Dresden House Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected this service on 25 November 2016. This was an unannounced inspection. Our last inspection took place in August 2015. At that time we found the provider was meeting the required Regulatory requirements.

The service is registered to provide accommodation and personal care for up to 25 people. People who use the service may have a physical disability and/or mental health needs, such as dementia. At the time of our inspection 23 people were using the service.

There was a registered manager at the home. 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 and associated Regulations about how the service is run.

At this inspection, we identified a number of Regulatory Breaches. The overall rating for this service is 'Inadequate' and the service has therefore been placed into 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

At this inspection, we found that the provider did not have effective systems in place to assess, monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the registered manager or provider.

Risks to people's health, safety and wellbeing were not consistently identified, managed and reviewed and people did not always receive their planned care. Medicines were not always managed safely.

People were not always protected from the risk of abuse because suspected abuse was not always reported as required. Safe recruitment systems were not in place to ensure staff were of suitable character to work with the people who used the service.

Safety incidents were not always analysed and responded to effectively, which meant the risk of further incidents was not always reduced. There were not always enough suitably skilled staff available to keep people safe and meet people's individual care needs.

People told us they enjoyed the food. However, we found that some people did not always receive the support they needed to eat and drink. People's risk of malnutrition and dehydration were not being effectively monitored.

The requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) were not always followed to ensure decisions were made in people's best interests when they were unable to do this for themselves. We identified one person who was potentially being unlawfully deprived of their liberty.

We found staff did not always have the knowledge and skills required to meet people's individual care needs and keep people safe. Prompt referrals to health and social care professionals were not always made in response to changes in people's needs or behaviours.

People were involved in the planning of their care. However, people's care plans were not always accurate and up to date which meant staff didn't always have the information they needed to provide safe and consistent care.

There was a programme of social and leisure based activities on offer to people. However, we found some people were not always supported to engage in activities that were meaningful to them.

The registered manager and provider did not always notify us of reportable incidents and events as required. The inspection rating was not being displayed at the home as required by law.

People spoke fondly about the staff and at times, we observed some positive interactions between staff and people. However, we found that people were not consistently treated in a caring manner as staff were often busy supporting people with care tasks.

Some people were offered regular choices about their care. However, improvements were needed to ensure all people were offered daily choices about the parts of their care they could make decisions about.

There was an effective system in place to enable people to complain about their care. Complaints were investigated and managed effectively to make improvements to people's care.

People's right to privacy was promoted and people and staff described the registered manager as approachable.

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. Risks to people's health, safety and wellbeing were not always assessed, planned for, managed and reviewed to promote people's safety. Medicines were not always managed safely.

Staff were not always available to keep people safe and meet people's care needs. Effective systems were not in place to ensure staff were suitable to work with the people who used the service.

Incidents of potential or alleged abuse were not always reported to the local authorities safeguarding team as required.

Is the service effective?

Inadequate

The service was not effective. People did not always receive the support they needed to eat and drink. Staff did not always have the knowledge and skills needed to meet people's needs effectively and safely.

People's health needs were not effectively monitored and managed and, prompt referrals to health care professionals were not always made when people's needs changed.

The requirements of the Mental Capacity Act 2005 were not always followed. This meant we could not be assured that decisions were made in people's best interests when they could not make decisions for themselves. The requirements of the Deprivation of Liberty Safeguards (DoLS) were not always followed and people were potentially being unlawfully deprived of their liberty.

Is the service caring?

Requires Improvement

The service was not consistently caring. Staff were not always available to respond to people's requests for care and support. Most people were involved in making choices about their care. However, improvements were needed to ensure everyone could consistently make choices about their care when they were able to do this for themselves.

Staff knew people well. However, information about people's preferences and care needs were not always recorded in people's care records for all the staff to follow.

People were encouraged to be as independent as they could be, but improvements were needed to ensure people had access to the right equipment to improve their care experiences.

People's privacy was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive. The information in people's care records was not always accurate and up to date. This meant people were receiving and/or were at risk of receiving inconsistent and unsafe care.

More improvements were needed to ensure people were supported to engage in meaningful activity throughout the day.

