Mr Michael Discombe

Yew Tree House Residential Care Home for the Elderly

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This was an unannounced inspection. Yew Tree House is a care home registered to provide care and support for up to 13 older people. The home is located at the end of the village high street and serves people in the local area and surrounding villages. The majority of people living there had capacity but were unable to cope with independent living and needed some additional support. A few people were living with the early stages of dementia but this did

Summary of findings

not as yet impact on their day to day quality of life. There were twelve people living in the home, including two people who occupied two ground floor flats in the grounds of the home, and who needed less staff support. The service had also started to offer on a limited basis day care to people in the village; this offered people company, an assisted bath if they wished and also a hot lunch.

There was registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Our observations, and feedback from people and their relatives, showed us that people were well cared for, and that they felt safe. People told us that they were happy with their choice of home and satisfied with the care and support they received from staff. People told us they felt well supported by staff and that they were always available.

The majority of people had capacity to make their own decisions, but staff were not aware of what actions they needed to take when this changed. No one was currently subject to a Deprivation of Liberty Safeguards (DoLS) authorisation but the manager and staff awareness of when an application should be made needed improvement, as they had not kept up to date with recent changes which widened and clarified the definition of a deprivation of liberty.

All essential care documentation was in place but this was not always well completed and minor changes in people's care needs might not be immediately recorded, this could impact on delivery of consistent care. The service could not always evidence that people consented to the support they received. People were supported to access healthcare at the home or in the community when they needed to.

A system for reviewing care records was not sufficiently robust to highlight these shortfalls. People were encouraged to maintain a level of independence for as long as they could and staff understood this could vary from day to day. People had little occupation and could become bored. There were no tailored activities to support people to continue with hobbies or activities that interested them.

Staff said they were provided with training but records showed updates of training were long overdue for some staff and this could place people at risk of experiencing support for their care needs that was not current or best practice. This is a breach of Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Staff told us how they would recognise and respond to abuse they were aware of the importance of disclosing concerns and were informed about the organisations whistleblowing policy. Most staff had received safeguarding training.

The registered manager had failed to notify CQC of some important events that happened to people at the home as required by the regulations. These were breaches of regulation 16 HSCA 2008 (Registration) Regulations 2009 Notification of death of service user, and also Regulation 18 HSCA 2008 (Registration) Regulations 2009 Notification of other incidents. You can see what action we told the provider to take at the back of the full version of this report.

We found that the processes used by the registered manager and provider to assess and monitor the quality of service quality were not used effectively and showed they were not monitoring some areas of service delivery and quality to ensure people were kept safe and all their needs were fully addressed. This was a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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 and improvements were needed.

People told us that they felt safe and staff told us about the practical steps they took to ensure people's safety.

The majority of people in the home had capacity. However, staff knowledge and understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) was basic, and they were unaware of the arrangements they needed to make when people needed help with decision making or the least restrictive measures needed to be made to keep people safe. Staff understood safeguarding and their reporting responsibilities.

Risks were assessed to ensure people remained safe but these were not always well completed and some risks could be overlooked. Policies and procedures to inform staff about how to manage emergencies were inadequate and fire records were not always completed.

Staff demonstrated an understanding of the processes for reporting accidents and incidents. Our observations and records viewed showed that medicines were managed safely. Safe recruitment practices were in place and pre-employment checks were made prior to staff commencing work.

Is the service effective?

Requires Improvement

The service was not always effective.

There was an experienced staff team who received essential training although this was not always kept updated in accordance with the provider and training body frequencies. And this was a breach of Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010.

No overall system was in place to monitor the performance of the manager or staff although staff met with the manager on a regular basis. New staff received an induction to ensure they had the right skills. Staff understood people's specific needs and their particular preferences about what they ate and drank. People told us they enjoyed the meals.

People were supported to access health care appointments and staff monitored their weights and general health involving relevant health professionals as required. Issues of concern were passed verbally to colleagues in handover meetings to ensure consistency in care, but were not always underpinned by changes to care plans and this could lead to some minor changes being overlooked initially.

Is the service caring?

Good

The service was caring.

Summary of findings

There was a welcoming culture in the service, and people spoke positively about how it felt like 'home' to them. Staff demonstrated compassion, kindness and thoughtfulness in their conversations with the people and their relatives. People could bring some pets to live with them, visitors could bring pets into the home and some of these were people's pets that had been rehomed with friends or relatives. People enjoyed these visits.

