Mrs Manny Wragg

Ashlands Care Home

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?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 16 May 2018 and was unannounced. Ashlands 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. It provides accommodation for older people and those with mental health conditions or dementia. The home can accommodate up to 30 people in one adapted building. At the time of our inspection there were 19 people living in the home.

At the time of our inspection there was not a registered manager in post. A new manager who will be referred to in the report as 'manager' had been appointed who was intending to register with CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

The service had previously been rated as 'requires improvement'. At this inspection the service remained 'requires improvement'. We found breaches in regulation. The service had failed to address the issues raised at previous inspections and ensure arrangements were in place to deliver safe care and improve quality. This is the third time the service has been rated Requires Improvement.

Guidance was not consistently in place to ensure people received their medicines when required. Medicines were administered safely, however we found a number of issues in relation to medicine management. Medicine records were not consistently completed.

Where people were unable to make decisions arrangements had not been consistently made to ensure decisions were made in people's best interests. Best interests decisions were not always specific to the decisions which were needed to be made.

A system was being developed to carry out suitable quality checks but appropriate checks had not been regularly carried out. The provider had ensured that there was enough staff on duty. In addition, people told us that they received person-centred care. Sufficient background checks had not been completed before new staff had been appointed according to the provider's policy.

There were systems, processes and practices to safeguard people from situations in which they may experience abuse including financial mistreatment. Risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. The environment was clean. There were arrangements to prevent and control infections. Staff did not always follow best practice to avoid cross infection.

Staff had been supported to deliver care in line with current best practice guidance. People were helped to

eat and drink enough to maintain a balanced diet. People had access to healthcare services so that they received on-going healthcare support.

People were supported to have choice and control of their lives. Staff supported them in the least restrictive ways possible. The policies and systems in the service supported this practice.

People were treated with kindness, respect and compassion and they were given emotional support when needed. They had also been supported to express their views and be involved in making decisions about their care as far as possible. People had access to lay advocates if necessary. Confidential information was kept private.

Information was provided to people in an accessible manner. People had been supported to access a limited range of activities. However people did not access local community facilities. The manager recognised the importance of promoting equality and diversity. People's concerns and complaints were listened and responded to in order to improve the quality of care. Arrangements were in place to support people at the end of their life.

The manager promoted a positive culture in the service that was focused upon achieving good outcomes for people. They had also taken steps to enable the service to meet regulatory requirements. Staff had been helped to understand their responsibilities to develop good team work and to speak out if they had any concerns. People, their relatives and members of staff had not been regularly consulted about making improvements in the service. There were arrangements for working in partnership with other agencies to support the development of joined-up care.

Further information is in the detailed findings below.

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.

Medicine records were not consistently completed.

Staff did not consistently follow arrangements to prevent the spread of infection.

Recruitment checks were not fully completed.

Risks to people's safety had been assessed, monitored and managed so they were supported to stay safe. Arrangements were in place to safeguard people against avoidable accidents.

Arrangements were in place to ensure there were sufficient staff to care for people safely. There were systems, processes and practices to safeguard people from situations in which they may experience abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider did not act in accordance with the Mental Capacity Act 2005. Arrangements were in place to protect people from having their liberty restricted unlawfully.

Staff had received sufficient training and support to assist them to meet the needs of people who used the service.

People had their nutritional needs met. People had access to a range of healthcare services and professionals.

The environment was not appropriate to meet people's needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People had their privacy and dignity maintained.

Care was not consistently provided in an appropriate manner.

Staff responded to people in a kind and sensitive manner.

People were able to make choices about how care was delivered.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care records were personalised However reviews had not consistently ensured records were up to date and reflected people's current needs.

People had access to limited activities. People did not access the local community.

The complaints procedure was on display and people knew how to make a complaint.

The provider had arrangements in place to support people at the end of their life.

Is the service well-led?

Inadequate

The service was not well led.

Quality assurance processes were not consistently effective in identifying shortfalls in the care people received and improving the quality of care.

Staff were listened to and felt able to raise concerns.

The provider had not notified the Care Quality Commission of events in line with statutory requirements.

Ashlands 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. This was a comprehensive inspection.