People knew how to complain and complaints were managed appropriately to improve people's care experiences. People were also supported to complain about other services that they received care and support from if this was appropriate.

Is the service well-led?

Inadequate

The service was not well led. The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care.

Effective systems were not in place to monitor safety incidents, so action was not always taken to reduce the risk of further harm occurring.

The provider did not always notify us of reportable incidents and events that occurred at the service and the inspection rating was not being displayed as required by law.

Dresden House Limited

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 was 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 25 November 2016 and was unannounced. The inspection team consisted of two inspectors.

We chose to complete this inspection after we received a notification from the provider that informed us of an incident that occurred at the service where a person sustained serious injuries. We are reviewing the information relating to the circumstances of this specific incident outside of this inspection to identify if a criminal investigation is required. However, the information about the incident indicated potential concerns with the way the registered manager and provider managed people's risk of falling. This inspection examined those risks.

Before the inspection we checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. We used this information to formulate our inspection plan. We also met with representatives from the local authority to discuss the concerns they had with quality and safety at this service.

We spoke with eight people who used the service and two people who visited the service. We also spoke with, four members of care staff, the registered manager and one of the provider's directors. We did this to check that good standards of care were being met.

We spent time observing how people received care and support in communal areas and we looked at the care records of seven people to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included staff rotas and staff files. The registered manager was unable to show us staff training records and quality assurance audits during the inspection. Therefore, we requested that this information was sent to us following the inspection. We did not receive this

information as requested.

After our inspection, we met with representatives from the local authority again to share our findings and concerns. We did this to safeguard people who used the service.

Inadequate

Is the service safe?

Our findings

One person who used the service told us about a serious incident that had recently made them feel unsafe. They said, "I felt frightened at the time, but I feel safer now as I use the lock on my door now. It's always been there, but I've only just needed to use it". We found that this incident was preceded by an earlier incident where the person was threatened by another person who used the service. This earlier incident was not managed effectively to prevent the second and more serious incident from occurring.

We found that risks to people's health safety and wellbeing were not always assessed and planned for. For example, care records showed and staff confirmed that some people who used the service regularly displayed behaviours that challenged. These behaviours included physical and verbal aggression towards other people who used the service and staff. No plans were in place to guide staff in how to support these people and keep themselves and other people safe during incidents of aggression. One staff member told us, "[Person who used the service] can be abusive, we just have to take it and try and calm them down the best we can". Another staff member said, "We can't really do much, we just try and calm them down". We asked staff how they calmed these people down. Staff gave us different answers. For example, one staff member said they would try and find out what was upsetting the person and another staff member told us they would give the person space and remove themselves from the situation. This meant staff did not have the information they needed to manage people's behaviours that challenged in a safe, effective and consistent manner.

Care records showed that some risks to people's health, safety and wellbeing had been planned for. However, we found that the plans in place to manage people's risks were not always followed to promote people's safety. For example, one person who was at high risk of falls and had fallen several times since September 2016 had a risk management plan in place that outlined how their risk of falling should be managed. Their plan recorded that a sensor mat should be placed in front of their lounge chair so that staff would be alerted when the person was attempting to move. We saw that this sensor mat was not placed in front of their lounge chair as planned. Staff we spoke with told us the sensor mat was needed, but were unable to explain why it was not placed in front of the person as planned. This showed that people's risks were not being managed as planned.

We found that safety incidents did not always trigger a review of the risks to people's health, safety and wellbeing. For example, one person's risk of falling was last reviewed in June 2016. However, records showed this person had fallen on several occasions after this date. This meant we could not be assured that action was taken to reduce this person's risk of falling again.

We found that safe systems were not in place to ensure people's medicines were administered safely. We observed two staff members directly handle people's medicines. The Royal Pharmaceutical Society's 'Handling Medicines in Social Care' guidance recommends that staff do not directly handle medicines due to safety risks. We also saw a staff member leave a person with a dose of liquid medicine to take without direct supervision. Staff confirmed that this person and the people sitting around them were often confused. Therefore, the member of staff who left the medicine would have no way of knowing if the person had taken

their medicine as prescribed, or if another person who not prescribed this medicine had taken it.

