Ms Michelle Bernadette Beattie

Tudor Care Home

Inspection report

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NA

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Ratings

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

Overall summary

This inspection took place on 18 November 2015 and was unannounced. It was carried out by the lead social care inspector for the service, a Specialist Professional Advisor with a background in the care and support of older people and an Expert by Experience with an interest in the care and support of people with dementia. The service does not have a Registered Manager, and has not had one for over 12 months. 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. There was an acting manager in place: this person was appointed on 1 November 2015 after the previous acting manager left the service. Following this inspection visit, this new acting manager explained that they would not be putting their application in for registration with the CQC. The explanation given was that they felt that they did not have the skills to fulfil the duties of a Registered Manager. The acting manager and senior carer supported us during our inspection visit. We found documentary evidence to show that limited risk assessments and safety plans were in place relating to different aspects of the home. For example: care planning, treatment, infection control,

Summary of findings

medication, healthcare and environmental safety. However, these were sometime incomplete, and the information contained within them was limited and unclear. Personal Emergency Evacuation Plans (PEEPs) in the event of a fire had not been drawn up for each individual living in the home. Staff were aware that they had to notify CQC of deaths at the home, but were unsure of the other types of incidents that were notifiable. Care staff were seen to be involved in providing personal care and support, but one of the two staff were also involved in preparing, cooking and serving the meals. Staff explained that this occurred on a daily basis, and although they enjoyed providing meals for people, they acknowledged that it took them away from the caring duties. This potentially put pressure on their colleagues at busy times of the day. We noted that one person did not have any employment references on file, even though their application form had highlighted who their referees should be. The home did not have a lift, and was cited on four floors. The home had an unusable chair lift, due to the parts needed to repair it were said to be obsolete.

We found that some parts of the building were in a poor state of repair, and the 4th floor was found to be unusable as part of it needed significant attention and repair.Although staff knew the different types of abuse that could take place, and were aware of the procedures in place that they should follow if they had safeguarding concerns, the records showed that a safeguarding referral had not taken place in one instance, when a service user was found with unexplained bruising and scars.The processes for the safe and secure handling of medicines were found to be appropriate. The service was found to have a clear process in place for the handling of controlled drugs when necessary.The service provided had not ensured that staff received the support, training, professional development, supervision and appraisals that was necessary for them to carry out their role and responsibilities.We looked at people's care records and found documentary evidence to show that their nutritional and hydration needs, and food intake monitoring took place. However, the records were found to be completed sporadically. Staff said that although there was a menu on offer at the home, this was not always followed, as staff would discuss people's meals preferences on a day to day basis, which would be dependent on what was in stock.People living at the home were seen to be very comfortable in the presence of the staff. People were seen to engage and interact with the staff, and conversations were relaxed and jovial. We noted that the relationships between the staff and the service users were very positive. Staff knew the people they cared for very well.Although a home for people with dementia and associated memory problems, the service had not engaged with best practice in this area of care and support. There were no signs of dementia related activities available such as rummage boxes or reminiscence objects that could be used to promote conversation and reduce social isolation.

The home had a complaint's procedure, and this was displayed within the home. We looked at the record of complaints.We found there to be unsatisfactory leadership from the registered provider: strategic management and guidance was lacking. Despite being committed to caring for the people living in the home, the registered provider was only in a position to undertake short term fixes to problems such as cosmetic maintenance of the building. The larger issues such as staff development, business development and on-going governance was found to be out of their grasp. The service did not have a registered manager in place.We identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report. The overall rating for this service is 'Inadequate' and the service is therefore in '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

Summary of findings

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.Following our visit, we expressed our concerns, regarding the safety of the building and the welfare of people living at the home, to the Registered Provider. They engaged with us, and gave us details of how they intended to address some of the issues at the home.

However, following discussions with their stakeholders, the Registered Provider told us that they had taken to the decision to close the home. The Registered Provider submitted an application to cancel their registration with CQC, and we accepted this application. The Registered Provider made arrangements to alert all relevant parties to the decision, and at the time of writing this report, measures were in place in secure placements for the nine people living at the home, and the home to close on 31 December 2015.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.Staffing levels did not always meet the assessed needs of people living in the home.The building was found to be in a poor state of repair, and placed people at risk.Safeguarding alerts were not always made in a timely manner following incidents.People received the right medicines at the right time.