Staff had a good understanding of how to promote people's privacy and dignity and put this into practice. They showed sensitivity when engaging with people who did not know them and in their management of confidentiality issues.

Visitors were made welcome and relatives told us they felt that communication with them was good and they felt informed about their relative's care and any events that took place.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff took account of peoples preferences and diverse needs. People told us that they felt staff understood their needs and delivered care in accordance with their wishes. Other professionals told us they had no concerns about the service, and said people were well cared for and enabled to access the community and maintain a level of independence suited to their abilities.

Staff respected people's choices, and were able to spend time with them. People did not want structured activities, but more could be done to find things that might interest them individually or as a group. People were assessed before coming to live at the home so that the manager knew their needs could be met there. However, information gathered was not always completed and was brief and this could pose a risk that some needs might be overlooked and not met and this was an area the provider might wish to improve.

People and their relatives told us they were very happy with the service and knew about the complaints process. They said they felt able to approach staff with any concerns they might have.

Is the service well-led?

Requires Improvement

The service was not well led and improvements were needed.

People told us they felt able to discuss any concerns they might have with staff. They said that they were not actively asked for their views about the service on a regular basis, nor received feedback when they did, or were informed of what actions the provider had taken. Policies and procedures were in place but were not kept up to date to reflect current best practice to inform staff. Staff understood the procedures for responding to concerns, accidents and incidents but records of investigations of incidents were not always documented.

Summary of findings

The home had not routinely kept the Care Quality Commission informed of significant events as required by Regulation 16 & 18 of HSCA 2008 (Registration) regulations 2009. Some audits were in place but these were not adequate to provide assessment and monitoring of service quality to assure the provider and manager that all areas of the service were working well. This was a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010.

A written development plan showing planned investment and improvement of the service was not in place. However, people knew about the planned developments but were unclear what this might mean for them. Staff felt well supported by the manager and also felt listened to and able to raise issues. They understood whistleblowing processes and felt confident of approaching the manager. Staff understood accident and incident reporting procedures. Records showed investigation of these events however, was not always documented to evidence this had been completed thoroughly.

Yew Tree House Residential Care Home for the Elderly

Detailed findings

Background to this inspection

Before this inspection the provider was asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at other information we held about the home. This included notifications and complaints. We did not receive a completed PIR before we started our inspection but received this subsequently.

Because we did not receive a contact list prior to the inspection we have made contact with a range of other agencies, health and social care professionals such as the GP surgery, chiropodist, community nurse, care managers, fire service, safeguarding team and local authority commissioners to obtain their views about the home and inform our findings, but have received very little feedback to further inform this report. Those that have responded said they had no concerns.

We visited the home on 24 July 2014. This inspection was carried out by two inspectors and an expert by experience. An expert by experience was a person who has personal experience of using this type of care service; including knowledge and understanding of older people's care services and people with dementia.

We met and spoke with three care staff, a cook, the registered manager and the registered provider.

The Home was small and the atmosphere was welcoming. We were shown around the premises and viewed all communal and bedroom areas. We visited all the bedrooms which were well lit, bright and cheerful with room to move around and many personal possessions on display as well as small pieces of furniture.

People living in the home had capacity and were able to engage fully with the inspection process. We also spoke with three visitors who also commented positively about the Home and the care their relative or friend received.

During the inspection we looked a range of records including three care plans and associated risk information, staff rota's, staff recruitment , training and supervision files, records of safety checks and tests on equipment and gas and electrical installations. Medicine records, records of complaints and audits conducted by the registered manager. We spent time observing the care and support people received and their interactions with staff. During our inspection we also spoke with three relatives and 11 out of the 12 people living in the home.

At our last inspection in May 2013 we had not identified any problems with the Home.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, the inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They cannot be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is this safe' sections of this report.

Requires Improvement

Is the service safe?

Our findings

When we asked people they told us without exception that they felt the home was a safe environment, and they felt safe living there. Comments received were, "It is home from home but I don't have to worry about the cooking". "I come as a day visitor several times a week and I enjoy the company, I would be so lonely without this". Another comment was "I feel safe here and the staff do take care of me and have a chat with me" people said there were always staff they could talk to or ask things of.

We were informed that no one at the home was currently subject to a Deprivation of Liberty safeguards (DoLs) authorisation, (this is part of the Mental Capacity Act 2005 and ensures people can be given the care they need in the least restrictive regimes and prevents decisions being made without consultation that deprive vulnerable people of their liberty).

