Hometrust Care Limited

Silver Howe

Inspection report

Dalton Drive
Kendal
Cumbria
LA9 6AQ

Tel: 01539723955

Date of inspection visit:
14 June 2016
15 June 2016
30 June 2016

Date of publication:
31 August 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We did an unannounced responsive inspection on the evening of 14 June 2016 due to concerns alerted to us about the number of staff on shift in the home. During that inspection we found there was not sufficient staff on duty to meet people's needs safely. We also found other significant concerns relating to the safety and wellbeing of people and the quality of the service. We visited the home unannounced the next day 15 June 2016 and completed a comprehensive inspection. We also completed an unannounced focussed inspection on the evening of 30 June 2016 because of further concerns raised by relatives and visiting professionals to the home.

We last inspected Silver Howe in September 2015. At that inspection we found a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014 in relation to fit and proper persons being employed. We issued a requirement notice in relation to that breach and asked the registered provider for an action plan to tell us how and when they would be complaint with the regulation.

During the inspection in June 2016 we found seven breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These included a continued breach of Regulation 19 found during the last inspection. We also found that some of the incidents that had occurred in the home should have been reported to CQC and other agencies but the registered provider had failed to do so. These were breaches of Regulations of the Care Quality Commission (Registration) Regulations 2009.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Silver Howe is a residential care home that provides personal care and accommodation for up to a total of 30 people. Accommodation is provided over two floors and there is a separate unit with six beds for caring for people living with dementia (Bluebell unit). Silver Howe is located close to the town centre of Kendal. There are gardens and seating areas for people living there to use and car parking.

There was a registered manager in post. A registered manager is a person who has registered with the (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However at the time of the inspection visits the registered manager was not present in the home or available to contribute to the inspection.

Concerns found during the inspection about the safety and wellbeing of some people who lived at the home led the inspectors to share information with the local authority and the service's commissioners.

There were not sufficient numbers of staff to safely meet people's needs. The level of staffing during the time of the inspection required additional staff to be sourced from the registered providers other care homes to ensure people had their needs met. Staff and relatives told us they had concerns about the numbers of staff

available to provide safe and effective care.

Medicines were being administered and recorded appropriately but were not stored in a safe way.

Staff had commenced working without all of the required checks of suitability. Two people had commenced employment without all of the checks required to ensure they were fit and proper persons.

Training records were not accurate and we could not determine if staff had commenced working with the appropriate skills. Staff told us about what training they had received however we were unable to confirm this with the records that were provided. Staff also told us that they had commenced working without some of the essential training required to ensure they had the appropriate skills and knowledge for the job.

There were no assessments of people's needs made prior to people being admitted to the home. Care plans and risk assessments made were not always accurate about the needs of people's health and support that they required.

Care records lacked vital information about peoples individual care needs. Care was not provided in a person centred way. People preferences and choices was not always recorded or considered. We did not see that people had always been involved in their care planning or had consented to their care.

When accidents and incidents had occurred these had not always been reported by to the appropriate authorities including CQC. A number of incidents of a safeguarding nature had not been reported to any external agency.

People had restrictive measures in place without risk assessments, consent or appropriate applications having been made to deprive them of their liberty. Requirements relating to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were not being met.

The registered provider did not have effective systems in place to monitor the safety and quality of the service.

People living at the home told us they enjoyed the food served and that they had been able to personalise their bedrooms.

The interactions we observed that took place between the care staff and people living at the home was respectful and kind despite the low numbers of available care staff.

The home employed a designated person to coordinate activities for people living at the home. We saw a variety of activities were provided if people wanted to join in.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will

seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There was not sufficient staff to keep people safe.

Not all the required safety checks had been completed when staff had been employed.

People were not always protected against abuse because incidents had not been reported to the appropriate authorities.

Prescribed medicines were not stored safely.

Is the service effective?

Inadequate

The service was not effective.

Consent to care and treatment had not been obtained.

People's rights were not protected in line with the MCA and DoLS

Staff had not always received training to enable them to deliver safe care.

People were supported to join in a variety of activities

Is the service caring?

Inadequate

The service was not caring.

Care was task orientated as staff struggled to meet people's needs.

People did not receive care and support in a timely manner.

People at the end of life had no prescriptive advanced care plan in place to fulfil their needs or wishes

Staff were kind and respectful of people.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not person centred.

Referrals and the involvement of other agencies were not always completed or recorded.

