Alban Quality Care Limited

Alban House Residential Care Home

Inspection report

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Date of inspection visit:
29 October 2020

Date of publication:
08 February 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Alban House Residential Care Home is a 'care home'. The home is registered to accommodate up to 23 people in one adapted building. At the time of this inspection there were 22 people living there. The home cared for older people, including people with dementia, learning disabilities and other mental health needs. The home also cared for younger adults with physical disabilities, including neurological conditions such as Multiple Sclerosis.

Alban House has been adapted from three adjoining Victoria terraced houses. There are four floors accessed by a shaft lift.

People's experience of using this service and what we found

At the time of the last inspection in 2019 a new manager had recently been registered with the CQC. During the Covid-19 pandemic there were further changes to the management team. The new manager had been absent from the home for a period during the spring months of 2020. They later applied to cancel their registration and the application was approved in September 2020. This meant the home did not have a registered manager in post at the time of this inspection. An existing member of the staff team was appointed as acting manager while the provider sought to appoint a new registered manager. At the time of this inspection the provider had been unsuccessful in appointing a new manager. There had also been a change of key members of Alban Quality Care Ltd at the end of 2019.

Systems were not in place to ensure people received safe care and treatment. There had been a high turnover of staff. New staff had been appointed but they did not always have the knowledge or skills to meet people's needs safely. The provider had found records relating to staff induction, training or qualifications were missing. They also found a number of care plans were missing, out of date, or did not provide sufficient information about people's care needs. At the time of this inspection the acting manager was in the process of writing new electronic care plans and risk assessments.

Care plans did not provide evidence of each person's ability to make decisions about all aspects of their lives. Mental capacity assessments had not been carried out. Staff had not received training on the Mental Capacity Act 2005. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

At the last inspection we found some areas of the home appeared tired and dated, and some areas of the home and equipment had not been fully maintained. At this inspection we found little progress had been made on redecorating and maintaining the property. Some works were planned for the near future, including the replacement of some flooring.

In recent months the provider had received support from the local authority to help them draw up a service improvement plan and put in place monitoring systems to help them identify any further issues in future. However, this service has been rated as Requires improvement for the last four inspections. Systems that had been put in place following previous inspections to monitor and improve the service had either been ineffective or had not been maintained. The new systems being put in place to monitor and improve the service had not yet been established and therefore we could not be confident the service will maintain the improvements being made.

People and relatives told us they were happy with the care people received. A person living in the home said, "They are absolutely brilliant!" Comments from relatives included, "I love the care, I love the people. They are looking after [relative] beautifully" and "On the whole it's ok".

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 14 October 2019). There were three breaches of regulation. The provider completed an action plan after the last inspection to show what they would do, and by when, to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 18 and 19 July 2019. Breaches of legal requirements were found. Since the last inspection we had also received concerns.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. The inspection was also prompted by the recent concerns we had received including tissue viability, constipation, poor moving and handling procedures and lack of adequately trained staff. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has remained Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the Safe, Effective and Well-led sections of this full report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Alban House Residential Care Home on our website at www.cqc.org.uk.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to need for consent, safe care and treatment, premises and equipment, good governance and staffing. Please see the action we have told the provider to take at the end of this report.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not entirely safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Alban House Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector.

Service and service type
Alban House Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. The provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we looked at the information we had received from the home, and about the home,

since the last inspection. We sought feedback from the local authority and professionals who work with the service before, during and after the inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection-
We walked around the home and spoke briefly, or observed staff interaction with, most people living there. We spoke with the provider, acting manager, three staff, one relative and two health professionals who were visiting the home that day. We looked at records including one care plan, training records, recruitment records and medicine administration records.

After the inspection –
We continued to seek clarification from the provider to validate evidence found. We looked at records including four care plans, health and safety records, training data and quality assurance records. We spoke with one professional who has worked closely with the service. We spoke with five staff on the telephone, one relative and one health professional.

Requires Improvement

Is the service safe?

Our findings

Our findings - Is the service safe? = Requires Improvement

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as Requires Improvement. At this inspection the rating has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management. Learning lessons when things go wrong
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- People were at risk of harm because staff had not received suitable training and did not have sufficient information about the risks to each person's health and well-being and the actions they should take to mitigate the risks.
- Four people had developed pressures ulcers. A community nurse told us they were concerned that the staff did not always contact them quickly when pressure ulcers showed signs of deterioration. It was sometimes several days before they were contacted by staff, and in this time the ulcers had become worse.
- Some care plans contained insufficient information about specific risks and how to reduce or prevent them. For example, we received a concern from a health professional when a person became ill and required hospital treatment. The health professional told us the person had a grade 2/3 pressure ulcer which staff seemed unaware of. We looked at the person's electronic care plan which stated they were a low risk of pressure ulcers while their previous paper care plan showed them as being at medium risk. It was unclear how each risk level had been assessed.
- Risks to people were increased further because staff training records did not contain evidence of training on skin care or prevention of pressure ulcers.
- Where creams and lotions had been prescribed for skin care the records of administration had not always been completed. This meant it was not possible to check if measures to prevent skin damage were being followed.
- Measures to protect people and staff from accident or injury when people needed assistance to move were not always in place. Not all staff had received training in manual handling. A health professional contacted us and said they had witnessed poor manual handling.
- Where people were at risk of constipation their care plans had not identified the risk of constipation. They did not explain how to recognise the signs of constipation or the measures necessary to reduce the risk of further episodes of constipation. For example, one care plan stated, "bowels are monitored on the bowel chart and mild laxative given when required". There was no further information to explain how to recognise the signs of constipation, or when a laxative might be required. Training records showed that staff had not received training on the risks associated with constipation.
- We were told a hoist was not safe to use. We spoke with the provider who said the hoist had been missed