Only one staff record viewed showed that the staff member had attended a DoLs training course. Staff demonstrated a basic level of understanding of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards and the distinction between them, their knowledge was not supported by appropriate policy and procedure information for them to refer to for guidance. There was no awareness by the manager or staff of the recent changes to how DoLS was interpreted following a recent court ruling and whether this would change the status of people in the home and this should be reviewed.

Peoples care plans were personalised to reflect their specific needs and support requirements. Identified support needs had corresponding risk assessments. These identified any areas of risk such as people falling, and these were written in a way that ensured staff balanced risk reduction without overly reducing people's abilities and rights to take risks. However, minor shortfalls within the risk information were noted.

We found the use of a generic risk assessment template meant that in some examples seen the risk assessment although personalised to the individual had the wrong name left on it. This showed the risk assessment had been overwritten using another person's risk assessment. This practice could result in risk information becoming muddled between different people or risks being overlooked.

In another example risk information was not being used effectively we saw a risk assessment that made clear the person was at risk from not drinking enough and needed to be prompted to do so, however, there was no mechanism in place for monitoring the persons fluid intake thereby reducing the risk. We did however, observe staff reminding people to have plenty to drink and asking if people had taken drinks during our visit, we also saw that jugs of juice were placed where people could access them.

We saw that mental capacity assessments (these are assessment of a person's ability to make and understand the consequences of important and everyday decisions about their life) had been completed for some people in relation to specific decisions, for example their admission to the home. Staff told us that there were people with capacity who chose not to self-administer their own medicines and said there were others who would not be able to self-administer because they would not be able to complete all aspects of the administration process. However, consents and capacity assessments had not been completed to support these decisions.

There was a policy for emergencies and this informed staff what type of emergency they might experience with gas, electricity, or water supply problems, and provided them with emergency contact telephone numbers for these services. However the policy did not extend to informing staff what to do in the event that the operation of the home was severely affected and people needed to be evacuated to a place of safety. The provider may wish to consider making these arrangements clear to staff within the emergencies policy.

Fire records showed that there was a lack of fire drills and personal evacuation plans (these highlight whether people require specific support in an emergency to evacuate the building) for the people living in the home had not been completed.

There was no recording system for the reporting and monitoring of repairs. The present system was reliant on the provider and manager remembering what needed to be done. This meant that sometimes some minor repairs could take time to be addressed and made it difficult for the manager to monitor how long repairs were taking to complete.

Training records showed that staff had received safeguarding training. They demonstrated a good

Requires Improvement

Is the service safe?

understanding of safeguarding and the types of abuse people might experience. They showed awareness of the reporting process and said that although they would raise any concerns immediately with the registered manager, but also knew there were other agencies they could report abuse to including the police.

No one currently needed the use of an advocate but the manager understood how to access local services if needed.

The home did not support anyone whose expressed behaviour challenged others but some people experienced periods of anxiety. We observed one such instance and saw that the staff member present remained calm and engaged with the person in accordance with their support plan. Providing them with clear responses and explanations, and seeking to divert and distract them until they had calmed, protecting the person's dignity.

One person had taken the decision to request a 'Do not attempt resuscitation' (DNR) form. We saw this had been discussed with the person concerned and their relatives and was appropriately signed and dated. This meant that the person and their relative's wishes in regard to their end of life care had been listened to and taken into consideration. Staff were aware of end of life wishes and felt strongly that DNAR were a decision that should be made by the person themselves.

We asked staff what steps they took in their everyday work to make people feel safe. They told us some of the practical steps they took for example, ensuring people had slippers properly fitted, walking frames to hand, call bells in easy reach, and regular wellbeing checks.

Staff records showed that there was a safe recruitment system in place that ensured all necessary checks were undertaken before staff commenced work. A programme of training was in place but some essential training had not been updated in line with the providers preferred frequency of training update or the suggested cycle of updates by the training provider. This meant that not all staff were kept informed of current practice and this could impact on their delivery of safe appropriate care to the people in the home.

People told us there were always staff available to assist them. The manager was assessing staffing levels to ensure there were enough staff to meet people's needs and staffing rota's confirmed this.