The above evidence demonstrates that effective systems were not in place to ensure people received their care in a safe and consistent manner. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that staff were not always available to provide prompt care and support. One person told us that staff couldn't always come quickly when they needed support. This person was at high risk of falling and required the support of two staff to enable them to move safely. They said, "I have fallen because I have tried to get up on my own". We saw that this person used their call bell to request staff support. However, at the time they needed this support, only one staff member was available. The staff member told the person politely that they would need to wait for another staff member to become available. The person was then left alone to wait for the staff to become available to assist them. This left the person at risk of falling as they were known to try and move without staff support which had resulted in a significant number of falls. We observed this person wait for a significant amount of time before we had to move away from the area where we were completing our observations. This showed staff could not promptly assist this person when they asked for support which left them at risk of harm to their health, safety and wellbeing.

Staff told us that they were not always able to provide people with the full support that they needed. One staff member said, "People's needs are getting worse. There are more behaviours and higher needs". This staff member gave us an example of one person who had started to need more time and support from them. We saw that this person did not get the support they needed at mealtimes to help meet their eating and drinking needs. Another staff member said, "People have to wait for the toilet or support. When two staff are supporting a person, it just leaves me, so if I have to help another person it leaves no staff in the communal areas". This was particularly significant as some people did display behaviours that placed themselves and others at risk of harm. There was a risk that staff would not be able to manage this risk of harm if they were not present to observe these behaviours.

Care records showed that staff were not always available to promote people's safety. For example, one person's records showed that an incident had occurred when just two staff were on shift. This incident required both staff members to spend some time with the person who was agitated and distressed. This left no staff members available to identify and respond to any safety concerns involving other people who used the service.

The above evidence shows that staff were not always available to keep people safe or meet people's care needs and preferences. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us how they identified, recorded and reported potential abuse. However we identified at least three incidents of potential abuse or neglect that had not been reported to the local safeguarding team as required. One of these incidents involved staff physically placing their hands on a person to prevent them from hitting another person who used the service. Care records showed that these two people were then involved in a serious incident the following day. Local and national safeguarding guidance states that incidents of alleged abuse should be immediately reported in order to safeguard people from further potential abuse. This showed that the registered manager did not consistently follow safeguarding procedures to report all incidents of alleged abuse as required. This left people at risk of harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from the risk of abuse and avoidable harm because systems were not in place to

ensure staff were of suitable character to work with vulnerable people who used the service. We looked at three staff files and found that safe recruitment systems were not used for all three staff members. For example, references had not been sought for one staff member to check they were of suitable character to work at the home. When checks of staffs' criminal history checks came back positive, risk assessments were not always completed to identify if the staff were suitable to work with people at the home. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Although people told us they enjoyed the food at Dresden House, we saw and staff confirmed that people did not always get the support they needed to eat and drink. One person's care plan for eating and drinking stated, 'staff to observe mealtimes as on occasion [person who used the service] will store food in their mouths, staff to encourage to swallow between mouthfuls'. We saw that staff did not observe this person at breakfast or dinner and the person received no encouragement to eat. For example, the person did not touch their toast at breakfast time and the full plate of toast was removed by staff without prompting or encouraging the person to eat it. Staff confirmed that this person needed support at meal times and accepted the support hadn't been given. One staff member said, "We should have sat with [person who used the service] this morning. There's no excuse for that". Another staff member said, "The girls should have put the toast in their hand to prompt".

Another person's eating and drinking care plan stated 'will often refuse meals, staff to encourage [person who used the service] and offer an alternative such as a sandwich'. We observed this person at lunch time. They were presented with a plate of chips and peas which they did not touch. After 26 minutes a staff member entered the room and said, "Eat your chips". After another six minutes, the untouched plate was removed and a staff member said, "I'll swap you this for a pudding", a pudding was then placed in front of the person. The untouched pudding was removed after 15 minutes. This meant staff did not encourage the person to eat their meal as planned and an alternative meal was not offered. A staff member confirmed that an alternative meal should have been offered. They said, "Staff should sit and offer something different if needed". We saw that later in the afternoon this person was offered and accepted a bowl of ice-cream which they did eat, but no alternative was offered at lunch time.