This inspection took place on 16 May 2018 and was unannounced.

The inspection was carried out by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We examined information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about.

Due to technical problems, the provider had not been asked to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report

During the inspection we spoke with 15 people who lived at the service, three relatives, a visiting friend, three members of care staff, and the manager. We also looked at three care records and records that related to how the service was managed including staffing, training and quality assurance.

Requires Improvement

Is the service safe?

Our findings

We observed inconsistencies in how medicine administration records (MARs) were completed. For example, one medicine which was administered by the district nurses had been recorded in three different records. One of the records recorded different stock availability to the others. Another medicine had been recorded as given however the bottle did not have the start date recorded on it which meant it was unclear if the medicine had been given out of it. In another record a person was recorded as having refused their medicine however on the MAR the medicine was signed as given. This meant it was difficult to check what medicines had been given. Medicine front sheets were in place however allergies were not consistently recorded on these or on the MAR. There was a risk people could receive medicines they were allergic to.

Information to support staff when administering as required, (PRN) medicines, was usually available to staff to ensure people received their medicines when they needed them. We found three occasions when PRN protocols were not in place. Where people received their medicines without their knowledge (covertly) we observed the appropriate arrangements had been put in place to ensure the method of administration did not affect the way the medicines worked. We found that suitable arrangements were in place to safely manage people's medicines in line with national guidelines.

Relative's views on staffing levels were mixed. One relative said "They are very understaffed". Another said "There's not always enough, especially in an evening. They all seem to be running around doing too many jobs." Staff we spoke with told us that they felt staffing numbers were adequate given the current occupancy level. During our inspection we did not observe any occasions when people were not responded to. The manager told us they had put in place arrangements to ensure there was sufficient staff to support people. We saw that call buttons were within easy reach for people so they could get assistance if they needed. We observed call bells were responded to promptly. A relative told us, "The staff are good at responding when you want them e.g. if (family member) wants the toilet."

We found that in relation to the employment of new staff the registered persons had not consistently undertaken the necessary checks. We looked at three staff records and found in two of the records the provider had not obtained the appropriate number of checks to ensure staff were appropriate to work with vulnerable people. We checked the provider's policy which stated, "A minimum of two references." These measures had helped to establish the previous good conduct of the applicants and to ensure that they were suitable people to be employed in the service. We spoke with the manager who told us they had completed risk assessments because they had been unable to obtain two references. This meant the provider had not recruited staff according to their policy to reduce the risk of unsuitable staff being employed. The registered persons had carried out checks with the Disclosure and Barring Service to show that the applicants did not have relevant criminal convictions and had not been guilty of professional misconduct.

People told us they felt the home was clean. We observed suitable measures were in place for managing hospital acquired infections and staff were aware of these. An audit had recently been carried out and actions put in place where issues had been identified. Staff had received training however we observed two occasions when staff actions promoted a risk of cross infection. During lunch we saw that a member of staff

dropped the lid of a juice jug into the juice. We saw that they retrieved the lid out of the juice and replaced it on top of the jug. Although the member of staff was wearing gloves these had been worn throughout lunch. The jug of juice continued to be used in serving people drinks. We also observed a member of staff assist a person with a biscuit by breaking it into small pieces and putting the pieces directly into the person's mouth. We saw that the staff member was not wearing gloves and whilst assisting this person was also touching another person.

People told us that they felt safe living in the service. Relatives also told us they were confident that their family members were safe. One relative said "I believe [family member] is mostly but sometimes that room [main lounge] is left with no staff, it's worse in the afternoons, they [staff] are doing their notes then in the dining room. It would be better if there was just one in the lounge with them. Whilst [family member] can't move, not mobile, [family member] is vulnerable to those that are walking around."

There were systems, processes and practices to safeguard people from situations in which they may experience abuse. Records showed that care staff had completed training and had received guidance in how to protect people from abuse. We found staff knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk. This included reporting issues to external agencies such as the local authority. Staff told us they thought people were treated with kindness and they had not seen anyone being placed at risk of harm. We also noted that the registered persons had established transparent systems to assist those people who wanted help to manage their personal spending money in order to protect people from the risk of financial mistreatment.