Appropriate systems were in place for the ordering, receipt, storage, administration and Disposal of medicines. Only care staff that had completed an advanced 14 week medicine course were able to administer medicines. Although there were appropriate systems for the ordering, receipt, administration, recording and disposal of medicines, it was unclear in the absence of the registered manager who would fulfil the ordering, receipt and disposal of medicines role and this needed to be clarified within the staff structure. The manager said she sought advice from the pharmacist with medicine issues but these contacts were not recorded for medicine audit purposes.

One person self-administered their medicines and they were monitored taking these by staff. We spoke to the person concerned who confirmed they were responsible for some of their medicines and was happy with this arrangement. A risk assessment was in place for this to ensure they were taken safely.

Requires Improvement

Is the service effective?

Our findings

We saw that staff had good relationships with all the people in the home and were able to tell us a little about their diverse needs. People told us that staff helped them to access healthcare appointments,

Most of the staff team were experienced and had worked for some time at the home. We saw that for a newer staff member an induction programme was in place, and the staff member told us that when they first commenced work they been additional to the staff rota. This had given them time to read policy and procedure information and learn about the routines of the home and peoples care support needs. They said that during this time they had also shadowed other experienced staff, which was helpful in understanding the way people preferred to be supported. The manager said that staff induction was tailored to the individual level of experience and knowledge of the new staff member. For example, for another new and inexperienced staff member the manager told us that she was concentrating the allocation of training resources on them because they had not previously worked in care.

Staff records showed that they received training in essential areas for example, fire, food hygiene, moving and handling, infection control, medicines management, first aid and safeguarding, However, there was not a robust system in place to ensure that staff training was kept updated when it became due in line with the suggested frequency of updates by the provider and also by the training body. This could place people at risk of receiving inappropriate or outdated support and is a breach of Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010.

Staff told us that they found the registered manager approachable and could ask to speak with them in private at any time. Formal supervision sessions with the registered manager were scheduled for each staff member. A yearly plan was in place for these. There was also evidence that the manager undertook direct observation of staff practice from time to time to ensure they were supporting people appropriately, but staff did not receive annual performance appraisals to consider their overall performance and areas for development.

The manager met regularly with the provider but no record of these discussions was made, and the provider may wish to consider doing so in order to monitor actions taken in response to issues raised.

The cook told us that she had completed an advanced level food hygiene and nutrition course upon commencing her employment there. Kitchen staff were seen to respect the privacy of people they were taking drinks to, knocking on their doors before receiving permission to enter and offering drink choices. This showed that there was a culture throughout the staff team of respect for people's privacy, dignity and the right to make choices.

The cook knew all the people in the home and had come to understand their individual preferences and dietary requirements. Menus were developed on a weekly basis; this took account of seasonal changes and was not repetitious for people. People were given time to make their meal choices for the next day and decided where they wanted to eat their meal. The food provided was enjoyed by everyone we spoke with. Staff said that the hot weather meant they were particularly vigilant to ensure people who needed to be were drinking enough. The provider ensured that the people who lived in the two supported flats had food items they requested such as fresh milk and this enabled them to maintain a level of independence in when and what they ate and drank.

Staff told us that they participated in staff handovers at the end of each shift, and we saw completed handover records. Although information within these was sparse staff also maintained daily reports for each person and entries were made after every shift. This detailed the care delivered to people during the course of the day and reported on the person's mood or state of health, appointments undertaken or visitors seen. The manager told us that she used handover information and daily report information to inform changes to care plans.

Staff told us that they always asked people each day what support they might need as this could vary from day to day. Staff identified people who they felt needed more support, and said that if they suspected someone was struggling to maintain their own personal care, they would observe and intervene by suggesting they work together with the person or help them with aspects of their personal care if they preferred.

Requires Improvement

Is the service effective?

Health contact records showed that people were supported to access routine and specialist healthcare appointments. During our inspection a person was observed going to the doctor's surgery for a routine appointment accompanied by the registered manager. The registered manager told us that where able to every person was encouraged to access their doctor appointments at the surgery and was supported to do so. A chiropodist visited the home on a regular basis to attend to people's foot care needs. We were told that a visit from an optician was due soon.

In discussion some people said they had their own dentists but had not visited them for some time, but meant to do so. When we spoke with the manager she agreed there was a lack of clarity about who took responsibility for arranging these appointments and agreed to clarify this with people and their relatives who often provided transport so that routine checks could be established.

Good

Is the service caring?

