Zinnia Healthcare Limited

Yew Tree Manor Nursing and Residential Care Home

Inspection report

Yew Tree Lane, Northern Moor,
Manchester, M23 0EA
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Ratings

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

Overall summary

This inspection took place over two days on 20 and 24 August 2015. 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 15 October 2014, when we checked to see whether the service was now complying with regulations in two areas. We had found that the service was not complying with those areas at our inspection on 9 May 2014. On 15 October 2014 we found that the service was now meeting the regulations in those two areas.

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 34 residents. The building is a large house which has been extended several times. There are two large lounges and

Summary of findings

a smaller lounge which leads into the garden. Bedrooms are on the ground and first floors. There are two lifts (although one was out of action at the date of inspection). 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.

We found evidence that the numbers of staff on duty were not always sufficient. Although the registered manager told us that staffing levels had increased, in practice there were not always enough staff on duty to meet the needs of residents. Some residents complained that staff took too long to arrive when they pressed the buzzer, although response times were monitored. We found there was a breach of the Regulation relating to staffing levels.

We saw that appropriate checks were made before employing new staff. Disciplinary procedures were used when necessary but the records of these were incomplete. With the exception of newer recruits, staff were trained in safeguarding. The registered manager had reported safeguarding issues and attended a number of safeguarding investigation meetings.

We heard from a resident, and confirmed by observation that staff did not always check that medicines had been taken before signing the Medicine Administration Record. There was no guidance for when people should take 'as required' medication. We found that the systems for recording and storing and administering medicines were in need of improvement. This was a breach of the Regulation relating to the safe management of medicines.

The service had recently acted in response to adverse criticism by the fire service of its fire detection equipment. The fire register which was intended to assist firemen if they needed to evacuate people in an emergency was out of date. This was a breach of the Regulation relating to reducing the risks to people living in the home.

One of the two lifts had been out of service for about six weeks, which meant that some people had longer journeys to reach their bedrooms.

There was some paperwork in place to record that consent was given when necessary, but it was used inconsistently. This was a breach of the Regulation relating to providing care and treatment only with consent.

The registered manager was aware of the need to apply for Deprivation of Liberty Safeguards (DoLS) authorisations, and a number of applications had been made.

We saw from training records that the majority of staff were up to date with their training, but there were gaps and newer recruits had not yet received some essential training. Six established staff were not up to date with practical manual handling. The methods of providing supervision and appraisal for staff were also not adequate. This was a further breach of the Regulation about staffing, relating to enabling staff to carry out their duties properly.

The food was generally liked and the cook had a good understanding of how to meet people's nutritional needs. The dining area was too cramped. Although some steps had been taken we observed there could be tension at mealtimes. There were some adaptations of the building for people living with dementia but more could be done. We have recommended that the provider consider and apply the latest guidance on providing a suitable environment for people living with dementia. The garden was a pleasant place to sit and was being well utilised on the days we visited.

We found evidence that action was not always taken promptly to deal with and treat health conditions. We also found that people's basic personal care needs were not always being met. There was one person confined to bed who was unable to use the call buzzer and became distressed. We found this was a breach of the Regulation relating to treating people with dignity and respect.

Summary of findings

We found evidence that Yew Tree Manor was not providing a good service for people at the end of their lives, and a higher proportion of people than in other comparable care homes were being transferred to hospital when they were nearing the end of life.

We found variations in care plans, but that in general they were of a poor quality and did not provide a basis for good person-centred care. Significant events had not been included in recent reviews of care plans. There was a breach of the Regulation relating to providing appropriate care that meets people's needs.

There was an activities co-ordinator and some entertainments were provided for residents.

The system for recording and learning from complaints was not thorough. This was a breach of the Regulation relating to complaints.

The division of responsibility between the registered manager and the clinical lead was unclear. Some audits were carried out but they were lacking in rigour. Reviews carried out by the provider were lacking in detail and depth. This was a breach of the Regulation relating to effective quality monitoring of the service.

There was scope to obtain more feedback from residents and their relatives about the service. The staff meetings could also be used to hear staff's ideas about improving the service.

In relation to the breaches of regulations you can see what action we told the provider to take at the end of the full version of the 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?

Inadequate

The service was not safe.

There were not always enough staff on duty to meet the needs of residents.

The systems for ordering, recording, storing and administering medicines were unreliable.

The register for use by the fire service in an emergency was out of date and might have caused life-threatening delay.

Is the service effective?

Requires improvement

The service was not effective in all respects.

Consent was not always obtained and recorded correctly. The service was making appropriate applications under the Deprivation of Liberty Safeguards.

The majority of training was up to date, but not all. Supervision was not being used to support staff.

People told us the food was good. There was scope to improve the dining experience.

Is the service caring?

Requires improvement

The service was not caring in all respects.

Although we received some positive feedback about the caring approach of staff, people's basic care needs were not always met and their dignity was sometimes neglected.

The home was not well set up to deal with people who were reaching the end of life.

Is the service responsive?

Requires improvement

The service was not responsive in all respects.

Care planning and the review of care plans were disorganised. Significant events were not recorded or used to review care plans.

Some activities were provided.

Complaints were not always recorded and there was no system of learning from them.

Is the service well-led?

Requires improvement

The service was not well led.

The home had a registered manager in place who was supported by a clinical lead, but their individual roles and responsibilities were not clear.

Summary of findings

The system of internal audits was poor and there was no effective scrutiny of the problems within the home.

There was little attempt to learn from residents and their relatives or to utilise the views of staff, in order to improve the quality of the service.

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 20 and 24 August 2015. The first day was unannounced which means we gave no notice of when we were coming. The second day was by arrangement. The inspection had been brought forward due to a number of recent safeguarding incidents at the service

The inspection team comprised two adult social care inspectors, a bank inspector and an expert by experience. 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 experience of caring for older people.