We found that risks to people's safety had been assessed, monitored and managed so that people were supported to stay safe while their freedom was respected. This included measures that had been taken to help people avoid preventable accidents. For example, risk assessments were in place to manage the risk of falls. Arrangements were in place to protect people in the event of situations such as fire or flood.

Staff were supported to promote positive outcomes for people if they became distressed. For example, guidance was available in people's care plans so that they supported them in the least restrictive way. When we spoke with staff they were able to tell us about these. Relatives told us that staff dealt well with people who were confused or distressed. One relative said "There was one person that did cause a lot of disruption and they [staff] were very professional, very gentle. I never witnessed anything that caused me concern."

We found that the registered persons had ensured that lessons were learned and improvements made when things had gone wrong. Staff told us they received feedback on incidents and accidents. Records showed that arrangements were in place to analyse accidents and near misses so that they could establish how and why they had occurred. We also noted that actions had then been taken to reduce the likelihood of the same thing happening again.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The law 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found that arrangements had been made to obtain consent to care and treatment in line with legislation and guidance but these had not been consistently applied. Staff were supporting people to make decisions for themselves whenever possible. Records showed that when people lacked mental capacity the registered manager had put in place a decision in people's best interests. These were not decision specific as required by national guidance. There was a risk decisions were being made on people's behalf inappropriately.

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 service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Information was not available to confirm we had been notified when people were subject to DoLS. We asked the manager to send this information to us.

Where people were able to consent documentation had not been consistently completed with them for issues such as access to records and photography. We spoke with the manager about this who told us they were in the process of completing these. There was a risk people received care they had not consented to. We found care records did not show where people had capacity to consent to their care and treatment or if another person had legal authority to give consent that this had been given. Do not attempt cardiac pulmonary resuscitation orders (DNACPR) were in place where appropriate and had been reviewed.

A refurbishment plan was not in place. There were few obvious adaptations to assist people who required assistance with orientation around the home. People's room doors were all the same colour and upstairs they were the same as service doors, for example, toilets and bathrooms. All the bedroom doors had numbers and name plates. There was no use made of memory boxes or photographs to assist people who were unable to read in locating their bedroom. There were few directional signs and some signs were in a poor condition for example, one to the main lounge with text and an image had slipped off the wall and were wedged behind the door architrave.

We observed lunchtime and found the experience was not relaxing for people. We observed staff occasionally communicating with each other across the room and between the dining room and lounge by calling loudly over the heads of people. People were encouraged to eat and drink but this was often from a distance with no real one-to-one engagement and without staff waiting to see if their encouragement had been effective. For example, a member of staff encouraged a person to drink but left the person immediately without seeing if the person in fact taken a drink.

The meals looked appetising and the portions were of a good size. A relative said, "The food is excellent, everyday there are vegetables and meat and home-made puddings." Another relative said, "The food and drinks are of a very high standard". One person said, "It's always very nice, you are given a nice choice and if you don't feel like something that's alright you can have something else." The menu was written on a board in the dining area and a menu was also displayed on the tables. It was not available in pictures to support people who were unable to read to make decisions. However we observed staff asking people what they would like for lunch in the morning. We saw if a person did not like the food the staff offered an alternative.

People were supported to eat and drink enough to maintain a balanced diet. We observed drinks and snacks were provided throughout the day in communal and bedroom areas. Where people had specific dietary requirements we saw these were detailed in care records and staff were aware of these.
We found that arrangements were in place to assess people's needs and choices so that care was provided to achieve effective outcomes. Initial assessments had been carried out prior to people coming to live at the home. We observed these had established if people had cultural or ethnic beliefs that affected how they wished to receive their care.

People were confident the staff knew what they were doing and had their best interests at heart. Members of staff told us and records confirmed that they had received introductory training before they provided people with care. The manager was in the process of introducing the National Care Certificate which sets out common induction standards for social care staff. Staff had received some refresher training to keep their knowledge and skills up to date. The manager was in the process of revisiting this with staff and had recently changed the provider for delivering training. When we spoke with staff we found that they knew how to care for people in the right way and where people had specific needs arrangements had been put in place to provide training to staff. For example, staff had received training around dementia care.