Our findings

People and staff told us that the Home felt like 'home', and we saw many examples of kindness and care shown by staff towards people during our inspection. People said that staff respected their privacy and dignity. People were helped to maintain a community presence in the local village but there was a lack of social activities to alleviate boredom and social isolation. People told us they had no complaints but said if they did they would feel able to raise this with staff and the registered manager.

When we asked staff whether they referred to the people in the Home as residents, clients or service users, they were adamant that they would not refer to the people as anything other than by their preferred name. This was borne out during the inspection where no staff member was heard referring to anyone living in the Home other than by their name.

They also spoke positively about how much time they were able to spend with people and felt this gave them an opportunity to build relationships, and have a better understanding of what made them anxious.

Visitors were made welcome and relatives told us they felt that communication with them was good and they felt informed about their relative's care and any events that took place. Some people had been able to bring their pets to live with them; other people's pets were able to visit them at the service.

We observed and overheard some very good conversations between staff and the people in the home, and nonverbal exchanges such as shared smiles and nods of acknowledgement. Staff were heard and seen to demonstrate, kindness, thoughtfulness and compassion. The day of inspection was hot and staff were seen to ask people going out into the sun if they had sun cream on, wanted a hat or had ensured they were drinking plenty. Another person was offered a choc ice to cool down.

We asked staff how they thought they provided kind and compassionate care to people. They told us that they were always conscious of the tone of their voice and the language they used and also their body language to reassure people. Staff said they had time to ask people how they were, and about them and their day. One staff member told that she had lunch with a person the previous day as their usual visitor was away, this helped reassure the person. Staff told us that people more often than not requested their family's involvement in care decisions but it was their choice to do so. People, staff and visitors thought that communication was good between them.

We asked staff about how they ensured they maintained people's privacy and dignity when providing them with support. Staff spoke about people's preferred appearance and presentation and how they supported them to maintain this, even where they may have lost the capacity to undertake some aspects of this. For example, their preference for wearing make-up every day before they left their room, or ensuring they continued to have their hair dressed the same way they always liked to wear it. We saw that there were mirrors around the home for people to check their appearance. Inspection team members were introduced to people living in the home who were asked if they would like to speak to team members. Personal care giving support or assistance was undertaken discretely by staff.

There were locks on doors and we were told that people could have keys if they wanted them, however, staff said it was not 'that sort of house', it was very open, no one wandered into each other's bedrooms, people shut their doors and others respected that they wanted privacy.

Staff said they always talked with the people they were supporting, always closed doors when undertaking personal care and asked people what they could do for themselves and what they needed help with. If people were having a bath staff said they always ensured they were supported to dress fully before exiting the bathroom. Staff told us that they encouraged independence as much as possible and within the capability of people.

Staff said they were expected to know about every person's needs, and the service was small enough for them to do so. A staff member told us that in conversation with a person they had picked up some early history information, this was not recorded in the person's records but gave an important insight into their previous interests and skills. They said they would share this information at handover and in their daily report. This would inform the registered manager when updating care records. Staff demonstrated sensitivity in how they gathered information about people to inform care plans.

Staff showed an interest in the people they supported. We observed a staff member reminiscing with a person about a

Good

Is the service caring?

location they had both lived in and sharing stories about people they had known there. Another staff member said they had found out about different people's past careers and spoke to them about their experiences, all examples of care and respect for the individual.

Staff said they were mindful of people's confidentiality and took care not to draw attention to anyone by name when it was necessary to pass information to a colleague in shared areas.

Requires Improvement

Is the service responsive?

Our findings

People liked to sit in the garden although there was only seating provided at the front of the home. The registered provider was aware that people preferred to use this area and had provided a table to add to the seating so people could have their drinks there if they wanted to.

A visiting health professional told us “The clients within the home are all well cared for; independence is promoted within the patient's capability”, residents are often seen out and about in wheelchairs being pushed by care staff, or the more able ones being encouraged to get involved with the garden.” This showed us that the home was enabling people to access the community and maintain a level of independence suited to their abilities.

A staff member told us “We have open visiting here; visitors come in when they want and stay mostly for as long as they want, some bring in their dogs” “The latest I remember a visitor staying for a normal visit was 11 pm. This was because they wanted to see a special event on the television with their relative; they shared drinks and snacks and made a night of it.” There were no unreasonable restrictions on visiting and the one visitor we spoke with told us "We are so lucky she is here, it is more than a home from home," "We are kept informed if she has a fall". A person told us "I do go and sit in the garden if I feel like it" A second person said “the carer or manager sometimes takes me for a walk along the road to the shops".