People had not been involved in their care planning or reviews.

Is the service well-led?

Inadequate

The service was not well led.

Systems were not effective in quality monitoring and identifying the safety of the service provision.

Staff told us they had felt supported and listened to by the registered manager. Staff told us they did not feel the registered provider had listened to or supported the registered manager.

Staff were concerned about the way in which the registered provider would respond if they shared information with us.

Silver Howe

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.

Prior to the inspection we had received some information of concern about insufficient levels of staffing and we responded by doing an unannounced inspection that took place on 14, 15 and 30 June 2016. The inspection team consisted of two adult social care inspectors on 14 and 15 June and on the 30 June this was the lead inspector and an inspection manager.

Before the inspection we looked at the information we held about the service including information from the general public, staff, community nurses and the local commissioners of the service.

During the inspection process we spoke with four people who used the service and four relatives, a registered manager from one of the providers other care homes, the newly appointed deputy manager and six staff members. We looked at all of the records relating to the requirements and actions we had asked the provider to take following the last inspection in September 2015. We observed how staff supported people and looked at the care records for 11 people who lived at Silver Howe.

We looked at the staff files for all staff recruited since our last visit. These included details of recruitment, induction, training and personal development. We were given copies of the training records for the whole team.

We also looked at records of maintenance and repair, the fire safety records, food safety records and quality monitoring documents. We also looked at how medication was managed and stored.

Inadequate

Is the service safe?

Our findings

People who lived at Silver Howe had experienced incidents where they had been unsafe. One person told us they had felt unsafe because another person who lived at the home entered their bedroom at night. Another person had been locking their bedroom door at night following an incident involving another person who lived at the home. Relatives spoken with during the inspection process told us they had concerns about a number of elements relating to the care of their relations. Two of those relatives told us that ''The staff work very hard but there's not enough of them''. All the care staff we spoke with confirmed they had not had sufficient staff for a while. One staff member stated it had not been good since January 2016. Three staff members told us they often worked extra hours to ensure people received their care. We were also told that the registered manager had frequently worked as part of the care team because there had not been enough care staff on shift.

We first visited the home in the early evening on 14 June 2016. There were 25 people residing in the home at the time. We found two day time care staff on duty and one regular night staff carer who had been requested to come on to shift early due to staff shortages. Staff told us with three care staff they found it difficult to monitor and support certain people who lived at the home because of their specific needs. One person required 15 minute visual surveillance safety checks at the time of the inspection. Another two people were being cared for as they were at the end of their life. The number of staff on duty were not sufficient to meet people's needs.

We looked at the staffing rotas and saw that the total number of staff available to cover the rota over the week was not sufficient. We saw on the rota the week prior to the inspection that the number of staff on each shift varied between four and two. The rota for the week of the inspection visits the number of staff on each shift varied between three and four. Staffing levels within the home were inconsistent throughout the shifts. We saw that staff members had worked 72 hours in one week. Staff told us that the number of staff on duty was not based on the dependency needs of people who lived at the home. A senior carer said, ''The number of staff on each shift is based on who is available to work''. We were told any gaps on the rota were usually covered by the registered manager working the shift. Staff told us morale had been low due to the low numbers of care staff. Relatives, professionals and staff told us a number of staff had left employment in the last few months which meant consistency of staff who understood each individual's care requirements was not always in place. Two relatives told us they were concerned about the number of staff who had left employment since January. One relative said, ''Some good care staff have left in the past few months and they haven't been replaced.''

At night there had been two staff on duty throughout the night. A regular night time carer told us, ''We only ever have two staff on we take it in turns to check on Bluebell unit (dementia care).'' On the night of our first inspection visit on 14 June 2016 a third carer was sent by the on call manager to support the needs of people living at Silver Howe. The home has a separate dementia care unit (Bluebell) for six people which was fully occupied. Staff told us this unit was frequently left unstaffed through the night as two staff were required to work together to meet other people's needs in the main building. Some people living in the home were known be at risk when left unsupervised and known to walk around during the night. We were

told about and saw that a cleaning schedule was completed by the two staff working during the night. This evidenced that additional duties to caring and oversight of people was required and completed by the two members of care staff working on the night shift.