Inadequate

Is the service effective?
The service was not effective.The staff understanding of the requirements of the Mental Capacity Act 2005 in obtaining valid consent and appropriate DoLS applications was poor.People's food and fluid intake was monitored to ensure people had sufficient fluid and dietary intake to meet their needs. However, their choice of meals was limited at times.Staff had not received sufficient training to meet people's needs.

Requires improvement

Is the service caring?
The service was not always caring. The staff were caring people, and were dedicated to looking after the people in their care.Due to the poor quality of parts of the building, people were not always treated with dignity and respect. Although people were happy, they were not always offered choices in relation to activities and meals. Independence was not encouraged or supported.

Requires improvement

Is the service responsive?
The service was not responsive. People's individual needs were not met because the service had not responded appropriately to people's individual needs. Care plans were not personalised to show how staff should respond to identified risks and conditions. A lack of meaningful activities meant that people were at risk of social isolation.The service did respond appropriately to concerns raised by relatives and people living in the home.

Requires improvement

Is the service well-led?
The service was not well-led A lack of clear and robust management systems had contributed to deficits in staff development, business development and on-going governance.The quality of the services provided were not always checked and monitored.

Inadequate

Tudor Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.The inspection visit took place on 18 November 2015 and was unannounced. The inspection was undertaken by the lead adult social care inspector for the service, a Specialist Professional Advisor with a background in working with older people, and an expert-by-experience. An expert by experience is a person who has personal experience of using or caring for someone who uses services such as those provided by Tudor Care Home. We reviewed the records we held regarding the operation of the service prior to our visit. We found that the service provider had notified CQC of events such as deaths of people at the home. We also reviewed the information we held about safeguarding incidents in the home, and found that there were no on-going safeguarding incidents. During this inspection we spoke with six people who lived at the home, three visitors and three members of staff. Throughout the day we observed care practices in communal areas and saw lunch being served in the dining room. We looked d at a number of records relating to individual care and the running of the home. These included five care plans, medication records, three staff personnel files and quality assurance files.

Inadequate

Is the service safe?

Our findings

We spoke with six people who lived at the home. All of them said they were happy living at the home, and said that they felt safe. One person said, “This is a very ‘homely’ home. I am very happy living here. The staff are very caring.” Some of the people living at the home had difficulty expressing themselves when we asked them about safety concerns, so we spent some time observing people’s engagement and interaction. People looked content and happy, and were seen to interact freely with others. We found written records to show what the arrangements were to provide safe and effective care in the event of a failure in major utilities, or other types of emergency. Equipment had regular safety checks and there was a quality monitoring system in place. Records held within the home showed that the fire alarm system had been tested. However, we found that the emergency lighting had recently been tested and found to be faulty. We found that staff had taken part in regular fire drills, but people living at the home had not. We explained that assisting people to take part in a fire drill would be of benefit so that they were familiar with the procedures. Under current fire safety legislation it is the responsibility of the registered manager to provide a fire safety risk assessment that includes an emergency evacuation plan for all people likely to be on the premises in the event of a fire. In order to comply with this legislation, a Personal Emergency Evacuation Plan (PEEP) needs to be drawn up for each individual living at the home. Although staff said that they were sure that PEEP’s had been completed, they were unable to locate these documents in the office or people’s individual care files. Accidents and incidents were documented. However, we noted that one person in the home had recently experienced an injury, possibility following a fall. We found written care notes that showed that staff had found the person with cuts and bruises on their arm and head, but the records showed that no medical attention had been sought by the home. We also found that only one of the nine staff working at the home held an up to date first aid qualification. These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service provider must prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. The service provider must assess the risks to people's health and safety during their care or treatment, and take action to minimise or eliminate those risks.

Staffing levels were checked and were found to be operating at a minimum level. We found that there were two care staff, the acting manager and the cleaner on duty. There were nine people living at the home, all with differing degrees of dementia, and one who displayed challenging behaviour. Care staff were seen to be involved in providing personal care and support, but one of the two staff were also involved in preparing, cooking and serving the meals. Staff explained that this occurred on a daily basis, and although they enjoyed providing meals for people, they acknowledged that it took them away from the caring duties. This potentially put pressure on their colleagues at busy times of the day. Although three staff members were usually assigned to work with people from eight in the morning until two in the afternoon, this reduced to two in the afternoon and evening. The rotas showed that from time to time, only two staff members worked from eight in the morning until eight at night. This reduction in the staffing levels from three to two, had a significant impact on the amount of time the staff could work with people on either a 1:1 or 2:1 basis, depending on their assessed needs. If a person required 2:1 support at these times, others people in the home would be left to care for from themselves and this potentially put people at risk.These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service provider must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs. Information held within the records showed that care workers had received training in safeguarding adults during their induction. Although staff knew the different types of abuse that could take place, and were aware of the procedures in place that they should follow if they had safeguarding concerns, the records showed that a safeguarding referral had not taken place in one instance, when a service user was found with unexplained bruising and scars. Safeguarding information was visible in the acting manager’s office that gave details of how to recognise potential abuse, and how to respond to it appropriately. The acting manager alerted us to a recent safeguarding referral that had been made by the registered provider. The referral related to the allegation