At lunch time one person changed their mind when the lunch came out and asked for soup instead of roast beef. Staff responded quickly to this request and gave reassurance whilst the cook prepared a soup. This meant that the home was responsive to people’s needs and preferences. However, the provider may wish to consider making better use of the rear garden area so that more people could be accommodated and able to make use of the outside space.

A relative told us “There are no set activities but mum enjoys cards and puzzles. Everyone started to go to the local pub as a group for lunch which they said was going to be a regular thing once a month but it didn’t take off.”

The television was on and people came and went from the lounge, to walk around the home or sit in their bedrooms or the front garden. There was no planned activity taking place, and no activities information was displayed. When we spoke with the registered manager she confirmed that there were no organised activities now. Previously there had been activities such as bingo, and cards, but the existing group of people when asked had shown no interest in this type of activity. We were told that for this group of people the home staff concentrated more on getting them out during the week when possible and also in spending time with them to talk about things they were interested in, which they enjoyed. We saw that on some people’s care records there was evidence of trips out with staff to appointments and visits to the local high street.

Activities and stimulation were not issues particularly raised by people. When specifically asked however, people told us about things they liked to do, and were able to think about things that interested them. For example, we spoke with someone who moved in recently. They told us that prior to admission they had undertaken numerous tasks around their house that had kept them busy. They said they would still like to do something with their time and also enjoyed being in the garden. We discussed with the provider what opportunities there would be for people to help with the garden and they were open to the idea of people helping with for example, potting up flowers and plants. The provider said that designated staff hours for the garden would be utilised to also support those people who showed an interest in helping with growing seeds, and flowers and this would be looked into.

The pre-admission form for new referrals allowed for a range of detailed information and background history to be gathered, but the provider may wish to note that records showed these were incomplete and information was brief. This could pose a risk of the home not understanding fully the needs of people that were admitted and people not receiving the most appropriate care and support.

When we looked at people’s care records these were tailored to their personal needs and their preferences around support. A monthly evaluation of each care plan was also carried out. Records viewed were undated and we found some examples where minor changes to people’s support had not been added and there was a risk that some small changes to care needs could be overlooked. However, people told us they felt their care needs were attended to in accordance with their wishes and met their needs, they felt communication was good and felt comfortable about discussing things with staff if needed.

Requires Improvement

Is the service responsive?

They said if there was anything they wanted changed they would talk to staff about it. We discussed recording shortfalls with the manager who agreed to make changes to the review process.

Records showed that staff were responsive to more significant changes to people's needs. Action was taken to provide equipment or seek input from other health professionals to support care delivered. Our observations showed that staff treated people as individuals. For those people who needed more assistance than others staff provided this, for others who wanted their independence staff supported them with this.

We spoke with staff who were able to compare this home favourably against previous places of employment, and they spoke enthusiastically about how relaxed and 'home like' it was, and how much time they got to spend with people. One staff member explained how great it had been to be able to spend quality time with a person that morning sorting out their wardrobe and discussing with them what they wanted to do with clothing, or if they needed more. A new member of staff told us that she had seen care plans and was now finding out more about people as she worked with them and was encouraging them to talk about their past. She said this provided staff with a better understanding of the people they supported as individuals and how this could inform their support to them.

Many people had been assessed as needing walking frames to enable them to remain independently mobile, staff ensured these were located close to where people sat but not where they could cause a hazard. Other people were given the time they needed to do things for themselves.

A complaints procedure was displayed in the home for people to view. No complaints were recorded and the manager said she tried to respond quickly to people's concerns, so as not to escalate the problem. People told us on several occasions that there was no reason for complaint but if there was they did feel that they could talk to the registered manager or the registered provider about it. One person told us "the staff are lovely here, has anyone complained, because everyone takes care of us really well".

A visitor we met and spoke with told us that they had not felt the need to complain but knew how to and would feel confident of approaching the manager with a concern if they had one.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with and a visitor told us that they felt able to discuss the home with staff, so minor issues did not escalate and people did not worry about making comments to staff. People told us staff always tried to accommodate their wishes and commented "its home from home without the cooking" "It's more than home from home here (a visitor) "I'm very happy here I can do what I like".

