Parkcare Homes (No.2) Limited

Ashridge

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 29 and 30 November 2017 and was unannounced.

Ashridge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Ashridge accommodates 18 people with learning disabilities or autism. The home comprises of a main house and a single story extension referred to as the "bungalow" which is for more able people.

There was a registered manager for the home. 'A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.'

This is the second consecutive time the home has been rated requires improvement.

The provider was not meeting the legal requirements in relation to good governance and the premises. They had not ensured that the systems to monitor the quality of care were effective and had not taken action when they had gathered the views of people living at the home. In addition the premises had not been maintained to and appropriate standard. You can see the actions we have asked the provider to take at the back of this report.

People were supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the home did not support this practice. People were able to access information in a format they could understand.

People were comfortable with the staff and happy to go to them for support. However, we saw that staff were not always able to comfort and calm people. Staff supported people's relationships and gave them time to be private.

Staff had received training in keeping people safe from abuse, however, they had not always followed the systems in place to support people. Staffing levels had been set by the provider and did not take account of people's needs. In addition, at times the home had been short staffed and this had impacted on people. Recruitment processes ensured staff were safe to work with people living at the home.

People had not been fully supported to help plan their care. Care plans did not fully reflect people's needs and risks to people had not been fully identified or care planned. People's end of life wishes had not been recorded. When incidents occurred the provider did not always ensure that lessons were learnt to prevent similar incidents in the future. The activities provided did not fully support people.

Medicines were safely administered. However, medicines in bottles were not always dated when opened. People were happy with the quality and choice of food provided. The kitchen was clean and tidy and systems ensured that food was safe to eat. However, other areas of the home were not clean and in parts there was an offensive odour. The environment was not maintained to support people's wellbeing.

People's needs were not assessed when they moved into the home and care was not always planned to support the best practice guidelines. People had been supported to access healthcare professionals but their advice was not reflected in people's care plans.

The provider had not supported the registered manager to improve the quality of care people received. People's views about the care they received were gathered and complaints had been responded to appropriately.

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 consistently safe.

Care staff had received training in keeping people safe from abuse but at times did not follow the provider's policies without prompting.

Care was not fully planned to keep people safe.

Staffing levels did not always meet people's needs. Recruitment processes supported people's safety.

Medicines were administered safely, but medicines in bottles were not always dated when opened.

The home was not clean and did not minimise the risk of infection.

Lessons were not always learnt from incidents.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The home was in need of maintenance and decoration and did not support people's wellbeing.

Appropriate applications for Deprivations of Liberty Safeguards were submitted. However, best interest decisions were not always recorded when people had restrictions placed on them.

Appropriate assessments had not been completed when people moved into the home and best practice guidelines were not always followed.

Records did not show how care was coordinated when people moved between services.

Staff received appropriate training and support.

People were happy with the quality of food provided.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People had not been fully supported to be involved in decisions about their care.

People's communications needs were supported.

People's privacy and dignity were respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were able to access information in an appropriate format.

Care and treatment was not fully planned to meet people's needs.

Activities did not fully support the needs of people living in the home.

People knew how to complain.

People's end of life wishes were not recorded.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had not supported the registered manager to develop into their role.

Systems to assess and monitor the quality of care were not effective.

People's views of the care were gathered.

Records had not been appropriately managed.

Ashridge

Detailed findings

Background to this inspection

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

This inspection took place on 29 and 30 November 2017 and was unannounced. On the first day our team consisted of an inspector and a Specialist advisor who was a social worker. On the second day our inspector returned alone to complete the inspection.

In preparation for our visit we reviewed information that we held about the home. This included notifications (events which happened in the home that the provider is required to tell us about) and information that had been sent to us by other agencies including the local authority contracting and safeguarding teams. We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the home, what the home does well and improvements they plan to make.

We spoke with the registered manager, the operations director, the provider's senior quality improvement lead and two members of care staff. We also spoke with two people living at the home.

We looked at a range of documents and written records including key parts of all the people's care files and two staff recruitment records. We also looked at information relating to the administration of medicines and the auditing and monitoring of care provision.

Requires Improvement

Is the service safe?

Our findings

Records showed that care staff had received training in keeping people safe from abuse. A member of staff was able to tell us about the different types of abuse they needed to monitor for and knew how to raise concerns. Records showed that the registered manager had investigated any concerns raised.