Staff told us they were able to speak with the manager if they needed to. Arrangements were in place for staff to receive one to one support. Records showed supervisions and appraisals on a one to one basis had taken place and were planned for the future. This is important to ensure staff have the appropriate skills and support to deliver care effectively.

A relative said "I asked for a GP to come and give [family member] an MOT when they first came here and they [staff] arranged that. My [family member] is diabetic and I asked them to give [family member] a snack between meals and they are doing that." Records confirmed that people had received all of the help they needed to see their doctor and other healthcare professionals such as specialist nurses, dentists, opticians and dieticians. Reviews were held with people and professionals who were involved in their care. These included meeting with their GP, personal representatives and other health professionals. This helped to promote good communication resulting in consistent and coordinated care for people. Where people had specific health needs for example diabetes, care plans reflected this and detailed how to meet these needs. 'Grab sheets' were not in place to use when people were admitted to hospital to ensure staff had an understanding of people's care needs. We spoke with the manager about this who told us they were in the process of introducing these.

Requires Improvement

Is the service caring?

Our findings

Observations of staff's approach in supporting and interacting with people were found to be inconsistent in terms of the quality of care provided. We saw occasions when people were treated with kindness and were given emotional support when needed. For example, we observed a member of staff pull up a chair and sit in front of a person and help them with their drink. We saw they did this at the person's pace in a caring, kindly and patient manner. We saw that the staff member was constantly talking to the person checking they were alright and offering praise and reassurance. However we also observed a staff member remove cups from people without speaking to them or checking whether or not they had finished their drinks. We saw that some interactions were conducted at a distance with staff asking people if they were "alright" whilst walking past or calling out to them across the room but not waiting for or responding to any response.

People and their relatives were positive about the care they received. One person told us, "They are good girls, kind." A relative said, "Staff are brilliant, I really like them." Another said, "From what I see they are really lovely and [family member] says they are lovely, they treat them like relatives, don't talk down to them, they know the individuals. I just want [my relative] to be happy and they are."

Where people required specific support to prevent them from becoming distressed this was detailed in their care records and guidance was in place to support staff. When we spoke with staff they explained how they reassured people and tried to distract them from the issue that was making them upset. We observed staff using terms of endearment and the residents preferred name. The staff were calm with people even when they were upset.

We found that people had been supported to express their views and be involved in making decisions about their care and treatment as far as possible. For example, a care record stated, a person preferred a wet shave. Another record stated, "I like to put my nightwear on and sit in my room and watch TV." We observed staff supporting people to move and saw this was done safely and at people's own pace. Staff explained what they were doing and how people could assist them when moving. One relative told us that when staff hoisted her family member, "They do it safely and gently." Another relative told us, "They are very good with the lady in the hoist, there are always two of them when they use it and they are very gentle, don't rush."

We saw two members of staff assist a person to walk into the room. We saw they did this at the person's pace and allowed them to do as much for themselves as they could whilst remaining attentive and staying close. Another staff member assisted a person to walk from the lounge to the dining room using a frame. We saw that the carer asked the person where they wanted to sit but that as they approached the chosen seat the person said they needed to go to the bathroom. The member of staff immediately responded, in a warm and patient manner and accompanied the person out of the room.

Most people had family, friends or representatives who could support them to express their preferences. In addition, records showed and relatives confirmed that the registered manager had encouraged their involvement by liaising with them on a regular basis. Furthermore, we noted that the provider had access to

local lay advocacy resources. Lay advocates are people who are independent of the service and who can support people to make decisions and communicate their wishes.

People's privacy, dignity and independence were respected and promoted. A relative told us, "When doing [family member] personal care they treat [family member] with dignity, they close the doors and windows." Another said "They are fine when giving personal care. They do treat [family member] well, with respect yes." We observed there were a number of areas within the home where people could go for quiet time and privacy if they required. We observed staff knocked on people's bedroom doors and called them by their preferred name. People told us staff were usually respectful when supporting them with personal care and they had never felt undignified or embarrassed.