During the inspection visit on 15 June on arrival at 9.00 to the home staff told us that they were to inform another manager from one of the providers other care homes if CQC were to visit as there was no managerial presence in Silver Howe. There were three care staff on duty in the home. While a senior member of care staff was completing a medications round the other two care staff were providing personal care on the upper floor of the main building. This left the main lounge, dining room and dementia unit unstaffed for an observed period of 20 minutes. The inspectors saw that people's needs were not being met safely and raised an alert to the local authority and commissioners. People were not supported or supervised during breakfast by any care staff. One person with poor mobility was requesting assistance to get to the toilet and the inspector had to go to find a member of staff to assist.

Staffing levels were not sufficient to meet people's needs in a safe manner. We also looked at care records and discussed staffing levels and skill mixes with staff, visitors and individuals who lived at Silver Howe.

This was a breach of Regulation 18 (1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staffing levels were inadequate and unsafe.

We looked at records for incidents that occurred in the home and people's individual care and daily records. We saw that a number of incidents that had occurred with safeguarding concerns had been recorded but had not been reported to the appropriate authorities. We did not see any actions recorded in the care records to ensure that people were protected from reoccurrence of those incidents or acts. Where the records for incidents identified any actions to be taken these had not been completed. The Inspectors identified eleven people who had been either the subject of or perpetrator of such acts and referred this information to the lead authority for safeguarding the local authority. These incidents included physical assaults, theft of personal belongings and other behaviours that may have caused harm.

This was a breach of regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people had not been protected from harm or the risk of harm.

The Commission had been alerted by the local authority on the 9 June 2016 about a serious incident which had occurred the night of 8 to 9 June 2016 in the home. During the night the home was attended by the police to break down the bedroom door which had been locked by a resident. The two care staff on duty could not access the bedroom as the bedroom door was locked and they had no means of unlocking the door. The arrangements in place for dealing with emergencies were not effective in ensuring people were not put at risk.

During our inspection on 14 June 2016 we found the fire door on the entrance to Bluebell dementia unit to be propped open with a wooden wedge. This door was not an automatic self-closing door in the event of the fire alarm system being activated. Staff told us they could monitor people more easily with the door propped open as there were not sufficient staff on duty to stay on the unit.

We found the temperatures recorded of the cupboard used for the storage of medications to have been higher than recommended. Where medication was recommended to be stored at below 25 degrees Celsius we saw the temperature had been consistently above that on 9, 10, 11 and 12 June 2016 for at least four of the medications stored. We also saw that the recommended temperatures of the fridge used for storage of

medications should have been between two and eight degrees Celsius. Records showed it had varied between two and twelve degrees Celsius and one medication required storage at no more than eight degrees. This meant that the storage of medicines were not managed safely.

We saw that risks associated with the delivery of safe care and treatment had not always been recognised. We saw that when risks had been identified they were not always recorded accurately or managed appropriately. For example one person living at the home had no risk assessments or detailed plan in place about the management of inappropriate and behaviours that challenged which had occurred towards other people in the home. This person was under visual surveillance as part of a plan however we did not see that this had been risk assessed or that a management plan was in place for staff to follow. Another person living at the home had no risk assessment in place or detailed plan about the management of aggressive behaviours following an incident with another person and towards staff. People living with dementia were not being protected as possible risks to them had not been identified on admission to the home. We saw one person had no risk assessments of any needs in place following admission to the home on 3 June 2016 until the 7 June 2016. During that time an incident had occurred on 5 June 2016 and this person had many risks associated with dementia. People who were receiving care as at the end of life did not have risk assessments or end of life management plans in place to deal with specific needs such as hydration or pain. We did not see risk assessments completed relating to their pain management or hydration and nutrition. Risk assessments were not completed for the use of bedrails that were in use.

Where equipment such as bedrails and hoists were being used to support people we did not see any risk assessment for their use or any systems used to confirm they had been regularly maintained.

One person who after discharge from hospital had changes to their ability to mobilise and now required the support of two staff and the use of a hoist. We saw that their risk assessment for manual handling had not been updated and was not accurate for their current identified needs. We also saw that the emergency evacuation plan in place for this person did not accurately identify the level of support required should they need to be evacuated in the event of a fire.

This was a breach of regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because risks were not being managed or mitigated where possible.

At the last inspection in September 2015 we found a breach of Regulation 19 Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because not all the suitability checks required by law to ensure that the persons being employed were of good character had been made. During this inspection we found that this was a continuing breach. Two people had been employed in April 2016 without all of the appropriate checks being completed this was a continued breach of Regulation 19 because checks to ensure people were of good character had not been completed.