Before the inspection we reviewed all the information we had, including notifications from the service, and minutes of recent safeguarding meetings. We had attended some of these meetings and obtained information from the Adult Safeguarding Co-ordinator and contract officer of Manchester City Council.

We spoke with eight residents and four relatives who were visiting people at the home during the inspection. We interviewed the registered manager, clinical lead, the cook and assistant cook and six other members of staff. We spent time observing care in the lounges and dining area and used the Short Observational Framework Inspection (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us.

We examined 10 care records, six staff recruitment records and records relating to the maintenance of the building, the equipment used to support people and the management of the service.

We talked with three visiting professionals during the inspection.

Inadequate

Is the service safe?

Our findings

We talked with people living in Yew Tree Manor and asked them if they felt safe. The majority of residents responded positively to this question. However, one person said: "I get frightened when they forget to put the sides of the bed up and I need to have the room door open always because it is so hot in here."

We asked residents and visitors whether they felt there were enough staff. Their answers varied. One resident said: "Yes", as did two of the visitors we spoke with. But a third visitor said: "This morning there are plenty of staff but normally there are not as many." One resident said: "No there are never enough staff." Another person said: "No there are not, I asked the question can I have something and they don't come back at all. At night I ring the bell and no one comes. I heard a man crying out for help all night and no one came to help him. I went once to the dining room and had to wait 45 minutes after I had finished my lunch for the girls to take me back to my room. The girls were just standing around chatting."

We asked the registered manager about staffing levels. She said that numbers had recently increased because of an increase in dependency needs of residents. She told us that the morning shift from 8am to 2pm was covered by one nurse and six care workers, and the afternoon shift from 2pm to 8pm by one nurse and four care workers. At night there was one nurse and three care workers. The registered manager added that sometimes staff came in at 7am to help get people up and to attend hospital appointments with residents. She explained that the reason for the higher number of staff in the morning compared with the afternoon was that there were visits from district nurses in the morning. This was because staff were needed to help people be ready to be seen by the district nurses.

We asked to see staff rotas in order to confirm the staffing levels. We obtained copies of the rotas for the three weeks commencing 10, 17 and 24 August. The rotas for 10 and 17 August contained a large number of deletions and additions so it was difficult to determine how many staff had been on duty on any particular day. However we could see from a copy of the rota that had not been amended for the week commencing 17 August that five care workers (rather than six) had been scheduled to be on each morning, and four in the afternoon. For the following week, commencing 24 August, there were six staff scheduled.

We asked members of staff about whether they thought there were enough staff on duty. One person told us: "It's luck that there are six staff here this morning. The rota doesn't always have six. Usually there are four on in the morning, and sometimes three in the afternoon." They added: "I have worked at weekends and it is four in the morning, and three in the afternoon." They stated that on one occasion on a weekend afternoon one member of staff had accompanied a resident to hospital, leaving only two staff on duty. We took into consideration the registered manager's assertion that staffing levels had recently changed. Nevertheless this was evidence that staff numbers had been insufficient at times.

We asked this staff member what impact reduced numbers of staff had on residents, and they said it meant they did not get help on time, and it was not fair on them. They added that from their knowledge all the staff were unhappy with the staffing levels. One other member of staff confirmed this was the case, saying that the number varied between four and six in the morning, but in their view at least five were needed. They added that when there were fewer staff they had to rush and had less time to spend with residents. On one afternoon about two weeks earlier, they said there had been a nurse and two staff. We knew of two examples within the last few months where people had left the building unobserved. This was an indication that more staff were needed.

There are risks to the safety and wellbeing of residents if there are too few staff available. The CQC does not define a safe staffing level because it is affected by many factors including the dependency needs of the people living in the home. At Yew Tree Manor one third of the 34 residents had nursing needs. Many needed help to mobilise, and two were in bed, which meant they should receive regular visits both for care and for company. The above evidence showed that there were at times insufficient numbers of staff to meet those needs. We observed during our observation in the quiet lounges that staff did not have time to interact with residents in a relaxed way, but were constantly moving from one task to the next. The accumulated evidence of shortage of staff at times demonstrated a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment records for six staff members. We saw that each staff member had completed an

Inadequate

Is the service safe?

application form and staff had been checked with the Disclosure and Barring Service (DBS) before they started work at the home. 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. In each of the files we checked we found that the staff member's identity had been established and two references from previous employers had been requested. Each of the files contained a record of their job interview.

We enquired about disciplinary procedures. We knew from our records that the provider had taken action against members of staff in the past. One former member of staff had been reported to their professional body. We also were aware that following revelations of poor practice with regard to writing care plans, the local authority had proposed that one member of staff should be reported to their professional body. Despite that suggestion, the provider and registered manager had declined to do so. We also found that the records relating to disciplinary proceedings against another member of staff were incomplete. Included in the file was an allegation written by hand on scrap paper, not signed or dated. There was no documentation relating to any investigation or the outcome. The paperwork regarding this person's previous employment history was also confused and incomplete. If records are not maintained there is a risk that patterns of behaviour may not be identified. The record keeping was an area that required improvement, in order to ensure a robust disciplinary process.

We asked staff about their knowledge of safeguarding and whether they knew what to do if they suspected or witnessed any form of abuse. We saw from the staff training record that 23 staff had received training in the safeguarding of vulnerable adults within the last three years. Seven staff including four recent recruits had not yet received it. One of the newer members of staff told us they had experience and were trained in safeguarding from their previous employment, but this might not be the case for all new staff. This person told us they had not seen any issues which concerned them since starting at Yew Tree Manor, but if they did they would report them immediately to the registered manager. They were not sure what to do if the allegation involved the registered manager in some way. They were aware of who the proprietors were but had never met them.