Is the service safe?

that a service user had been potentially financially abused. Monies that should have been used to pay for a newsagent's bill had gone missing and the bill had not been paid. This only came to light after the person's relative questioned, why the newsagent's bill had not been paid. As the local authority safeguarding team had been alerted to this issue, they were investigating the allegation in conjunction with the police. The acting manager explained that the financial paperwork relating to the payment of the newsagent's bill could not be located, and they believed that issue had been on-going for some time. There was no evidence to show that financial transactions like these were monitored or audited, and as a result, people's best interests and financial security were put at risk.These issues were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service provider must ensure that people are protected and safeguarded from potential abuse; this includes providing robust financial protection through the systems operated at the service. The systems relating to the safe recruitment of staff were not robust. We looked at 4 personnel files and found that the service had assessed the character of applicants during an interview process, and had undertaken appropriate safety and employment checks to ensure people were either clear to work in care, or unsuitable for employment. However, we noted that one person did not have any employment references on file, even though their application form had highlighted who their referees should be. These issues were a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service provider must ensure that all the proper employment checks are undertaken when staff are employed at the home. This will ensure that the registered person has all the relevant information available to them, in order to make a judgement about a person's fitness to work at the home. After people were employed, the service provider had a procedure in place if they needed to take disciplinary action against a staff member for whatever reason. This included referrals onto other relevant agencies, be that their professional body or the Disclosure and Barring Service.

The home was registered to accommodate up to 18 people, and this is how the home was advertised on websites such as the NHS Choices Website. The home did not have a lift, and was laid out across four floors. The home had an unusable chair lift, due to the parts needed to repair it were said to be obsolete. We found that some parts of the building were in a poor state of repair, and the 4th floor was found to be unusable as part of it needed significant attention and repair. The conservatory was found to be leaking on the day of our visit. Staff explained that this only occurs following heavy rain, and that when this occurs, the conservatory was unusable. Some of the water coming into the home was seen to be very close to electrical wiring. As a result of the water damage, some wall paper was seen to be peeling away from the wall. We noted that a large, water soaked towel, was lying across the corridor near the conservatory, in order to collect the leaking water. This was seen to present a serious trip hazard to people living and working in the home. The Registered Provider was contacted following this inspection visit, and they advised CQC that due to limited funds, and a need to prioritise spending, some areas that were in need of repair would not be looked at for some time. The toilet and shower room on the lower floor on first glance looked clean and tidy. However, we noted that the shower facility, on a slightly raised platform, needed attention. The two front corners of this platform were broken, exposing broken material such as wood or concrete. This was found to present both an infection control hazard as the area could not be cleaned effectively, and an injury risk, as people could easily bang or scrape their feet on the damaged area when entering or leaving the shower. These issues were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service provider must ensure that the premises are properly maintained so that it is fit for purpose. The processes for the safe and secure handling of medicines were found to be appropriate. The service was found to have a clear process in place for the handling of controlled drugs when necessary. The process in place to ensure a person's prescription was up to date and reviewed was found to be appropriate, and took into account their needs or changes to their condition or situation. Information held within the records showed that staff received training in the safe administration of medicines.

Requires improvement

Is the service effective?