All members of staff we spoke with enjoyed working at the Home. One told us "it is lovely to work here we don't have special people to look after so it really is teamwork". A second staff said that they felt that they would be listened to if they raised suggestions or ideas. A third told us "Everyone is treated as an individual and we learn so much about them"

We asked the provider and the registered manager what quality checks they undertook to assure themselves that the quality of care people received was good. The manager told us that she undertook a medication audit monthly, we looked at the latest audit but found this related only to quantities of medicines and was insufficiently robust to provide assurance that the process of medicine management in the home was satisfactory.

The manager told us that they also undertook a room risk assessment of everyone's bedroom and this was reviewed every month, We viewed examples of these and although these were meant to be personalised, the practice of overtyping other people's risk information meant one out of three viewed did not provide assurance that it was relevant to the person named. There was no monitoring of the quality of recording to pick up some of the shortfalls highlighted through this inspection. Apart from the quality checks highlighted there was no further evidence that an adequate and established system was in place for the assessment and monitoring of the quality of the home provided, to ensure people were protected against the risks of unsafe care. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Previously the home manager had notified the Care Quality Commission (CQC) appropriately in regard to any significant events. However, records showed that there had been a recent death of someone living at the home that had not been notified to CQC as required by legislation. In a separate incident a person had required urgent hospitalisation following a serious injury and this had also not been notified to the Care Quality Commission. These are breaches of Regulations 16 and 18 Health and Social Care Act 2008 (Registration) Regulations 2009.

A policies and procedure folder was in place and accessible to staff, in discussion staff understood where to find this and new staff said they had looked at this as part of their induction. There were a wide range of policies and these showed some evidence that they had been looked at annually. However we found the review process was not robust. For example, we saw a number of policies that still referred to predecessor commissions to the Care Quality Commission (CQC). Policy content was dated and lacked detail to inform staff practice, for example the medicine policy did not reflect on the procedure for ordering, and storage of medicines, or the procedure for self-administration by people in the Home. This meant that staff might not be working to current best practice or be supported by adequate guidance and showed that the manager was not ensuring that staff were kept updated.

There was a whistleblowing procedure in place and when we spoke with staff they confirmed they had read it and felt confident about approaching the manager directly with concerns or an outside agency if necessary. Staff felt that the registered manager 'has her finger on the pulse', and said that she was not afraid to 'get stuck in'. The example a staff member gave was "if a toilet needs cleaning she will clean it, if necessary, everyone knows her position and respects that but she is happy to work alongside you". A staff member told us "I feel more motivated here, maybe because it's a different set of challenges but also because there is good team and management support".

Staff showed that they understood the procedure for responding to and reporting accidents and incidents. Records showed that people experienced few accidents in the home. Staff used body maps appropriately to record injuries bruising or abrasions. However, the process of investigation of incidents and decisions regarding actions taken was not always well documented. For example a bruise on a lower arm was documented and dated but there was no evidence that the cause of this had been investigated or the reasons for not raising a safeguarding referral with the local safeguarding team were made clear.

Requires Improvement

Is the service well-led?

When we discussed this incident with the manager, we were satisfied that all necessary actions had been taken and a referral had not been needed, however the provider may find this an area they may wish to improve upon.

The registered manager told us that feedback surveys were sent out to people at the home and their families. We saw that survey returns were limited and it was unclear if everyone was sent one. Where comments had been made there was no evidence that this had been looked into and addressed with the person who raised the issue. Evaluation of survey information and actions to be taken as a result were not fed back to people in the home or their relatives, so that they understood this was a useful and valued exercise. House meetings for the people in the home and or their relatives were not held. This showed that people's views were not actively sought by the home or used for service development and improvement.

We were informed both by the registered provider and registered manager about a programme of upgrading and possible development of the home but this was not recorded and no timescales were established for when improvements and developments might take place and how this might impact on the people in the home. A few people we spoke with said they had heard about improvements but were not clear about what this meant for them and the extent of the works.

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 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services **The registered person had failed to notify the Care Quality Commission of the death of someone living at the home Regulation 16 (1) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered person had failed to notify the Care Quality Commission of a serious injury to a person living at the home that required treatment from a health professional in hospital Regulation 18 (2) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The registered person had failed to operate an effective system to regularly assess and monitor the quality of the service provided in the carrying on of the regulated activity, and this could place people at risk of inappropriate or unsafe care. Regulation 10**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person had failed to ensure that staff had received appropriate training, and appraisal of their personal development and performance to deliver care to an appropriate standard**