We knew from our records that the registered manager was aware of her duties under the regulations to report safeguarding incidents both to CQC and to the relevant local authorities. The information submitted relating to some incidents had been insufficient but the registered manager had supplemented the details at our request. There had also been a number of safeguarding issues raised by others including relatives and visiting professionals. The registered manager had attended safeguarding meetings and contributed to discussion of the cases. This meant that the registered manager was made aware of issues that needed to be addressed.

Nurses administered all medicines to people living at Yew Tree Manor with the exception of those given by visiting district nurses. We observed a morning medicine round during our inspection. The medicine round did not start until 9am as the nurse was busy with other duties, and it finished at 11.45am. This meant that some people did not receive medicines prescribed to be taken in the morning until nearly midday.

We saw that medicines were given to people without an explanation of what they were and the nurse did not always wait for the person to take them before signing the person's Medicine Administration Record (MAR). A MAR should only be signed when it is known that a medicine has been taken, so leaving people before they have taken medicines means that the MAR cannot be signed correctly. This meant that the MAR might not be an accurate record of what medicines a person had taken. It also meant that people might not be receiving the medicines they needed.

One person told us: "My antibiotics are given to me at all different times. I am asked to chew the tablets without a drink and they do not stay with me to make sure I take them." We observed that this person had just tried to finish chewing a tablet when we came into their room to speak with them, with no member of staff present, and they asked us to give them a glass of water. This meant that staff were not always checking that medicines were taken and also that they were not administering them in a safe manner.

We looked at the medicines files and found that several MAR sheets were in poor condition and could easily fall out of the file. If MAR sheets fall out and are lost, or fall out and are put back in the wrong place, people might not receive the medicines they need when they need them.

Inadequate

Is the service safe?

During our visit we looked at the systems that were in place for the receipt, storage and administration of medicines. When we arrived on the first day there were more than 16 boxes of medicines that had been delivered from the pharmacy, in a downstairs office. They were still there when we left that evening and the door was open and unlocked all day. This meant that during that day the medicines were not stored securely.

We saw that a monitored dosage system was used for the majority of medicines with others supplied in boxes or bottles. We found that once medicines had been checked in they were stored safely when not in use and only administered by nurses who had been appropriately trained. We checked MARs for 10 people. One person had run out of a short acting inhaler over two weeks earlier and the nurse was not sure if it had been re-ordered. This was potentially dangerous because if the person had experienced an episode of acute shortness of breath they would not have had the correct medicine to ease their symptoms.

We observed that on one MAR a medicine that should be given once a day had been signed as being given in the morning and in the evening for eight days; the morning signatures had then been crossed out. It was not possible to tell from the MAR whether the person had received double the dose of medication or whether the MAR had been signed in the wrong place and then amended. This means the MAR could not be relied on as an accurate record of the medicines the person had taken.

One person was prescribed an injection every 3 months that was to be given by a district nurse. We asked if there was a system to check that people got the medicines they needed from the district nurses, but we were told there wasn't one in place. However, the provider told us the record for medicines administered by district nurses was recorded in the Nurses' Diary.

We saw that at least five people were prescribed medicines 'as required' but did not have protocols for them. These medicines are ones which people take when they require them. A medicine protocol describes when a person should receive 'as required' medication. For example, a person with a headache who cannot make their needs known may behave in a certain way when their head is sore; the protocol should describe this behaviour so that staff can make sure the person gets pain medication when they need it. Medicine protocols are useful especially for new staff and agency staff if they don't know people well. Not having medicine protocols in place for 'as required' medication could mean that people don't receive medicines when they need them or alternatively receive them when they do not need them.

We saw there was no system in place to record stock levels of 'as required' medicines. This meant that these medicines could run out and people may not get 'as required' medicines when they need them.

We looked at the storage of controlled drugs and checked a random sample of stock balances. Controlled drugs are prescription medicines controlled under Misuse of Drugs legislation and there are special rules relating to their storage. We found that one box of medication had the label of the person it was prescribed for on the front, and the label of someone who no longer lived at Yew Tree Manor stuck to the side. This meant that the person whose medication it was might not receive it if a nurse looked at the wrong label.

When we checked the controlled drug book where the stock for each person is recorded, we saw that a controlled drug had been received from pharmacy and recorded in the controlled drug book the day before. When controlled drugs are received it is best practice they should be checked by two people, one acting as a witness. There was only one signature in the controlled drug book which meant that only one person had received the controlled drug. This showed that medicines management guidelines were not being adhered to.

We checked the stock of three controlled drugs and found that they were present and correctly recorded.

We saw from one person's notes that a district nurse had asked Yew Tree Manor to get a topical cream for them. The district nurse had returned seven days later to find the cream had still not arrived; the district nurse requested it again and it arrived three days later. The registered manager said she was aware that there was confusion amongst the staff about how to request medicines correctly. People could suffer harm if the medicines they need are not requested promptly and in the right way.

During the inspection we noted that several people were prescribed topical skin creams on their MAR sheets. When we looked at two people's care plans we saw that there were no medicine sheets for staff to record the application of these creams or corresponding body maps. Medicine

sheets say how often creams and lotions should be applied and record when it is done. Body maps show where the cream or lotion should be applied. Without medicine sheets and body maps for creams people may not have the creams they need applied often enough or in the right place.

Topical creams were stored in people's rooms. We saw that creams were not labelled on the date that they were opened so it was not possible to tell if creams that had expired were being used. When medicines are not dated at the time of opening there is a risk of people receiving medicines after the expiry date which may potentially cause them harm. We also found a pot of topical cream in one person's room that did not have a prescription label or any other instructions for use. The cream was not listed on the person's MAR chart. This meant that the person was receiving a cream that had not been prescribed for them and might do them harm.

For all the above reasons we considered that the management of medicines was in need of improvement, because it created risks to people's safety. The systems of ordering, storage and administration of medicines were defective. The deficiencies were a breach of Regulation 12(1) and 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked around the building and found that most areas were clean and odour-free. Rooms were stocked with soap and paper towels, and aprons and gloves were available for staff. We saw radiator covers that had a collection of dust and dirt inside and one commode had rusty paintwork. This meant that the commode could not be cleaned hygienically and the person who used it could be at risk of developing an infection.