We observed a senior carer during a medication round and saw that medicines were safely administered. We also looked at the handling of medicines liable to misuse, called controlled drugs. These were stored safely and recorded correctly and this reduced the risk of mishandling.

Inadequate

Is the service effective?

Our findings

Our findings
Staff told us and the records we saw showed that they had not received all of the required training to ensure they could deliver safe care and treatment. One member of staff told us they had not received all of the appropriate induction training on commencing employment. They told us and records we looked at showed they had not received training in moving and handling until one month after commencing employment even though they had been involved in moving and handling of people living at the home. Records showed that two care staff employed in May 2016 had not received any induction or formal training since they had started work in the home. The records also showed that only one of the care staff on nights had training in first aid this meant that on night shifts there had been no staff member trained in first aid.

We could not be certain that the training records for the staff were accurate. Training records supplied on the day of the inspection did not correlate with the training records that we had requested from the provider on 10 June 2016 following an incident in the home 8 and 9 June 2016. At the time of the inspection the home was caring for people with a wide range of needs, including end of life care, people living with a dementia and people who had been assessed as at risk of malnutrition. The records for staff training did not show that all staff had received specific training in dementia care or end of life care. The supporting registered manager present during the inspection visit on 15 June 2016 could not confirm that the staff training records were accurate and had to seek further information from another one of the providers home managers when requested by the inspectors.

Two of the staff files we looked at did not contain records to show they had received any formal supervision or support in their roles on a regular basis. Staff told us they used to get regular sessions of supervision with the registered manager but that they had not had many recently. The systems in place to support staff were not consistent. Some staff had no records to show they had received any supervision since commencing employment.

This was a breach of regulation 18(2a) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people who used the service were being supported by staff without the necessary skills and knowledge to deliver safe and effective care.

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called 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. There was no one living at

Silver Howe that was subject to DoLS at the time of the inspection but we saw that an application had been made for one person. We saw that the information provided in the application did not identify all of the restrictive measures actually being used by the home.

We saw that restrictive practises were in place for five people who lived at the home. There were no records to show that the decisions for this had been made using a best interest process for people who lacked capacity to provide consent. This was not in line with the requirements of the Mental Capacity Act 2005 and that people's rights were not being protected. There was no evidence in peoples care records to show that people who were able to had consented to their care and treatment..

This was a breach of Regulation 11 Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because processes were not in place to ensure that people had agreed to their care and treatment and to make certain it would meet their requirements.

We saw that people had nutritional assessments completed to identify their needs and any risks they may have when eating. Where some people had been identified as at risk of malnutrition and weight loss occurred but we did not see that actions identified were sufficient to prevent further risks occurring. We observed over the breakfast period that no care staff supported those people who chose to eat in the dining room.

The lunch time experience on the day of the inspection on 15 June 2016 was much better than the breakfast time. Three more care staff had come on duty. We observed kitchen staff assisted with serving food in the dining room and we saw that people received the right level of support with their eating and drinking. The food served looked appetising and people were offered choices of foods that were available. People were offered a variety of drinks and snacks at regular times throughout the rest of the day. Two people we asked how their meal was both said, ''It's good and very tasty''.

Where people were living with dementia there was some signage to show people what different areas in the home were for. This was to help people with memory problems to be able to move around their home more easily and more independently. We saw that people had been able to bring personal items into the home and their bedrooms had been personalised with people's own furniture and ornaments to help them feel at home. We saw that a lot of people chose to spend time in private in their bedrooms if they wished or chose to.

Inadequate

Is the service caring?

Our findings

We spoke with people who lived at Silver Howe and their relatives and we were told they were not always happy with the care they or their relatives had received. We were told by two people who lived at home that they often had to wait for the support from staff to enable them to manage some of their daily routines. One person told us, '' When I call for help I often have to wait. I know they (care staff) are busy''. Staff we spoke with told us they had little or no time to spend socially with people who lived at the home and relied on the activities coordinator to interact and engage with people. One care staff member told us, ''We are constantly on the go, never get time to just sit and chat with people''.

The home had a complaints procedure in place and we saw that a recent complaint had been recorded as being dealt with appropriately by the registered manager. People who we spoke with also told us they usually resolved any concerns directly with the registered manager.