We found that suitable arrangements had been maintained to ensure that private information was kept confidential. 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 said that nurses and care staff provided them with all of the assistance they needed. We found that people received care that was responsive to their needs. However during our inspection we observed occasions when staff's interaction with people was not personalised. For example, we observed a member of staff come into the main lounge and sit down next to a person. We saw that the staff member began writing in a file. Although the member of staff spoke briefly with the person they did not look at them or have eye contact. When the staff member left the room they did not talk to the person. On another occasion we observed a member of staff take a cup from a table in front of a person. The member of staff did not speak to or interact in any way with that person.

Assessments had been completed before people came to live at the service. Records showed that staff had consulted with each person about the care they wanted to receive and had recorded the results in an individual care plan. Individual booklets were included in the care record to inform staff about what was important to people. For example, information about people's work history and life experiences. However we found these were not consistently completed. These are important because they help staff to understand people's needs and wishes. Care plans were not regularly reviewed and records did not accurately reflect people's changing needs and wishes. For example, a person no longer required a catheter however it was not clear from the records that this was the case. A care plan for catheter care remained in place. In another record we saw a person required specific care due to a hospital acquired infection however a care plan was not in place. Another person's health had recently deteriorated and they were no longer able to mobilise however the care records did not reflect this. There was a risk staff would not provide the appropriate care to people.

Care plans and other documents were written in a user-friendly way according to the Accessible Information Standard so that information was presented to people in an accessible manner. We saw people had been involved in discussions about their care plans. The Accessible Information Standards is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.

A member of staff was employed to lead on coordinating activities for two days a week. During our inspection we observed a small number of activities taking place in the afternoon. For example, 13 people played card bingo. They were supported by four members of staff and a relative. We saw there was a lot of laughing and friendly banter and that people appeared to be enjoying themselves.

People's views on and experience of the activities provided in the home were mixed. One person said "We don't do a lot really. There's not a lot we can do. We have cups of tea, talk." Another person told us, "We just do what they want us to do, just talk mostly." However, a relative told us "The vicar comes. The activities coordinator does word games with them, I've seen them doing jigsaws. They have little quizzes. They have sing songs, my [family member] likes that. There's arts and crafts for those that can do it." People were not supported to access the local community. Staff told us this used to happen but no longer does. They said, "We used to go for pub lunches, I would like to do that again with people as they enjoyed it."

Relative's told us they felt welcomed at the home and we observed staff speaking with relatives and chatting with them about plans for an event to celebrate the royal wedding.

We noted that staff understood the importance of promoting equality and diversity. This included arrangements that had been made for people to meet their spiritual needs. For example, one person had attended a local church on a regular basis. Furthermore, the provider recognised the importance of appropriately supporting people if they identified as gay, lesbian, bisexual and transgender.

There were arrangements to ensure that people's concerns and complaints were listened and responded to in order to improve the quality of care. When we spoke with people they told us they knew how to raise concerns. A relative told us, "If I've got any issues I go into the office, if anything upsets me for example clothes were an issue, [family member]) had a lovely wardrobe and they were getting their clothes mixed up. They've sorted all that now."

The provider did not have anyone who required end of life care. However we observed they had begun to develop arrangements to support people at the end of their life, for example, including appropriate care plans in the care records.

Inadequate

Is the service well-led?

Our findings

We have carried out three comprehensive inspections at this service. On all three occasions, the service has been rated as 'requires improvement', with repeated issues highlighted as concerns and any improvements not always being sustained. The service has not met some of the regulations since January 2014. We have taken this into account when considering our rating in this domain.

Breaches of regulation were identified in April 2016. We found breaches of the Health and Social Care Act (Regulated Activities) regulations 2014 in Regulations 17 and 12. The provider did not have effective systems or processes to assess, monitor and improve the quality of service. Accurate and complete record in respect of each person's care and treatment. The provider did not have effective methods in place to manage the risk of the spread of, infections. In November 2016 we found that improvements had been made in these areas however they were insufficient to revise the overall rating. At this inspection in May 2018 we found a breach in relation to Regulation 17. Quality monitoring systems did not identify the issues found at inspection. People's care records were not accurate and complete in respect of each person's care and treatment. The provider had failed to address issues previously identified at inspection. The provider did not follow policies.