Yew Tree Manor had an infection control lead responsible for checking and auditing infection control measures. They told us that they had recently increased the number of cleaners to four, and revised the cleaning schedule to improve the standards of cleaning. At the time of our inspection one of the cleaners was working in the laundry as cover for an absent colleague. But residents told us they thought the place was clean. One said: "Sometimes they hoover up twice in the same afternoon." However, one visitor said they had concerns about the cleanliness of their relative's bedroom.

We enquired about the systems of fire prevention, detection and evacuation. All staff apart from recent starters had received fire awareness training, although 13 out of 30 staff were overdue to receive it again as it was due to be renewed annually. We saw a letter from the Greater Manchester Fire and Rescue Service dated 1 July 2015 which stated that the fire detection system was "inadequate". We also saw evidence that four new smoke alarms had been purchased in July, which addressed the deficiencies identified by the Fire Service.

Each person must have a detailed Personal Emergency Evacuation Plan (PEEP) which describes their mobility and need for assistance in detail. In the event of a fire, we were told there was a 'fire register' available by the front door. When we looked at this, we saw it was dated 15 August 2014, over a year earlier. There was very little information about each resident and their mobility, and the information was out of date because it included some people who were no longer living at Yew Tree Manor and did not include people who had moved in within the last year. The registered manager expressed surprise that the fire register had not been updated. It could cause life-threatening delay in the event of a fire if there was a need to evacuate people.

Having an inaccurate fire register was a breach of Regulation 12(1) and 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We examined certificates relating to maintenance of equipment. We saw that some annual checks were out of date, although the records were not clear and some more recent checks were recorded on a scrap of paper. Gas safety checks and electrical checks were up to date. There was a water hygiene monitoring logbook which did not specify which year the latest check had taken place.

A stair gate was at the bottom of the main staircase. We were told the purpose of the gate was to stop people going upstairs. The back staircase had no such restrictions, which was a potential risk.

There had been an inspection of both lifts on 15 January 2015. One lift had failed on 6 July 2015 and was still out of order at the date of our inspection. There had been mechanical problems with this lift for some time. The fact there was a second lift mitigated the risk, but we saw that it meant some people had to be pushed further in their wheelchairs on both floors of the building. It would limit

Inadequate

Is the service safe?

some people's independence if they could not access their bedrooms by the nearest lift. It also meant that if the second lift failed the home might become unable to operate.

Requires improvement

Is the service effective?

Our findings

We looked at ten care files and checked to see whether people's consent to care and treatment had been obtained. Under the Mental Capacity Act 2005 (MCA) if a person lacks the capacity to consent on their own behalf, then a procedure must be followed to ensure the care and treatment are in their best interests.

We saw that Yew Tree Manor did use forms to record people's consent, but in an inconsistent manner. One person, who was considered to have capacity to consent, had not signed consent forms on their file relating to being weighed regularly and to managing their own medicines. This person's photograph was in their file and on the medication file. But there was no form present on this file relating to consent to the use of their photograph.

In most cases, where it was considered that people lacked capacity to consent, consent forms were included in the care plans in relation to photographs, medication and being weighed. These were usually signed by a member of staff. This meant that the correct procedure under the MCA had not been followed. This would involve holding a best interests meeting to determine whether the specific decision was in the person's best interests.

The only signature that we saw for consent was that of someone who attended the home for respite care. This person had signed consent to their photograph being taken and used. They had also signed consent regarding medicines, but had signed in two places, first to say that they agreed to the staff administering the medication and secondly to say that they agreed to self-administer their medication. This could potentially cause confusion for a nurse trying to decide whether or not to administer medication to this person.

These examples showed that insufficient care was taken to ensure that consent was obtained for care and treatment and that when a person lacked capacity to consent the correct procedure was followed. This was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which form part of the MCA. They are intended to protect the rights of people who lack the capacity to make their own choices about their care.

The staff training record did not show that any staff had received training in the MCA or DoLS. The registered manager told us that she had undertaken training online. It would be best practice for all care staff to gain a basic understanding of the MCA and of DoLS. We saw evidence that the nurses under the supervision of the registered manager had completed mental capacity assessments, and these mostly related to specific decisions in line with the MCA. There was evidence that these had been reviewed and in most cases the scores remained unchanged. However on one file there was the statement "she does not have capacity", which suggested a lack of understanding of the MCA, because each assessment of mental capacity must relate to a specific decision.

We discussed with the registered manager the relevance of DoLS in care homes. She was aware of the need to make applications for DoLS authorisations, where the resident lacked capacity to consent to a restriction on their liberty. This included whenever a resident stated or demonstrated by their actions that they wanted to leave the home, but was prevented from doing so. As mentioned earlier, we knew of two examples within the last few months where people had left the building unobserved. We saw that DoLS applications had now been made for these two people. in one case the application had been refused on the grounds that the person had the capacity to decide for themselves about leaving the home. The registered manager produced copies of these applications and three others, and we found one more on a care file. In another case there was no reference on the care file to the fact that a DoLS application had been made. This meant that care staff might not be aware of the restriction being placed on that person's liberty.

Under the legislation a provider must issue an 'urgent authorisation' when they believe they may be depriving someone using the service of their liberty. At the same time they must apply for a 'standard authorisation', to a supervisory body, in this case the relevant local authority. The applications we were shown were all for standard authorisations, and there were no copies of urgent authorisations associated with them. We discussed this with an Independent Medical Assessor who visited on the first afternoon of our inspection, in order to conduct a mental capacity assessment of the person who was subject of one of the DoLS applications. Their view was that

because of the timescale in dealing with applications it was reasonable in practice for Yew Tree Manor not to submit urgent authorisations which would need, technically, to be renewed every seven days.