We also saw this person struggle to drink form their beaker. They held their beaker of tea to their mouth with the straw touching their cheek for 12 minutes before a staff member assisted the person to place the straw into their mouth. The person then quickly proceeded to drink their beaker of tea in a manner that suggested they were thirsty. This showed the person didn't get the support they needed to drink when the drink was placed in front of them.

The above evidence shows that people did not always receive the support they needed to eat and drink. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us and care records showed that some people were supported to see health care professionals when they were unwell. However, we found that people were not always supported to maintain good health. For example, we found that professional advice was not always sought in relation to changes in people's needs and health. One person's care records showed they had fallen on four occasions in September 2016. This person's care records did not show that advice had been sought in relation to their recent falls. Therefore we cannot be assured that this person has received the assessment and support they need to help manage their risk of falling again.

We found that advice and recommendations from health and social care professionals was not always acted upon or included in people's care plans. A visiting nurse had recommended that two people should drink a certain amount of fluids each day. However, these two people's fluid intake was not being recorded or monitored as recommended. Another person's social worker had recommended the purchase of a plate warmer to keep the person's food warm as they ate their meals slowly. However, this piece of equipment had not been purchased or being used. We were given no explanation by staff or the registered manager as to why these recommendations were not being followed. This meant that these recommendations to enable people to experience good health and wellbeing were not being followed.

We found that some people's weight was not regularly checked when they had been identified as being at risk of malnutrition. For example, one person's care records stated their risk of malnutrition needed to be reviewed every eight weeks. This person's care records showed that their weight had only been checked and recorded on one occasion in a five month period. This person's care records showed they had a reduced appetite and a tendency to refuse meals. We were also not assured that accurate records of this person's food intake were maintained as on the day of our inspection their records stated, 'Didn't eat much of their lunch and declined pudding, but had ice cream later on'. This was not an accurate record of the person's nutritional intake as they had not eaten any of their lunch despite the records stated they had. This meant staff were not reviewing this person's risk of malnutrition as planned as they were not monitoring this person's weight or accurately recording their dietary intake.

The above evidence shows that effective systems were not in place to ensure people's health, safety and wellbeing needs were consistently monitored and met. This was an additional breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the requirements of the Mental Capacity Act 2005 (MCA) were not being consistently followed. The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Although some staff were able to tell us the basic principles of the Act, care records showed these principles were not consistently followed. For example, we saw and staff confirmed that one person did not have the capacity to consent to living at Dresden House. This person told us they wanted to go home to live with their mum. A mental capacity assessment in relation to this care decision had been completed in April 2016 and recorded that the person did have the capacity to make this decision. This person's ability to consent to this element of their care had since changed, but the assessment had not been reviewed to reflect this.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Although some appropriate DoLS applications had been made, we found that the staff did not fully understand the DoLS process. The DoLS only apply to people who do not have capacity to make decisions about their care. However, we found that a DoLS referral had been made for a person who the staff had assessed as having capacity to make decisions about their care. This meant the DoLS had been incorrectly applied. We saw and staff confirmed that another person who used the service was being unlawfully deprived of their liberty. We saw and staff confirmed that this person did not have the capacity to make the decision to live at Dresden House. Staff told us they would prevent this person from leaving the service as they would be unsafe in the community. No DoLS application had been made for this person, despite the staff being aware of the restrictions that were being placed on them. This meant this the requirements of the MCA and DoLS were not being followed and consent was not being sought in accordance with current legislation. This was a breach of Regulation

11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received training to enable them to carry out their roles. However, the registered manager was unable to show us staff training records during the inspection. We asked for these records to be sent to us immediately following the inspection, but these records had not been received at the time of drafting this report. We saw that some of the training staff told us they had received had been ineffective. For example, a person told us, we saw and staff confirmed that safe moving and handling was not always practiced. One person told us, "The staff help me to move, they hold me under my arms". A staff member told us how they supported this person to move. They said, "I scoop them under their arms to boost them up". We also saw two staff members assist someone to stand by positioning their arms under the person's arm pits. Supporting people to move by holding them under their arm pits is unsafe and places people at risk of significant shoulder injuries. We also saw that that staff were not consistently applying the requirements of the MCA and DoLS to ensure decisions were being made in people's best interests when they were unable to make these decisions for themselves. This meant some staff did not have the skills required to meet people's needs in an effective and safe manner. This was an additional breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