Continued breaches of the regulations demonstrate that the service is still not consistently well led and does not give us confidence that the provider can deliver and sustain the improvements needed to ensure the health, safety and welfare of people using the service.

We also found continued concerns about the management of the risk of the spread of infections due to poor staff practice and failure to ensure care records were up to date.

On arrival at the home the manager was not available and it was not clear who on site had the knowledge and authority to provide effective management. People we spoke to acknowledged that there had been problems with the home in the past but some recognised an improving situation. A visiting professional told us there had been a lack of consistency with regards to the management of the service. At our inspection in April 2016 we also identified concerns about this. At our previous inspection in 2016 the service had been rated as 'requires improvement' in all domains however we were unable to locate an action plan informing us how the provider intended to address the issues. We found at this inspection some of the issues remained ongoing.

The manager was in the process of developing a system for checking the quality of care and ensuring it was improved. Records showed that the registered persons had not regularly checked to make sure that people benefited from having all of the care and facilities they needed. For example checks on records had only been reviewed in April 2018. Despite the check we found records were not consistent and did not reflect people's needs. We found this to be an ongoing issue which had been identified at inspection in April 2016. Medicine audits were not in place and during our inspection we found there were a number of issues relating to the recording of medicines.

The provider had not ensured that policies and procedures were followed to ensure care was delivered according to best practice. For example, they had failed to follow their recruitment policy or ensure that staff were working to the medicines policy.

We looked at the Statement of Purpose which is a document providers are required to have in place detailing they details of the service. We looked at this and found it required updating and did not reflect current arrangements for management or appropriate reporting of complaints.

Records showed that the registered persons had not correctly told us about significant events that had occurred in the service, such as accidents, incidents and injuries. However we were unable to check if the provider had informed us about people who were subject to DoLS. The manager forwarded the notifications to us after the inspection.

We found that people who lived in the service, their relatives and members of staff had not been engaged in the running of the service. There were no formal opportunities for people to express their views and wishes about the care and support they received. Relatives we spoke with told us there used to be resident and relatives meetings but these hadn't been held for over a year.

There was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The provider had failed to address issues previously raised at inspections. Arrangements were not in place to ensure the provision of safe and effective services. Under Regulation 17(3), we have asked the provider to send us a written report setting out how they plan to improve the quality and safety of the service and the experience of people using the service. They must send this to us by no later than 28 days after receipt of our request. We will continue to monitor the service and may take enforcement action if we are not satisfied with their progress.

The provider had taken steps to ensure that members of staff were available to promote the service's ability to comply with regulatory requirements. For example, a deputy manager and an activities coordinator had recently been appointed.

A member of staff told us they thought there had been a number of improvements, for example the reviewing of care records. Regular staff meetings were held and staff received feedback from the manager with regard to issues in the home. Staff told us they felt there was a good team environment and staff understood their roles within the organisation. Some staff had been given lead roles in areas such as infection control.

Staff described the home as homely and caring. A staff member said, "The manager explains things to you before expecting you to do them. "We found that the manager had made a number of arrangements that were designed to enable the service to develop. This included linking with local organisations such as the CCG to introduce improvements. The manager had developed working relationships with local services such as the local authority and GP services. We observed staff had worked with partner agencies in order to resolve issues. For example, we spoke with a visiting NHS professional from the Care Home Support Team who told us things within the home had started to improve.

A relative told us, "Yes it's had its problems; the manager is trying to put paperwork and processes in place to make it better. I do think it has got better. They do the best they can with the staff and the resources they've got but not enough money is spent on the place I'd like to see a little bit more spent on furnishings. For example, the sun through the lounge windows is too strong and there's no blinds so they have to draw the curtains which is not good, blinds to just shade it would be good." Staff told us they thought the

manager, was approachable and listened to them. However they told us they rarely saw the registered persons. Staff told us they were confident that any concerns they raised with the manager would be taken seriously so that action could quickly be taken to keep people safe.

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 17 HSCA RA Regulations 2014 Good governance Quality monitoring systems did not identify the issues found at inspection. People's care records were not accurate and complete in respect of each person's care and treatment.The provider had failed to address issues previously identified at inspection. The provider did not follow policies.