We saw that there were common phrases repeated in the DoLS applications. Some unnecessary details were included. These included the phrase "may be at risk of malnutrition and dehydration" for a person whose care plan showed this risk was not applicable. Also the words "if he is not prompted to eat" were used in an application for a female resident. These examples showed a lack of individual attention to detail when writing and submitting the applications. Apart from that, the forms were completed correctly.

New staff received initial induction training. We spoke with two recent recruits who confirmed they had received this training. After that, according to the staff policies folder, each staff member should get five days paid training a year. The staff training record showed that this was true for many but not all of the staff. The registered nurses had received training in medication, with one exception for whom it was described as "assigned". Two senior care workers were also due to receive this training and the clinical lead explained the plan was they would become involved in administering medicines.

Different training courses required to be renewed at different intervals. The staff training record showed which subjects were 'compliant' for each member of staff which meant 'up to date'. Most staff had received training in the mandatory subjects within the relevant timescale. These subjects included food hygiene, infection control, safeguarding and first aid. One exception was 'Moving and Handling Practical' which is an essential training area for care workers. The record showed that six care workers (who were not recent starters) had not attended this training since at least September 2014 (the earliest date for which this training was recorded). The record showed their training was expired. This was despite the fact that the training had been available in June 2015, as four new members of staff had attended it then. We mentioned this to the registered manager at the end of the inspection who assured us that they would attend the training as soon as possible.

The staff policies folder specified that each staff member should receive supervision at least six times a year. All care staff should have a designated supervisor who was a senior staff member, and supervision should be either in a group or individually. We spoke with members of staff who had been in post for three months who had not yet had supervision. One said it had not been mentioned to them.

We looked at three staff records to see how often they had supervision and what form it took. We saw that standard forms headed 'supervision/appraisal' were used. We saw that there were forms on one person's file from January, March, and May 2015, but there was no record of the content of those supervisions, just a date at the top and a signature at the bottom. Earlier than January 2015 there were two forms which did have a list of items discussed, albeit limited to jobs not done and areas for improvement. We had received a report by officers from Manchester City Council of a visit on 1 June 2015 when they had established that supervision for the majority of staff was overdue.

We saw the same pattern on the other two files we looked at. Where details were recorded, they were brief comments such as "not filling charts in". There were examples of appraisals written on the same form, but the majority of forms were blank.

The registered manager told us that nurses had to take a competency assessment tool when they started. She stated that she planned to start doing supervisions with nurses, which meant that they had not been done regularly up to that point. She added she was currently getting her own clinical supervision from the providers even though they were not registered nurses. She believed that Manchester City Council had found somebody else to give her supervision. This detail was confirmed to us by the Designated Nurse Safeguarding Adults of Manchester's Citywide safeguarding team.

Both supervisions and appraisals should be an opportunity for staff to discuss issues arising from their work, including any training needs or other development. At Yew Tree Manor supervisions were not being used to support staff to carry out their duties. In conjunction with the lack of sufficient training in practical manual handling, this was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people were supported in meeting their nutritional needs. We asked people about the food. People told us there was no choice of main course at lunch. One person said: "The meals are okay." Another person said: "It's

Requires improvement

Is the service effective?

alright, the food's nice." Another person added "I like what they give us." A visitor told us "My relative said the food was smashing." Another visitor said "I know (my relative) likes the food."

Our expert by experience joined residents for lunch in the dining area. He stated that the food was palatable. The assistant cook confirmed that all food was made freshly. Potatoes were mashed in the food processor with plenty of butter.

In a previous report published in June 2014 we commented that the dining area was quite compact and that the lunch time was quite tense, as people did not have much room at the tables and the tables were quite close together. We discussed with the registered manager what steps had been taken since then. She told us that having two sittings at lunch had not worked. Instead, two people now ate their lunch at a separate table in the small lounge. This was intended to make dining for the other residents much calmer. The registered manager stated that relatives had been informed about this decision but we did not see a reference in the care plans to this discussion having taken place. We observed that these people were quite happy eating their lunch separately.

We observed however that the main dining area was still cramped and that arguments flared up quickly. We saw that staff intervened to reduce tension.

A discussion with the cook showed they were knowledgeable about any special diets that people needed and were aware of how to fortify foods to improve a person's nutrition. The cook said that they made milk shakes with full cream milk and ice cream. We saw that there were home baked cakes and scones cooling on racks in the kitchen.

There was one resident who received nutrition via a 'PEG feed' (a system using a tube for people who cannot swallow safely).There was a notice displayed prominently in the kitchen stating that only nurses should provide any additional food for this person. On this person's care file was a detailed nutrition plan with clear information about different methods of supplying nutrition, namely PEG and additional 'pleasure feeds' (thickened fluids which can be taken by mouth without causing any risk). We were aware that concerns had been raised by a speech and language therapist about the home not following recommendations about this person's access to pleasure feeds. At a safeguarding meeting in August 2015 the allegation that the provider had not been providing pleasure feeds was substantiated. The service had now rewritten this person's care plan and we knew from minutes of a safeguarding meeting that the service was now following the instructions regarding offering pleasure feeds.

There were risk assessments regarding nutrition on people's care files, and weights were recorded monthly, although we found this was not always done consistently. This meant that people's nutritional needs were usually being monitored.

There were some adaptations of the building to make it more suitable for people living with dementia. Different corridors within the service were painted in different colours and called by the name of a plant or flower. During our tour we observed that many of the names on bedroom doors of lead nurses and key workers were out of date as those staff had left some time ago. There were some photographs of old film stars in the corner of the quiet lounge but it was impossible to look at these as access was blocked by stored wheelchairs. We did not see any specific items around the home which could help people living with dementia, no tactile objects, very few pictures or objects for discussion between people or with staff. There were no items for triggering memories. The large calendar on the main lounge stated that it was Wednesday 19 August all day when we were there (on Thursday 20 August). This could be disorientating for some residents.