People who could tell us about their care spoke positively about the staff and the care they received. Comments included; "The staff are always nice to me", "The staff help me" and, "The staff are very helpful and friendly". However, our observations showed a consistent caring approach was not always provided by staff. For example, we observed one person shouted, "Nurse" intermittently throughout the day. There were multiple occasions when this person's request for support were ignored by the staff. On one of these occasions we saw that the person waited seven minutes before staff interacted with them. During these seven minutes, staff entered the room that the person was in, but interacted with another person who had not shouted for support. The periods when this person shouted for support were often mealtimes and staff appeared busy with other tasks at these times which meant they were unable to offer this person the support they requested.

Most people told us and we saw that they were given choices about some parts of their day to day care. For example, one person said, "I go to bed when I want to go". Another person said, "I get a couple of choices at lunch". However, we saw that some people were not always offered choices about their care. One person who ate a vegetarian diet did not always have a choice of meals as only one vegetarian meal option was available at meal times. This meant they did not have the same variety of meal choices each day as the other people who used the service who could choose from two meal choices.

Staff showed they had a good understanding of people's life histories and we saw some positive interactions between people and staff because of this. For example, we heard one staff member talk to a person about their family, which enabled the staff member and the person to sustain a meaningful chat. One staff member told us how they talked to a person about their family and offered them a cigarette when they displayed signs of agitation. They told us they used this approach as it appeared to have a calming effect on the person. However, this successful intervention was not recorded in the person's care records for other staff to follow. This meant there was a risk that other staff would not be able to respond in a positive and effective manner when the person became agitated.

We saw that some people were encouraged to be as independent as possible. For example, some people who needed specialist equipment to enable them to eat and drink independently were given this equipment to use. However additional equipment needed to make people's mealtime experiences more pleasant, such as a plate warmer for one person who used the service, were not being used as recommended by health and social care professionals. This meant further improvements were needed to ensure people had access to the equipment they needed to improve the quality of their care experiences.

People told us their right to privacy and dignity was promoted. One person said, "They are always very sensitive when they undress me". We saw that people's right to privacy was respected. For example, people were assisted to their bedrooms to meet with visiting health and social care professionals to promote their privacy.

Requires Improvement

Is the service responsive?

Our findings

People who could tell us about their care told us they had been involved in the planning of their care. Some care records we viewed showed this as some people had also signed their care plans, to confirm they agreed to the content. However, we found that people's care plans were not reviewed and updated on a regular basis. For example, two people's care records had not been updated following safety incidents with guidance to help staff to manage their behaviours that challenged. Because of this, staff were managing these behaviours differently. Another person's care records stated the needed a specific piece of equipment to help them to move safely. We saw that this equipment was not being used as planned. Staff told us that the person hadn't required this equipment for a significant amount of time, but the person's care plan had not been updated to record how staff should safely assist them to move. The staff we spoke with knew that this person's moving and positioning needs had changed, but there was a risk that new or temporary staff would not know how to safely support the person. This meant the information in these people's care records was not accurate or up to date. As a result of this staff didn't have access to the information they needed to ensure they provided consistent and safe care that met people's needs.

People told us and we saw that social and leisure based activities were promoted. On the morning of our inspection, we saw people were invited to join in a Christmas themed karaoke session and some people also received nail care from the activities coordinator. Staff told us the activities coordinator only worked three hours a day. In the afternoon and evening, we saw that people were not supported to engage in meaningful activities as staff were busy supporting people with their care needs. For example, we saw one person spend time repeatedly sliding their hands over their side table in a circular motion. This person wasn't encouraged to engage in any meaningful activity during these times, such as dusting or polishing. This would have given the person something meaningful to do with their hands. The limited activity provision at the service increased some peoples' risk of falling as they spent long periods of time not engaged in meaningful activity.