During the inspection process relatives told us about a number of concerns they had about the standard of care and support their relatives had received. Three relatives told us about specific care needs not being met including daily personal hygiene not being assisted with for several days. People also told us they had concerns that the staff did not know people who lived at the home very well. A relative who had concerns about a person's care also told us that they had arranged to meet to speak with the registered manager but had been told they were no longer available and no other staff member could assist them. Some of the concerns raised by relatives to us during the inspection process were of such a serious nature we reported them to the local authority safeguarding team.

We observed people did not get always their needs met when it mattered to them. We saw one person had repeatedly requested to go to the toilet did not have their needs met with dignity. Another person could not move freely around the home as there was not sufficient staff to support them. We observed incidents in the main lounge that caused the inspectors concern about people's safety and lack of care. This was reported by the inspectors to adult social care. Two members of the adult social care team immediately came to the home to provide some additional support. The provider arranged for a registered manager from another one of their care homes to also come to assist. This supporting manager arranged for two more members of care staff to come to the home to provide assistance.

We did not see that people's care and support wishes had been made clear in their records about what their end of life preferences were. The care records contained limited information about the care people would like to receive at the end of their lives and who they would like to be involved in their care. The care records we looked at for people at their end of life did not identify specific crucial care needs such as hydration and pain management. Training records showed that care staff had not received specific training to support people at the end of life.

This was a breach of Regulation 13 (4)(c)(d) Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's needs were not being met and they were subjected to degrading care and treatment.

Throughout our observations we saw the care staff that were on duty did their best under the constraints of insufficient staff
and treated people with kindness and were respectful when dealing with them. Bedrooms we saw had been personalised with people's own furniture and ornaments to help people to feel at home.

Inadequate

Is the service responsive?

Our findings

Relatives and care staff that we spoke with told us they had difficulty raising concerns directly with the registered provider and preferred to speak with the registered manager about things that mattered to them. A relative told us they felt confident that the registered manager would deal with any concerns whenever they had any and told us that they were unhappy that the registered manager had not been available recently. Two members of care staff told us they would only speak with the registered manager about any concerns they had as they were not sure what response they would get from the registered provider. Care staff told us, ''We know the registered manager has asked the registered provider for more staff to support us but we never got any help''.

The care records we looked at did not demonstrate that people's needs were assessed prior to their admission to the home or that their care was planned and delivered in line with their individual needs. Individual choices and decisions were not always documented within these records and we found that the records were not always subject to regular review or as and when people's needs changed.

Care plans had not been adequately developed to meet people's needs and we saw that care and support provided was task orientated. The care plans were not person centred as they were not tailored to individual preferences or abilities. Person centred care planning is a way of helping someone to plan their care and support taking into account their individual preferences and what is important to them. We did not see that people had always been involved in their care planning. Where people could not easily make decisions for themselves we did not see that relevant others had been consulted. Some care records did not contain relevant and appropriate information relating to current health and social needs. Where one person had been referred to professionals to support their individual behaviours there were no records to show what involvement or guidance had been shared with the staff team.

The care plans lacked sufficient information about how the person wished their care to be delivered and what tasks people were able to do themselves or could participate in. For example, personal preferences in terms of care routines such as bathing, showering, hair and nail care, continence needs and social activity, were not stated. We found one person preferred a particular gender of care staff for their personal care and this had not been recorded and this resulted in the person becoming distressed during their personal care.

There was no evidence of relevant other people being involved in the care plans. Out of the 11 care records we looked at there was only one pre admission assessment completed to inform staff of people's needs and identify whether they could be adequately met by the service. There were no records about service users' communication abilities or personal preferences in relation to their care.

One person who required full assistance from two carers and equipment to aid their transfer did not have accurate assessments relating to their moving and handling risks. The assessment had been reviewed on 16 May 2016 but did not reflect the actual requirements for their moving and handling. Their care records contained conflicting information as to the level of support this person required with moving and handling. The care plan for moving and handling was not personalised and was not accurate in addressing the risks

associated with transferring this person.

This was a breach of Regulation 9 Person-cantered care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because it was not possible to ensure that people received safe and appropriate person-centred care and treatment that was based upon their assessed needs.

We saw that there were planned activities for people to get involved in. There was a recently appointed activities coordinator and we saw from pictures in the home that people had enjoyed a variety of meaningful activities.

Inadequate

Is the service well-led?

Our findings

Throughout the course of this inspection we examined a variety of documentation and information that had been provided to us. We also had numerous discussions with care staff and relatives.