However, we found that people were not fully safeguarded from situations in which they may experience abuse. For example, systems were in place to manage people's money. However, people told us that staff needed prompting to follow the systems developed to keep people safe. One person told us, "My money is meant to be counted, they will count it and I'll say how much I want to take out and they tell me to keep the receipts. It does not always get done and I have to remind them."

In addition, we identified two situations where people had been required to pay for things that the home should have provided. The home had a mini bus for people to use. However, there was not always a member of staff available to drive the bus. This impacted on people's ability to access the community. The registered manager told us that if people were unable to use the minibus they arranged for a taxi instead and the people paid for the taxi. It was not acceptable to make people pay for a taxi when they should have been able to go out in the minibus.

Two people in the home had recently had new beds, one had been purchased by the people themselves and the other had been provided by the family. However, it was the provider's responsibility to ensure that there was sufficient furniture available in a suitable condition to meet people's needs.

Care was not fully planned to keep people safe. For example, we saw that one person had purchased their own walking frame. There was no information in their care plan to show that this had been discussed with or approved by an occupational therapist to ensure that the frame was appropriate to the person's needs.

Some of the people in the home accessed the local community independently and some steps were in place to keep them safe while in the community. One person told us, "When I go into town I have my phone and SOS information on a piece of paper." However, behavioural support plans were did not record the individual systems in place to keep people. We looked at the care plan of one person who was able to access the community independently. It contained no information on their needs and how they were kept safe in the community. This was a risk as the person was very friendly and would be open and confiding with strangers.

The registered manager had undertaken appropriate fire safety checks and had ensured that a fire folder was available if needed in care of an emergency. This would provide information to the emergency services on people's needs. However, other environmental risks had not been identified. For example, free standing wardrobes had not been secured to the wall to stop them from falling over.

The provider had set a staffing level for the home. However, the registered manager was not able to tell us how this had been set and there was no evidence that it reflected the current needs of people living at the

home. In addition, records showed that over a three month period there had been three weeks where care hours had fallen below the baseline set. People told us that at times staffing levels impacted on the care they received. One person told us, "We have been short staffed, sometimes there are only two or one on duty. One night this week there was no one to help me cook so I had cereal for tea. It doesn't happen often but it does happen."

We raised this with the registered manager. They told us that people in the bungalow were independent with their meals and support was provided for the more complex food preparation at teatime. However, if any staff had been needed to support people with healthcare appointments or if a person was upset and needed more support then people were asked to come to the main house and the chef would cook their meals for them. This reduced people's ability to maintain their independence

A member of staff told us that the home had not had a cleaner for a while. Some staff would pick up cleaning shifts and there was a list of what cleaning needed doing. There was a cleaning schedule in place for each bedroom. It showed that each room should be cleaned weekly. However, one room which was in needed of attention showed that it had been cleaned on 1 November 2017 and then not cleaned again until 22 November 2017 and no further cleaning had taken place.

One member of staff told us that staffing levels had been erratic. They said that interviews had been completed but that the checks to ensure that people were safe to work at the home were taking a long while. They said "Shifts have been short staffed."

In addition, the home lacked the staff with the skills to drive the minibus and this impacted on people's ability to access the community. One person said, "I would like to go to car boot sales, but I don't get to them. It depends if there is a driver on duty."

The provider had systems in place to ensure they checked if potential staff had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people had completed application forms and the registered manager had completed structured interviews. Any gaps in people's employment history had been identified and investigated. The required checks had been completed to ensure that staff were safe to work with people who live at the home.

We found that suitable arrangements were in place to safely order, administer and dispose of people's medicines in line with national guidelines. Medicine administration records (MAR) had been appropriately completed. Appropriate monitoring of storage temperatures were in place.
However, we found one bottle of medicine and one bottle of eye drops had not been dated when opened. It is important to date bottles when opening as some have a limited life and needed to be replaced after a set time period.

The registered manager had ensured that homely remedies such as pain killers and cough medicines were available for people when needed and they had checked with people's doctor to ensure that there would be no interaction with prescribed medicines. There were also protocols in place to support people to receive medicines prescribed to be taken as required in a consistent way. However, we did see that some protocols for as required medicines in people's care plans referred to medicines that were no longer prescribed.

We found that suitable measures were not in place to prevent and control infection. We saw that the home was dirty and had not been cleaned effectively. Light pull cords were dirty, and beds, mattresses and bedding were stained. There was an offensive smell in some people's bedrooms. Around the home there were no holder for hand towels and they were placed in baskets on top of the toilet cisterns, this increased

the risk of an infection.