People and their relatives knew how to complain and records showed that complaints were investigated and managed in accordance with the provider's policy to improve people's care. Staff knew how to record and report complaints and we saw that staff had supported one person to make a complaint about another service that were receiving care from. This showed people were also supported to make complaints about other services that delivered health and social care.

Inadequate

Is the service well-led?

Our findings

The information contained in people's care records was not being effectively monitored or analysed by the registered manager or provider to ensure the information contained within them was accurate and up to date. For example, one person had a 'Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order' in place. The registered manager and provider had not identified that this order had an invalid endorsement date. This meant that the order was not valid as the person could no longer confirm that they agreed to this DNACPR order. This meant there was a risk this person may receive emergency medical treatment against their wishes.

Effective systems were not in place to ensure people's care needs were being managed effectively. For example, the registered manager and provider had not identified that plans were not in place to help staff manage people's behaviours that challenged. This meant staff did not have access to the information they needed to manage these behaviours in a safe and effective manner. As a result of this, people received inconsistent care.

The registered manager and provider had not identified that people were not always receiving their planned care. For example, people's sensor mats were not always used as planned to manage people's risk of falling. There was also no evidence to show that hourly safety checks were being completed as planned during the night as these checks were not recorded by the staff. This showed that effective systems were not in place to ensure the quality of care was consistently assessed, monitored and improved.

Safety incidents were not being effectively monitored and analysed by the registered manager and provider to prevent further incidents from occurring. An accurate incident log was not maintained. For example, the incident log recorded that one person had fallen 13 times in 2016. However this person's care records showed they had actually fallen on 18 occasions. As a result of this inaccurate recording, incidents could not be effectively monitored to identify themes and trends. This meant effective action could not be taken to prevent further incidents of harm to people's health, safety and wellbeing.

Effective systems were not in place to respond to safety concerns at the home. For example, the potential risks associated with positive criminal history checks for staff were not being effectively assessed and monitored. No plans were in place to regularly review the potential risks positive criminal history checks posed to people. Adequate action had not been taken in response to a serious safety incident that occurred at the home. This incident had resulted in a person sustaining significant serious, life changing injuries. In the two weeks following the incident, the risk of further harm to people remained high as appropriate and immediate action had not been taken to reduce the risk of a similar incident from occurring again. This showed that lessons were not always learned from incidents to improve people's safety and wellbeing.

The registered manager was unable to show us any evidence of the systems they used to assess, monitor and improve quality at the home. They told us they would send this information to us following the inspection. However, this information had not been received at the time of drafting this report. This meant we could not be assured that systems were in place to assess, monitor and improve the quality of care at the

home.

Staff told us they had meetings with the registered manager to review their development needs. However, we found that significant gaps in the staffs' knowledge and skills were not being identified and addressed through these meetings. As a result of this we observed unsafe moving and positioning of people and care records showed that the requirements of the MCA had not been followed in accordance guidance. This showed that effective systems were not in place to ensure the staff had the right skills set to keep people safe and meet people's needs effectively.

The registered manager told us meetings were held with people to gain feedback about their care. However, people could not confirm this and we were only shown meetings from a meeting that was held in January 2016. Therefore we could not be assured that these meetings occurred on a regular basis to continually seek feedback from people about their care. We saw evidence of completed satisfaction questionnaires, but the registered manager was unable to show us evidence that they had analysed and used this information to make improvements to people's care. This meant we could not be assured that effective systems were in place to gain and use people's feedback to make improvements to the quality of care.

The above evidence shows effective systems were not in place to assess, monitor and improve the quality of care and manage risks to people's health and wellbeing. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We could not be assured that the registered manager and provider understood the responsibilities of their registration with us. The registered manager and provider had failed to notify us of at least two incidents of alleged abuse as required under our registration Regulations. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager and provider were not displaying their inspection rating at the home as required by law. This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and staff told us that the registered manager was approachable and supportive. This showed people and staff felt comfortable to share concerns about care with the registered manager. The registered manager told us that a deputy manager had been recently appointed and was imminently due to start in this role. They told us this would ensure they had more support to assess, monitor and improve the quality of care at the service. They also told us they had plans to start to monitor the content and quality of the information contained in people's care records. We will check the effectiveness of these changes at our next inspection.