We recommend that the provider should research and apply the latest guidance on providing a suitable environment for people living with dementia.

Requires improvement

Is the service caring?

Our findings

We asked two district nurses who were regular visitors their opinion of the home and one of them said: "The care staff are lovely." On the other hand they stated that their colleague had visited the home on the morning of the inspection and had found a resident "lying in a pool of urine". They expressed concern regarding this resident having red heels which had now blistered. On checking this person's daily notes we saw there was an entry on 11 August 2015 stating that this person was found to have developed blisters on both heels. At this point the district nurses team was contacted. However, the notes stated they had been first noticed on 8 August. There was no entry on that date to suggest anything had been found. An entry by night staff on 10 August recorded: "All routine checks were carried out. He was fine and no new concerns." This demonstrated a lack of proper care by the staff who noticed a problem on 8 August but failed to record it, which meant that nothing was done until three days later, by which time the blisters had become more serious.

We talked to a care worker about this resident who showed us their bedroom and the inflatable individual heel protectors that they wore at night. This reassured us that by the date of our visit the blisters were being treated. Because of the report by the district nurses we asked about the management of continence and the care worker explained that the resident sometimes removed the incontinence pad and then the bed became wet. However we were not confident that the known incontinence issue was being properly addressed.

We asked residents and their visitors whether they thought their privacy and dignity were respected. The majority responded positively. One person said: "It could be better. Some people persist in arguing." Another person replied: "We have to have our bedroom door open because it is so hot." Another person agreed with this but added that their door could be closed at night. However, one visitor shared their concern that because their relative's door was closed at night staff could not hear them, and the visitor was not sure whether they could use their buzzer. When asked how staff treated their relative, this visitor replied: "Staff are good with them and they're happy with the staff." They added that there were times when they felt their relative was not as well groomed as they would like, for example their hair hadn't been washed and their fingernails were dirty. This suggested a lack of care for basic personal needs.

This concern was amplified by a report we received shortly after the date of the inspection from a social worker who had visited a resident following concerns raised by Wythenshawe Hospital about their appearance. They wrote: "… was inappropriately clothed wearing pyjama bottoms with a shirt on his upper body. His grooming and personal care needs had not been met, he was unshaven and his hair was dirty. Again there was no evidence in his nursing notes of regular prompting of care or refusals of care offered. At his review by Trafford Council on 20.08.2015 the home were advised that they needed to prompt to have a shower on a daily basis …, there was no evidence in his notes that this was being offered…. I also noted that some of the other service users looked unclean."

We did see in the office a weekly bathing list which was arranged by room numbers rather than by name. It specified that each resident should receive a bath or a shower once a week. However, staff informed us that availability of staff meant that that schedule was not always kept to.

During our tour of the building we were shown the bedroom of one resident who was being nursed in bed. We were told that a person who came into Yew Tree Manor regularly for respite care shared this bedroom. The bedroom was large enough to accommodate two beds. However, there was a commode used by the person who came in on respite, which was behind a small chest of drawers at the foot of the resident's bed. There was no screen for privacy. This meant that the dignity of both people sharing the room was not being respected. The person who came in on respite had agreed to share a room, according to their care plan. But there was no record of seeking the involvement of the full-time resident in the decision about sharing the room. We were told that because they were confined to bed it was thought that having someone share the room from time to time might be socially beneficial.

Another resident told us that staff forgot to put up the sides of their bed and that they were frightened. We observed that they were in bed throughout the first day of our visit. They had only recently arrived in Yew Tree Manor and their care plan was not yet written. They told us that they had

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not yet had the eye drops which were due. They said they were unable to use the call buzzer. They were on the first floor so isolated away from most of the staff on the ground floor. Towards the end of our visit we heard this person shouting out for help and saying their sheet was wet. We asked a member of staff who was supporting another resident to get someone to help.

We considered that this person's basic needs for comfort and attention were not being met. In conjunction with the previous examples, this was a breach of Regulation 10(1) and 10(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we observed staff treating people respectfully, knocking on doors and waiting for a response before entering. There was a system which identified when a call buzzer was used and the room number was shown on screens around the home enabling staff to identify who needed assistance. The system produced a record of response times which was monitored by the provider. This meant that staff were encouraged to respond to calls promptly, provided there were enough staff on duty. One resident said: "Staff can be abrupt." As we observed the staff they appeared rushed and had little or no time to engage in pleasant chat with the residents. One member of staff commented that they were always busy because there were not enough staff on duty. This meant that the quality of care for residents diminished.

One resident told us they could get up when they wanted, and go to sleep when they wanted, and they usually watched TV in bed till the early hours of the morning. They added their daughter and spouse could visit until 9pm. They could not think of any ways in which their care could be improved.

The majority of staff had received training in dealing with 'challenging behaviour'. Staff told us that people sometimes got annoyed with each other, especially at meal times when they were in close proximity. We knew about some incidents from safeguarding notifications submitted by the registered manager. We witnessed an incident during lunch when two residents entered into a heated argument. Staff did not react immediately, but when they did they responded appropriately, separating the two people and calming them down.

The door from the small lounge to the garden was left unlocked until 9pm during the summer months. We saw that people were able to go into the garden independently; others who needed assistance were escorted out by staff. The garden was a pleasant place to sit and when we visited there were gazebos erected to protect people from the direct sunlight. The garden, like the other rooms, was signposted with pictures as well as words. There was a sign by the door to the garden reminding staff to make sure residents got suntan lotion and a hat to wear when going outside in the sun. This demonstrated care for residents' wellbeing.