Staff had completed training on infection prevention and control. They were able to tell us how they used protective equipment such as gloves and aprons to reduce the risk of infection. However, staff had not understood that the bags used to take soiled linen to the laundry would disintegrate when washed and had been removing the clothing and hence increased the risk of spreading infection.

We saw that the latest infection control audit had been completed on 21 July 2017. In it we saw a note which stated that the care staff could wear nail varnish to work. We raised this with the registered manager and the operations manager as it was not following best practice guidelines and increased the risk of infection.

We saw that the kitchen was neat and tidy and very clean, the food was stored in the fridges and refrigerators in a way which reduced infection. Systems were in place to monitor the temperature of food where served to ensure that it was hot enough to kill germs.

We found that the registered manager had established suitable arrangements to enable lessons to be learned and improvements made if things went wrong. This included the registered manager and the area operations manager carefully analysing accidents and near misses so that they could establish why they had occurred and what needed to be done to help prevent a recurrence. A member of staff told us that they discussed any recent incidents in staff meetings and considered if any changes could be made to reduce the risk of the same thing happening.

However, we found a number of issues that had been identified where appropriate action had not been taken. For example, in one bedroom we saw that extension leads had been linked together and this was a fire hazard. The registered manager told us that they had already identified this as a problem in another person's bedroom so this showed that they had not learnt a lesson and checked that the rest of the home was safe.

Records were completed to record events of people's behaviours that were challenging. These challenging behaviour forms were not clear and had no outcome sections completed. Situations that may trigger challenging behaviour were not identified and care was not planned to reduce the risk of incidents reoccurring. In addition, the registered manager and seniors had not signed incident reports to say that they were happy with the action taken to keep people safe.

Requires Improvement

Is the service effective?

Our findings

The home was poorly presented and in need of decoration and maintenance. It was not designed to support people's independence with poor signage and there were hazards within the home. The registered manager told us that the home had been identified by the provider as needing a refurbishment. The registered manager told us that one bathroom had been decorated to support some people who were living with dementia. However, it was not in line with the best practice for dementia environments. This showed that the registered manager had not fully understood how the environment could be adapted to support people living with dementia.

Walls, door frames, skirting boards were stained with coffee and tea stains up walls and on radiator covers. Some walls were cracked and needed repair. There were cobwebs in several rooms. The bathroom flooring was stained in most bathrooms and some of the bathrooms had mould around the shower enclosure and baths. In one bathroom the flooring was cracked. People's sinks had deposits of lime scale which would impede effective cleaning.

There was a defined smoking area for people living at the home. However, there was no shelter and no seats available in the area for people. This meant that if people wished to smoke when it was raining they would get wet. Concerns were raised with us that people were smoking outside of the designated smoking area showing that it did not meet their needs.

One person's room was in need of repair and decoration. This was because they liked to use a powered drill and had drilled multiple homes in their walls. We discussed this with the registered manager as there were numerous holes in one wall. They told us that the person would do this without staff's knowledge and that there were very little preventative measures which could be put into place. The room was heavily cluttered and this would impact on the well-being of the person using the bedroom.

We saw in another person's room that the wall was damp. We raised this with the registered manager as a concern. They told us that they had logged this with the provider as work needed to be completed on the roof and chimney. Repairs had not been made when an old fire alarm system had been removed. We saw that the pillows on their bed were flat and would not offer any support to the person. In addition, there was no headboard on the bed and the wall had been rubbed to bare plaster where the person rested their head.

One person was sat in the lounge and when we shook their hand they were cold. We asked about heating for the room and found the radiator was not working. The registered manager arranged for the maintenance person to look at the heating.

The garden lawn was large and well kept. However, the area around it did not enhance the environment. With the recycled garden project not being maintained and other areas of the grounds in need of support. There were a number of sheds in the grounds, some for people to store belongings that no longer fit in their rooms and one which was a day service building. This building had no heating, was damp and over crowded with clutter and archiving and not fit for anyone to use.

This was a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Premises and equipment.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications for 10 DoLS had been submitted and five had been granted, with five more assessments still to be undertaken. When DoLS expired, the appropriate paperwork for reassessments had been submitted. No one had any conditions on their DoLS authorisations.

We saw that in one person's bedroom the walls were bare and everything was fixed down. There were no clothes or toiletries in the bedroom. The registered manager told us this was because the person would drop things out of the window. There was no corresponding care plan relating to this behaviour and no capacity assessments or best interest decisions to show that depriving the person of their things was the least restrictive care that could have been put in place.

Staff told us that they helped people with daily choices and decisions but that any big decision needed to be supported by the person's social worker.