During the course of the inspection the registered manager was not present in the home. We were told by the registered provider they did not know the whereabouts of the registered manager. All the staff we spoke to expressed their concerns about the absence of the registered manager. Staff told us the registered manager often worked alongside them because there had been shortages of staff on most shifts. A relative and two care staff told us the registered manager had been supporting the care staff team as a carer on a regular basis since January 2016.

Staff and relatives told us they had a good relationship with the registered manager and thought the home was well managed. One relative told us, ''She (registered manager) made this a better place when she started, but since Christmas it's gone downhill''. Staff told us that they felt they were well supported by the registered manager. One staff member told us, ''She has been a good support and accommodated my requests around working hours even though we have been short staffed''. All the staff we spoke with said that they enjoyed working in the home despite the long hours and extra shifts some of them had done. One member of staff told us, "I love my job, and I do the extra hours because I want to make sure people living here are being looked after''. One relative told us they felt the registered manager had been put under pressure because of the low staff numbers.

We looked at the incident and accident records in the home and compared them to incidents recorded within the 'daily records' and individual care plans. We found that not all these records correlated with the information. For example one person's daily notes outlined challenging behaviour or mental health events without any records of corresponding action taken to support the individual; follow-up actions to manage their needs; monitoring of patterns or themes; or appropriate onward referral.

Additionally, we reviewed records to assess how the service supported people to meet their ongoing and changing health needs. Although we saw staff worked with other healthcare professionals, we found recommendations made at a safeguarding strategy meeting had not been transferred to a person's care plans.

This meant that by not consistently recording accident and incidents, records were therefore not accurate or complete and could not be used as a contemporaneous record of the events that had occurred within the home. In addition it was not possible for management to then identify any trends in accidents or incidents and take corrective action to ensure people received appropriate care and support.

We looked at eleven care records and found people were not always protected against the risks of inappropriate care. Risk assessments were either not in place, inadequate or were not informative about reducing or managing the risks. Reviews of records consisted of tick boxes and did not inform staff of changes or about how they should provide personalised support to minimise risk to people.

Care planning was poor because there was no clear guidance about people's needs and how staff could support them. Information about how to assist them was not always apparent or available and the required frequency of support was not documented. For example how to manage the behaviours of some people that might challenge the service. Care plans consisted of brief statements that highlighted needs without any detailed guidance for staff to assist them to meet their requirements. For example one person had suffered seizures but there was no care plan for staff to follow in managing the seizure.

Care plan audits had been completed. Audits of the care plans were not effective in identifying the shortfalls and evidencing any completed actions. An audit of care plans reviews was in place up to March 2016 but did not confirm what areas were reviewed. These consisted of a checklist and comments box. Audits carried out in March 2016 identified gaps in the care plans and detailed the corrective actions that were required. During the inspection we found that these issues remained outstanding as the actions had not been assigned to anyone for completion and review.

This meant that the quality assurance process in place failed to demonstrate how they drove improvement within the home. The process did identify issues but failed to demonstrate who was taking accountability for managing the required improvements. For example records of temperature control for the storage of medications but no corrective action was implemented to prevent this issue recurring.

We looked at records in relation to the Mental Capacity Act 2005. We did not see where people had restrictive measures in place that this had been done in line with legislation. Where we did see that an application had been made for legal authorisation to deprive someone of their liberty to safeguard them, the information provided in the application was not accurate about the restrictive measures that were in place. There was no documentation about best interest decisions/meetings, decision specific care planning or review of mental capacity.

We observed that there were occasions throughout our inspection when staff and the management team had failed to protect people's confidentiality. For example the senior carer's office was left unattended and unlocked leaving personal information unattended.

Maintenance checks were being done regularly and we could see that any repairs or faults had been highlighted and acted upon. However records in the home relating to utility service checks were not in date and the most recent records had to be requested from the registered provider.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not have effective systems or processes implemented, for the purpose of the continuous monitoring of the service and the quality and safety of care that was being delivered. The systems that were in place failed to ensure that where corrective action was required, that this action was carried out and assessed.

During the inspection we identified a number of incidents which under the conditions of registration with the Commission were required to be notified to us that had not been submitted.This was a breach of the Care Quality Commission (Registration) Regulations 2009 Regulation 18 Other Incidents. There was also a failure by the provider to notify us of changes relating to the management of the regulated activities in the home as outlined in the registration regulations this was a breach of the Care Quality Commission (Registration) Regulations 2009 Regulation 15 Notice of changes.