Yew Tree Manor had enrolled on the Six Steps programme in 2013. The Six Steps is an end of life programme, in the North West, designed to enable care homes to improve end of life care. We saw that one care plan included end of life wishes, which were simply to consult with the GP and district nurses. Two other files had DNAR forms on them. This stands for "Do not attempt to resuscitate" and is an instruction to staff and paramedics not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. However, we had evidence that the home was not applying the principles of Six Steps in order to enable people to end their lives in the home, if they wanted to. A nurse from the nursing homes team had calculated that between July 2014 and June 2015, 53% of deaths of residents' deaths occurred in hospital, which contrasted with the average in nursing homes across South Manchester of around 30%. This demonstrated that Yew Tree Manor was less effective in enabling people to die within the home. One example that the same nurse gave in her report was of a resident who was admitted to Yew Tree Manor for end of life care with haematuria. The home sent the resident back to hospital, and when the hospital tried to discharge them, a nurse at the home said they would refuse to receive them back, with the result that they died in the hospital. The report concluded that the nursing homes team were not confident that residents' and relatives' wishes in relation to end of life care and preferred place of care were being met. This was an area for improvement.

Requires improvement

Is the service responsive?

Our findings

We looked at 10 care plans, partly because some issues had been raised during safeguarding meetings about the quality of care planning. One example had been found of part of one care plan being copied and pasted into someone else's. Whilst care plans did include the same phrases with regard to personal hygiene and ensuring that people had a nutritious diet, there was evidence that the plans had been personalised. All names used referred correctly to the person whose file it was. There were some specific details which referred to the support required by the individual person.

It was not clear from the care planning process whether people were involved in creating or reviewing their care plan. Those visitors we asked about this had not seen a care plan and so did not know what was in their relative's care plan. There was information provided in some files "All about me" which for some people gave details of their interests, history and family. One person's file which used a different format included questions such as, "What is important to me?" "How best to support me?" There were also clear instructions to speak with this person while facing them, as they were hard of hearing. However, there was no evidence from the care plans about whether any of the people's interests and preferences were followed up.

One person's care plan stated 'unusual behaviour' under 'background of health needs' but there was no explanation of what the unusual behaviour was. This meant that any new member of staff or agency worker, or any visiting health professional, would gain no information regarding this from reading the file. The same person's care plan recorded that they required bed rails to prevent them falling out of bed. This person did not in fact have bed rails, but was using a low bed. We asked the registered manager about this. Her response was uncertain. First she said that they had tried using bed rails, but the resident had tried to climb over them. Then she stated that they had in fact never tried bed rails because they would not be safe. She could not explain why there was no mention of this in the care plan. She added that the resident suffered bruising easily and for no apparent reason, but again there was no reference to this in the care plan.

It was mentioned earlier that two residents, one of whom was on regular respite, were sharing a bedroom (when the person on respite was in the home). There was no reference to this on the care plans for either person, which meant there was no reference to discussion about the room sharing with either the residents or their relatives. We asked about this and were told that it was intended to benefit the full time resident, who was nursed in bed, by giving them some social contact. But without a record of the reasons for the arrangement or of anyone's agreement to it, there was no evidence that people's wishes were being respected.

The latest review of the care plan of the person who came in for regular respite was dated 4 January 2015. There was no record of a more recent review. On other files we saw more recent reviews of care plans, although often the reviewer had written simply "no change". In one case we were aware of a significant event in June 2015 when the person had left the premises and made their way to nearby shops. This had been raised as a safeguarding alert. This resulted in the person receiving one to one observation during the day. However, the review of the care plan in July 2015 made no reference to this event and recorded "no change". No amendment was made to the risk assessment or the care plan to indicate that there had been a change in circumstances and that the person was now having one to one support. This meant that the care plan was not reflecting important developments in this person's care needs. We raised this with the registered manager who could not provide an explanation but said she would talk with the member of staff who had completed the review.

We were told that two people had been moved to the smaller lounge for meals so that they would not disturb other people eating. When we looked at the care plan for one of these people, there was no reference to this move. The registered manager stated that relatives had been informed about this decision, but we did not see a reference in the plan to this discussion having taken place. This meant that the care plan did not record a significant aspect of the person's care.

The above deficiencies in care plans were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were no records of any activities in the care plans we looked at. The care plans focussed on people's physical and health requirements and there was very little about people's emotional wellbeing.

There was an activities co-ordinator in post who was on leave on both days of our inspection. There was not

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Is the service responsive?

anyone leading activities in their absence. One person told us: "What I'd really like would be to go out for a really long walk." We asked them if they ever went out and they said "no". We observed that each time we went into the lounges the TVs were on all the time, and people did not appear to be watching them, except for some staff members who were watching sport. Two of the residents told us that the activities co-ordinator, when they were present, spent a lot of time working on the computer in the office. But one visitor told us that the activities co-ordinator did put on some activities for the residents, and in addition there were musical entertainers who came in from time to time. There had been a barbecue on 9 July in the garden of the home. We asked the registered manager if there were ever any trips out and she said there had not been, but they were planning to have some in the future.

In the care plan of one person who was nursed in bed there was a reference to reducing their social isolation. The plan referred to their need for social contact, and the risk of withdrawal. Under the heading 'communication' in the care plan there was a stated plan to maximise opportunities for talking when assisting the person with their nutrition. However we knew from a safeguarding referral in relation to this person that some of the staff had described them as being unable to communicate, whereas in fact a social worker who visited had found they did want to communicate and could do so quite effectively, if enough time was devoted.

We asked to see the record of complaints and we saw that three complaints were recorded during 2015 to date. One of the records under 'details of complaint' said "As stated in letter", but since the letter was not present on the file it was impossible to know what the complaint was about.

There had been a big gap between July 2014 and June 2015 during which no complaints had been recorded, followed by one each month between June and August 2015. We knew from safeguarding issues which had been notified to us from other sources including relatives that there had been at least three other complaints during 2015. These should have been recorded. Only by recording, and analysing complaints can lessons be learned from them and any trends identified.