People's needs were assessed but the care provided did not always reflect best practice. For example, the registered manager told us how one person at the home was a hoarder. However, there were no care plans in place to reflect how staff were to support the person in relation to this behaviour. Risk assessments were basic and also not tailored to people's individual care needs.

Appropriate assessments had not always been completed when people moved into the home. One person living at the home had been admitted as an emergency six weeks prior to our inspection. No assessments of their needs had been completed and there was no care plan in place to ensure that the home could meet the person's needs. The registered manager told us that the home was not the right place for the person and they hoped the person would be moved.

Suitable arrangements had not been made to ensure that people received effective and coordinated care when they were referred to or moved between services. Staff told us that people had been supported to access healthcare professionals when needed to support their health and well-being and records showed people had been supported to see their GP or nurse.

People had also been able to see mental health consultants such as psychiatrists. However, there was no reflection of guidance from these professionals in their care plans to show how the staff were putting their guidance and advice into the support they provided people. For example, two people had received extra funding to support their well-being and relationships but there was no evidence of how this time was being used to support the people. Furthermore, there was a lack of effective recording of people's outcomes from

their reviews with social workers. There was no evidence of goals set for people and how they would be supported to grow. Therefore we could not be sure that people were receiving effective treatment.

The registered manager had put systems in place so that staff knew their designated role each shift. A member of staff told us that they were able to check the list in the clinical room to confirm the tasks they were responsible for completing.

Records showed that new care staff had received introductory training before they provided people with care. There was a structured three month induction in place for new staff. This ensured that new staff were familiar with the provider's policies and procedures. The first training new staff completed was safeguarding so that they were able to raise any concerns immediately. If the new member of staff did not have any care qualifications then they were required to complete the care certificate. This is a national set of standards that are required to ensure staff have the basic skills needed to provide safe care. New staff also shadowed an experienced member of staff who monitored their progress and who would feedback to the registered manager about their competencies. During their induction period they received four supervisions with the registered manager.

Staff had also received on-going refresher training to keep their knowledge and skills up to date. Staff told us they could go online and look to see what training they needed to completed and by when. The overall training for the home was monitored by the operations director and all homes were required by the provider to have 92% of their training to be completed. The provider had a formal process for the registered manager to follow if staff failed to complete their training in a timely manner. Staff told us that they received regular supervisions from the registered manager or a senior member of staff.

The home was theoretically divided into two parts the main house and the bungalow which was an attached extension. The people living in the bungalow were more self-sufficient and were able to make their own meals with support. For people living in the main house the food and menu was discussed at residents' meetings. People were happy with the quality of the food provided and we saw people enjoyed their main meal of the day. Different options were available to allow people a choice of food.

The refrigerators and cupboards were well stocked and there was fresh fruit within the main kitchen. When the cook was not about the kitchen is locked. However, hot water was available in the dining room for people to be able to make their own drinks.

Requires Improvement

Is the service caring?

Our findings

There was a good relationship between people living at the home and staff. We saw people were happy to go to staff for support or just to tell them about their day. One person told us, "It's good living here." However, another person said, "Living here has its ups and downs, sometime the staff are busy." We saw that staff interacted with people and knew their needs. For example, one person was crying because they had tooth ache. A member of staff administered some pain relief and gave the person some time and attention to help them calm down.

However, one person living at the home spent a lot of time upset and angry. They displayed this by shouting and crying. When upset they would often focus on other people who were in the area. A member of staff told us that the person liked to go out and then would be distressed when they returned to the home. Staff were not able to console this person and help them be calm and this upset others in the home.

Two people living at the home were in a relationship and had wanted to get married. Staff sat with them and discussed the implications marriage would have on them legally and financially. They then decided that they did not want a legal marriage but would like a blessing. This was arranged with them and they had a church blessing and a party to which they invited their friends. This couple now share a bedroom but the extra room is kept in case they need some time apart.

We found that people had not fully been supported to express their views and be actively involved in making decisions about their care and treatment as much as they would like. Most care plans did not show how people or their representatives had been involved in developing or completing their care plans. One person told us that they were not happy with their allocated key worker and would prefer another member of staff. A key worker is a member of staff with who takes responsibility for a person, ensuring they have enough clothes and toiletries as well as discussing their care plan and suggesting activities.