Our findings

People living at the home had difficulty expressing themselves when we asked them about the effectiveness of the home, so we spent some time observing people's engagement and interaction. People engaged with the staff team, and other residents at the home. The staff were seen to interact with people in positive ways, and this showed that they understood how they needed to respond to people's needs. Staff explained that the service did not have a robust training and supervision programme. Training was found to very limited, with staff being provided with basic mandatory training, and on-going updates via on-line providers or specialised DVD's. Staff with particular roles within the home, such as the administration of medicines, were provided with further training. Staff told us that there were delays in receiving update training on mandatory subjects such a movement and handling, first aid and health and safety. The records showed that there were gaps in the staff training updates. Staff supervision records were limited, and some could not be located. One staff member explained that they had not received any formal supervision for over 12 months, even though they thought that they would benefit from it. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service provided must ensure that staff receive the support, training, professional development, supervision and appraisals that is necessary for them to carry out their role and responsibilities.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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The acting manager explained that she had received some limited training in the MCA, and other staff we spoke with explained that they had not received any training in this area of care and support. This was confirmed when we checked the training records. None of the staff at the home had received training in how to use, and when to consider the use of a mental capacity assessment when supporting people with potential problems when making decisions. We found records relating to one person who had recently had a number of medical investigations, which had identified a potential health problem. We found a written record that showed that a discussion between the person's family and their doctor had taken place. A decision had been made that it was not in the best interests of the person to investigate this health issue any further. We did not find any details to show that a capacity assessment had been undertaken with the service user, and there was no record of the meeting between the family and their doctor which could be used to determine how they had reached their decision. We looked at the systems the home had in place relating to DoLS. We found two Standard Authorisations which had been completed by the local authority, along with a single part of a further authorization. The second part of this authorisation could not be located.This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had not made proper arrangements to ensure staff were fully conversant with the MCA, and did not have proper arrangements in people to ensure people's best interests were properly assessed and safeguarded. Staff spoke knowledgeably about the people they supported with personal care. They demonstrated a good understanding of how best to assist people who used the service effectively. We looked to see how people were supported to maintain good health. Support plans relating to health were inconsistent and lacked detail. We noted that records of when relevant professionals, such as the GP had been involved in the care of service users were maintained. Where a person required specific support with a health need, such as pressure area care, there were limited guidelines for staff about what to do. Records showed that people had been supported to access relevant health professionals when needed. However, in the case of one person who had been seen with bruises, potentially following a fall, there was no evidence to suggest they had been assessed by a healthcare professional. We looked at people's care records and found documentary evidence to show that their nutritional and hydration needs, and food intake monitoring took place. However, the records were found to be completed sporadically. We observed that food and hydration was provided and made available in sufficient quantities and on a regular basis. People living at the home

Requires improvement

Is the service effective?

expressed satisfaction with the food provided to them. We found there to be a choice of food and drink that took account of people's individual preferences. Staff said that although there was a menu on offer at the home, this was not always followed, as staff would discuss people's meals preferences on a day to day basis, which would be dependent on what was in stock.We looked to see how the building was adapted to meet people's needs. The third floor of the building was not in use of there was a problem with the roof. According to the acting manager, a leak in the roof had been looked at some time ago, but still needed fixing. Most of the service users lived on the ground floor, a type of basement area leading to the rear garden. Due to a leak in the roof of the conservatory, service users frequently used the dining room for social activities as well as meals. This room did not have any windows. A lounge on the first floor was seen to be used by one person, and the staff confirmed that this lounge was used from time to time. However, when there were only two staff on duty, the staff explained that it was difficult to supervise all the service users on two floors, so most were encouraged to use the conservatory or dining room on the ground floor. Two of the service users had their bedroom upstairs, and as there was no lift or chair lift at the home, they had to be supervised when using the stairs, as in parts, the stairs were found to be steep.This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had not put in place an adequate system to ensure that the building was properly maintained to ensure the safety and welfare of people living and working in the home.

Requires improvement

Is the service caring?

Our findings

People living at the home were seen to be very comfortable in the presence of the staff. People were seen to engage and interact with the staff, and conversations were relaxed and jovial. We noted that the relationships between the staff and the service users were very positive. Staff knew the people they cared for very well. One staff member said, "I see these people as my family, and I would do anything for them, in order to make their life comfortable and happy." People looked clean and tidy, and we noted that when one person had a problem with their food and spilt some food on their clothing, the staff responded quickly, and supported the person to change their clothing. The staff were seen to work positivity with people, and in a dignified and respectful manner. Staff used people's first names or preferred title, and when people needed support with personal care or whilst eating, this was done in a discreet manner. We noted that a bathroom door on the ground floor was very difficult to close: the door was too big for the space. This meant that when people used the toilet independently, they would have to use the toilet with the door half open. This undignified manner of using the toilet was pointed out the acting manager, who explained that she reported the issues regarding the door some time ago, but nothing had been done about it by the registered provider. We alerted the registered provider to this issue following our inspection, and action was taken to rectify the problem with the door. We looked in the care plans to see how people had been involved in their own care planning. The plans of care had been regularly reviewed and any changes in need had been recorded. However, those who used the service or their representatives had not always been given the opportunity to be involved in the assessment of people's needs or planning of their care. Information regarding advocacy support was available in the home. The records of one person showed that an independent advocate had been appointed to work with them. An advocate is an independent person who will support people to make decisions about their care, support and daily activities, which meets their rights and is in their best interests. The acting manager said that if and when people needed advocacy support, then the staff would be more than happy to provide people with information and make appointments on their behalf.

