their care.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The failure to ensure outstanding recommended remedial works have been completed satisfactorily, and that fire procedures are adhered to could place people at risk and this is a breach of Regulation 15 (b)(c)(d)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to ensure that all aspects of the service could be audited and those audits which were in place were not implemented effectively to highlight shortfalls. This is a breach of Regulation 17 (2) (a) There was a failure to ensure that there was adequate recording of meetings between the provider and registered manager, of staff meetings or of the analysis of surveys to provide feedback to people and their relatives. This is a breach of Regulation 17 (2) (d) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The failure to ensure that staff records comply with regulation is a breach of regulation 19 (3) (a)