We discussed with staff how they communicated with people. They explained that some people used British Sign language and some used Makaton. Makaton is another form of sign language. However, staff told us that they had not had specific training in these languages and it was what they had picked up as they worked at the home. They told us that one person living at the home had a book which helped staff to learn certain signs. They said that if they were struggling to communicate with this person they would bring the book along to support staff. However, one person living at the home would make up their own signs and so new staff needed support to leant and understand this person's method of communication.

In addition, we could not be sure that people were confident to say what they wanted instead of agreeing with staff suggestions. An example of this was one person who staff told us had capacity would review plans with their key worker and sign to say they were in agreement with them and then not keep to the agreement. For example, we saw that in July 2017 the person has signed a care plan to say they were willing to reduce their alcohol consumption but had not. Their drinking care plan did not support them stopping and there were no action identified for staff to support and encourage the reduction of alcohol.

People's privacy, dignity and independence were respected and promoted. One couple who lived at the home had their privacy respected. Staff had installed an intercom outside of their bedroom so that they could speak to the couple without interrupting their privacy. However, another person told us that staff did not always knock when they entered their bedroom. The person did have a key to lock their room if needed so could ensure their own privacy.

Staff respected that the building was home for people and never assumed that they could use the communal spaces for meetings. One person told us that staff always asked people for their permission before arranging any meetings or training in the home.

Some people living at the home used advocates. Advocates are independent people who can speak for the person in meetings if they are unable to speak for themselves.

Suitable arrangements had been made to ensure that private information was kept confidential. We saw that written records which contained private information were stored securely when not in use. In addition, computer records were password protected so that they could only be accessed by authorised members of staff.

Requires Improvement

Is the service responsive?

Our findings

People's needs around accessing information had been identified and information was presented to them in a format they could understand. There was a residents' board which showed the last CQC report in a format which was accessible for people. In addition, the results of the survey people had completed to give their views of the care they received was displayed along with the actions taken to improve care. One person told us that they did not see their care plan as they were unable to read. However, they told us their key worker would read it to them at times and they were 50% happy with it. However, people's communication needs were not always fully recorded in their care plans. For example, in one person's care plan we saw a blank communication support needs sheet with just their name on it.

Care and treatment had not always been fully planned to support people's needs. Care plans were out of date and had not been reviewed in a timely fashion. In addition, they did not fully support people's needs. For example, one person's epilepsy care plan had not been reviewed since 2014 and on the health section of their care plan epilepsy was not mentioned. The registered manager told us that each key worker was meant to keep the care plan for the people they support up to date and evaluations should be happening on a monthly basis.

We found that people had not always received the support they needed. This was because staff and care plans had not realistically identified their ability to be independent with some tasks. For example, some people had been classed as being able to keep their bedrooms clean with prompting. However, we saw that this was not the case. Beds had not been properly made and people's clothing was placed in their wardrobes so the drawers could shut. People's carpet were littered and in need of vacuuming.

In addition, people were not required to take responsibility for their choices. One person had some birds as pets. There was a care plan in place that they would clean them out every day and that staff would prompt them to do this. The care plan also stated that if the person did not look after the birds they would need to be rehomed. However, we saw that the cage was dirty and food trays were positioned perches and so were soiled. No action had been taken by the registered manager to ensure the wellbeing of the birds.

Some people living at the home chose to consume alcohol which lead to conflict. At times they would fall out and there had been some verbal and physical incidents. There were no care plan or risk assessments in place around this. One of the people had signed a plan to say they would reduce their alcohol intake. However, there was no care in place to support them and no reduction had occurred. In addition, both people had recently received care for taking an overdose of medicine and no care plan was in place around suicidal thoughts for people.

Activities did not fully support the needs of people living in the home. One person living at the home had been diagnosed with dementia and was struggling to access the community. The registered manager had raised with the person's social worker that they would benefit from some individual support to access the community. We saw that the person spent the morning alone in their bedroom. They told us they were not happy but were unable to express themselves to tell us why.

Most people were left to be independent with activities and some accessed the local community. One person told us, "I normally cut the lawns when the weather is nice." During the day we saw that some people were colouring pictures copied onto white paper from children's colouring books. This was not age appropriate for people and people did not have support staff.

There was an activity coordinator at the home and they provided activities for three people who received extra funding for day care activities from 9am until 3pm five days a week. We discussed this with the registered manager and operations director as this service appeared to only be providing a level of activities that we would expect all people living in a home to receive. In addition, four more people in the home were provided with five hours of extra support a week to help them access the community and activities. For example, one person was supported to go to some local events where they could socialise with other people. There was no record of activities undertaken. This meant we could not be assured people were receiving this support.