Requires improvement

Is the service responsive?

Our findings

We looked at the care files of five people who lived at the home and who had quite different needs. We found that the plans of care varied in quality with some providing specific details of a person's care needs, their likes and dislikes, and others providing very scant information. Although the plans had been reviewed regularly, when changes to a person's needs had taken place, these had not always been thoroughly recorded within the person's care plans. Vague terminology was often used, which did not provide staff with clear guidance about the needs of people, or how these were to be best met. For example, one person's plan said that they should drink "regularly", and eat "some" food to prevent dehydration and weight loss. These directions were not specific enough, and could not be measured. We looked at the choices available to people regarding their care and support on a day to day basis. These were limited to the times people woke and went to bed, which room they sat in, and the meals they ate. There were very few activities on offer to people, and due to the staffing levels, very few opportunities to leave the building. Although a home for people with dementia and associated memory problems, the service had not engaged with best practice in this area of care and support. There were no signs of dementia related activities available such as rummage boxes or reminiscence objects that could be used to promote conversation and reduce social isolation. When we arrived, people were found to be in the dining room watching a video. We heard on person say, “I’m not happy about watching this. I hate it in this room." The staff responded to the person, and sat and spoke with them and this helped to calm them down. We spoke with the staff regarding the types of activities on offer, and we were told that activities were limited due to staffing levels, and dependent on the weather. If the weather was nice, then service users were sometimes taken for walks or to local cafes. However, the staff acknowledged that people rarely went out if the weather was poor. We noted that a staff member conducted a quiz for a short period of after lunch. People were seen to engage in this activity.This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Registered Person had not ensured that proper systems were in place to meet the assessed needs of people by way of person centred and meaningful activities which could be offered to reduce the possibilities of social isolation.The home had a complaint's procedure, and this was displayed within the home. We looked at the record of complaints. The home had received two complaints over the previous 12 months. The first had been recorded appropriately, and a response sent to the complaint, who was satisfied that the issues had been looked, and properly resolved. The second complaint had been received a few days before our inspection visit, and related to the poor maintenance of the building. The registered provider was in the course of responding and dealing with this complaint.

Inadequate

Is the service well-led?

Our findings

We attempted to discuss the way the home was managed with people living at the home; however, their feedback was limited. People said that they liked the acting manager, and got on well with the registered provider. We found there to be unsatisfactory leadership from the registered provider: strategic management and guidance was lacking. Despite being committed to caring for the people living in the home, the registered provider was only in a position to undertake short term fixes to problems such as cosmetic maintenance of the building. The larger issues such as staff development, business development and on-going governance was found to be out of their grasp. The service did not have a registered manager in place. A senior carer had recently taken on the role of acting manager, but when we discussed the role with them, and talked about the responsibilities involved, it was evident that they did not want to take on the position of registered manager. Although the registered provider and acting manager were able to determine the culture within the home, that of a caring and supportive environment, the registered provider did not have adequate resources to support the development of the service, and continue to improve practice and service delivery. The acting manager explained that the poor fabric of the building, low staffing levels, low levels of investment in staff development, had put pressure on the staff, but she thought this had not had a negative effect on the quality of the care provided.We looked at the systems in place to ensure the quality and safety of service provision was effectively monitored. We saw that some audits were undertaken, but these were limited to care plans and medicines. Other areas of the home, and the systems operated there, such as infection control, risk assessment, record keeping and food safety were not routinely audited and monitored. Record keeping was found to be poor. We saw that one staff member did not have the required checks and documents in place in relation to their employment. Systems in place did not ensure staff were safely recruited following legal requirements and the service's own policy. We found risk assessments to monitor the safety of the environment were not always in place, suitable or up to date. The registered provider had failed to act in a timely manner in relation to known risks, such as those presented by faulty emergency lighting.Care plans and risk assessments, and management records were not well maintained. Care plans were not always person-centred and accurate, and records were not always completed and updated in a timely manner to reflect people's changing needs. There was no system in place for senior staff to regularly monitor the standard of record keeping. As a case of alleged financial abuse had been identified (that had occurred over a period of 12 months), it was clear that there inadequate systems in place to robustly and regularly check the financial records of people living in the home.The lack of governance in the home was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Good Governance.