The failure to record and respond to all complaints was a breach of Regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

Our findings

One visitor told us there had been "big changes in staff". The registered manager told us a large proportion of nurses had left but she had managed to recruit four new nurses to replace them. One of these was receiving their induction during both days of our visit. With such a high turnover of staff there were risks regarding continuity of care. The district nurses we spoke with were uncomfortable about commenting on the leadership of the home but when we asked what they thought the cause was of problems they had identified they said: "I think it's a management issue, you hand something over and it doesn't get done."

The management responsibilities were not entirely clear. As well as the registered manager there was a person who described their job variously as "infection control lead", "nutritional lead" and also "clinical lead". They said they worked two days a week and had recently been covering for the registered manager while she was on annual leave. One of the staff told us they thought that the clinical lead was "above" the registered manager, which showed there had been a lack of explanation of the management structure and that roles and responsibilities were not clearly defined.

There was a large volume of policies and procedures in the registered manager's office, which had been purchased from a commercial provider. The index did not match the order of the contents, which made it difficult to locate a particular policy. Staff were able to leave messages for each other in a communications book. However there were no entries since 6 August – a fortnight before our inspection. We enquired about this and were told it was because the registered manager had been on leave until 18 August. This suggested that the registered manager was the only person who used this book to communicate, which she accepted. She showed us there was also a diary in which events and appointments were recorded.

We asked about whether any internal audits were completed. We were shown medication audits which were completed at the end of each month by the registered manager. These were sheets with questions and boxes to tick which covered all aspects of the receipt, storage, administration and disposal of medicines. A score was given at the end. Provided each tick indicated a detailed examination of the question, this could be an effective audit tool. However, the problems identified with the safe management of medicines earlier in this report indicated that the medication audit was not effective in identifying issues.

We saw that an infection control audit had been done in July 2015 using a detailed 12 page tool to assess different areas of the building. Six of the pages were blank, very few parts of the other pages had been filled in and no actions had been raised for any of the issues noted. There were no other infection control audits completed by staff at the home available for us to view. This meant that there was no system in place to check that the building stayed clean enough for the people that lived there; they could therefore be at risk of developing infections as a result.

Manchester City Council had performed an infection control audit at Yew Tree Manor in November 2014. An action plan had been drawn up following this audit but there was no documented evidence to show that the actions required had been undertaken. The lack of an effective internal infection control audit meant that management at the home could not be sure any actions identified in November 2014 had been addressed.

There was a record of accidents but no analysis or record of lessons learned. We saw one incident recorded in July 2015 which was a confrontation between two residents which had resulted in one of them falling and lacerating their forearm. Consideration ought to have been given to reporting this to CQC either as abuse or as a serious injury, but it had not been.

The provider conducted 'quality visits' approximately every month. In our previous report from an inspection in May 2014 we noted that some of the answers recorded to the questions were identical from one report to the next. We saw that this was still the case, with a very similar summary used in each report dated 29 April, 29 May and 22 July 2015. The summary stated: "The care home was tidy and clean. Residents were happy with the home and staff. Residents' care plans had been reviewed." There was however little indication of how these judgements had been reached. For example, there was no analysis of how effective the care plan reviews had been, and whether writing "no change" was an effective review. There was little sign of an objective and rigorous internal audit of the home, which might have identified many of the deficiencies identified both in this report and in many reports and visits made by local authority officers in recent months.

Requires improvement

Is the service well-led?

The provider noted in his July report that the local fire prevention team had visited and stated: "They inspected and were happy." As noted elsewhere in this report, they had in fact written in a letter dated 1 July 2015 "The fire detection system is inadequate." This raised doubts about the thoroughness of the provider's report.

We saw a pressure ulcer audit had been completed for one person who had a pressure ulcer in the two months prior to our inspection. Pressure ulcers can develop when people do not move around enough or are not turned in bed if they need to be. They can be aggravated by other factors such as low weight, incontinence and other medical conditions. There were no pressure ulcer audits for any other people using the service. This type of audit is important as it uses people's information to help identify if there is anything the service can do to prevent people from developing pressure ulcers. Not having a regular audit means that people might be more at risk of developing pressure ulcers. The registered manager told us that she had attended a course on tissue viability and had shared the learning from that with nurses.

We considered that the deficiencies in the internal audit systems constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Questionnaires were available to be given to families. They were not given out at set times but handed out now and then. During 2015 only two questionnaires had been returned. There was scope for a more systematic approach to obtaining families' views. One visitor said they had not completed a questionnaire and had never been made aware of a relatives' meeting. We requested to see minutes of residents' meetings but none were produced. This meant that those residents who could contribute ideas about the quality of the service were not enabled to do so.

There were minutes of a staff meeting on 18 May 2015 on the wall in the staff room. These primarily recorded a list of things staff should do or not do. It appeared that the meeting had not included any issues raised by the staff themselves. This was therefore a missed opportunity to seek the views of staff on how the home was running and any suggestions they might have to improve it.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider was not always deploying sufficient numbers of suitably qualified staff:** **Regulation 18(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider was not always ensuring there were sufficient quantities of medicines to ensure the safety of service users.** **People were not protected against the risks associated with unsafe management of medicines:** **Regulation 12(1) and 12(2)(g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The risk of fire was not mitigated because the fire register intended to assist the emergency services was inaccurate and out of date:** **Regulation 12(1) and 12(2)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Care and treatment were not always being provided with the consent of service users. Where service users lacked capacity to give consent, the correct procedure under the Mental Capacity Act 2005 was not being followed: Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff were not receiving all the appropriate training, supervision and appraisal necessary to enable them to perform their duties: Regulation 18(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The care and treatment of service users did not always include supporting them to wash and dress appropriately: Regulation 10(2)(a)

Regulated activity	Regulation
	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care plans did not always reflect the care needs of users: Regulation 9(3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints There was not an effective system for recording and responding to complaints: Regulation 16(2)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems to assess, monitor and mitigate risks were insufficiently robust: Regulation 17(2)