People's needs and wishes at the end of their life had not been fully discussed with them or recorded in their care plan. While some people at the home were young and did not need to make plans immediately, others may have benefitted by having these wishes recorded. We raised this with the registered manager who told us that the provider had a form to record these in a format that was accessible to people. They told us they would look to put them in people's care plans.

There were robust arrangements in place to ensure that people's concerns and complaints were listened and responded to in order to improve the quality of care. Information about how to make a complaint was available to people in a format they would be able to access. People living at the home knew how to raise a complaint. One person told us if they were not happy they would talk to the senior care worker. A member of staff told us that if any one raised a complaint with them they would raise it with the registered manager. Two complaints had been received and both had been investigated and responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

The provider had taken a number of steps to ensure the home's ability to comply with regulatory requirements. There was a registered manager in post and they appeared caring towards the people and spoke about them in an affectionate manner. In addition, the registered manager had notified us about all the incidents they were required to tell us about by law. They had also displayed the rating form the last inspection on their website and in the home.

However, the home was not well led. The provider had recently reorganised their business and merged the learning disability homes into the same management structure as the older people homes. This had meant that staff at head office had been involved in a restructure. During our visit we spoke with the provider's senior quality improvement lead. They explained that their team had recently formed following the merger. They had plans in place to provide monthly support to registered managers whose services were rated as requires improvement. However, this support had not been offered to the registered manager. As this was the registered manager's first post having been promoted from the role of deputy manager the lack of supported had impacted on the quality of care provided.

As we walked around the home we identified a number of concerns to the registered manager about the cleanliness of the building and the standard of decoration and furniture available to people. They were surprised at the number of concerns we highlighted and that they had not identified the concerns themselves and were committed to improving the quality of care people received. In addition, they had not recognised, or been supported by the provider to recognise that some systems in place were inappropriate. For example, expecting people to purchase their own furniture.

This was a continuing Breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014 Good Governance.

We found that a number of systems were in place to help care staff to be clear about their responsibilities. For example, the provider had policies and procedures in place for staff to follow which outlined their responsibilities in key areas which included to health and safety and medicines management. In addition, there was a communication book in place and staff told us that if they had been on leave they needed to read the communication book to get up to date with any changes in people's care.

In addition, while there were audits in place to monitor the quality of care provided and identify areas for improvement they had not always been completed in a timely fashion or identified concerns. An internal audit of the home had not been completed since 2016. The senior quality improvement lead had visited the home to complete an audit on the day of our inspection. In addition, where issues were identified they had not always been rectified. For example, a recent medicine audit had identified that not all bottled medicine had been dated when opened and we also identified this as a concern. The registered manager had a monthly governance meeting during which they discussed a number of areas such as safeguarding, infection prevention incidents and equipment. The minutes of the governance meeting were shared with the provider's operations directorate.

Staff we spoke with told us that they found the registered manager supportive if they had any concerns and that they felt comfortable raising those concerns. In addition, they said that continual improvement of care was encouraged in the home. One member of staff told us, "We have regular staff meetings and learn from incidents what went well, what did not and how we can improve."

The registered manager told us that they kept up to date by reviewing appropriate magazines and websites. In addition, they had the opportunity to raise concerns and discuss the best way to implement changes with other registered managers at the provider's monthly meetings.

We found that people who lived in the home and their relatives had been engaged and involved in making improvements. One person told us, "I go to the residents' meetings and have raised issues." The provider had arranged local resident's meeting in the home on a monthly basis and then, quarterly regional meetings and an annual national meeting. People living at the home could say if they wanted to raise any issues at the regional meeting. Records showed that people had discussed ideas for activities at the last meeting.

We saw that records relating to the care people needed had not always been completed or kept up to date. We saw that numerous care plans had not been dated and so it was not possible to know if they were current. Information in people's care plans which was no longer current had not been achieved. This made care plans long and it hard to identify people's current care needs. We saw that some boxes of information had been identified for achieving. However, they were stored in a damp shed and we were concerned that information may be lost if the boxes were left there for some time.

The provider was taking some steps to improve the care people received. For example, they were in the process of having a new call system installed. This would provide more access to call bells for people to use.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014 Premises and equipment. How the regulation was not being met: The registered provider and not ensured that the premises were properly maintained Regulation 15(a) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance How the regulation was not being met: The registered provider had not ensured that the quality assurance systems were effective so as to enable them to identify and resolve any shortfalls in the care provided for people. Regulation 17 (1) (2) (a) (b) (c) (f)