at the last visit by their specialist contractor to service and check all lifting equipment. The provider did not have systems in place to ensure all hoisting equipment was checked and serviced by suitably qualified professionals at regular intervals to ensure it was safe to use.
● The security of the building had not always been maintained. We discussed this with the provider, and they agreed to take immediate action to ensure security is maintained in future.
● Risks relating to some aspects of fire safety had been identified by the local fire authority. The provider told us the actions required in the most recent fire report had been addressed. However, we noted a hole in one of the ceilings that might pose a risk a fire broke out in the building. The provider told us they would address this as a matter of priority.
● Where incidents had occurred, or concerns raised, the provider had taken actions to address the issues. However, we were unable to see evidence that measures had been put in place to fully analyse the reasons why the issues had occurred or to prevent issues and concerns recurring.

Risks to people's health and well-being had not been adequately managed. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were weighed regularly (where possible) and risks of obesity or weight loss were monitored. Where people were at risk of weight loss care plans identified the level of risk. Care plans instructed staff to make sure people had access to high calorie snacks. Staff recorded the food and drink people had consumed.
● After we spoke with the provider about the concerns raised by a health professional about a faulty hoist, they carried out their own check and found it was working safely. They also asked for their contractor to visit and inspect the hoist and provide the correct documentation to evidence it had been checked and was safe to use.

Using medicines safely
● The supply of medicines had changed in recent months from monitored dosage packs to bottles and packets. Each person had a named basket containing their medicines. In the past the monitored dosage packs had been stored in a locked medicine trolley. At the time of this inspection the baskets containing the medicines were stored in a locked room with a key coded lock on the door. We discussed the security of the room with the provider and manager. After the inspection they told us they had changed the lock to a Yale type lock. The keys were held by designated persons only.
● Controlled drugs were securely locked in a suitable metal cabinet.
● In a sample of administration records seen, recording of liquid and tablet medicines were satisfactory with minimal unexplained gaps. However, staff were not always recording creams and lotions when applied.
● At the time of this inspection eleven out of 29 staff had received training on the safe administration of medicines. Further staff were in the process of completing this training. However, there was no evidence to show staff understood the training or were following safe practice. A member of staff told us they were involved in administering medicines. They could not remember when they had completed any training on this topic, or if their competency to administer medicines had been checked.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the risk of abuse or neglect because there were insufficient measures in place to ensure staff understood how to recognise abuse, or the procedures to follow if they suspected abuse or neglect had occurred.
● Since the last inspection we have received concerns and safeguarding alerts about the service. These included concerns relating to poor moving and handling practice, low staffing levels, high staff turnover, lack of staff training, bullying and poor care practice.

● We spoke to the provider each time we received a concern. They told us they had been through a period of upheaval and problems due to changes of management of the service. They had been unable to find evidence of training completed by staff and had begun an intensive training programme to bring all staff up to date with essential topics.
● Staff training records showed that during August, September and October 2020 there were 29 staff working at the home. Of these, eleven members of staff had completed training on safeguarding. This meant there were 18 members of staff who did not have a training record that showed they had received any training on safeguarding. This topic was in the process of being provided to all remaining staff in the coming weeks.

We recommend the provider seek advice and guidance from a reputable source, to help them review their systems and training programme for staff on safeguarding people from abuse.

● Some staff we spoke with told us they had received training on safeguarding through previous employment. Staff told us there was information about safeguarding displayed in the home. They said they knew what to do if they suspected abuse had occurred.

Staffing and recruitment
● An administrator had recently been recruited who had responsibility for recruitment administration procedures. They had found staff files did not always provide evidence of safe recruitment procedures being carried out. They had taken prompt action to make sure references and checks were in place, and where they were missing these checks were carried out. They had found some recruitment records did not contain evidence of previous training or qualifications, and they were in the process of gathering this where possible. Procedures were in place to ensure safe recruitment procedures will be carried out in future.
● There were enough staff deployed to meet the needs of people living there. However, there had been a higher than average turnover of staff in the last year. At the time of this inspection the provider was in the process of recruiting more new staff to fill vacant posts.
● There was a core group of staff who were willing to cover vacant shifts to ensure sufficient numbers of staff were maintained.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Requires Improvement

Is the service effective?

Our findings

Our findings - Is the service effective? = Requires Improvement

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People were at risk of poor care because their needs and choices were not fully assessed. Care plans did not always provide sufficient information to ensure staff delivered effective care.
● At the time of this inspection approximately half of the people living in the home had a care plan that had been drawn up using a new electronic system while other people had care plans that were older style paper documents. We looked at four paper care plans and five electronic care plans. The information in the paper care plans was out of date and lacked sufficient detail in all areas of needs. The new electronic care plans were up-to-date and provided greater detail. However, some sections lacked sufficient detail. For example, where people had conditions such as multiple sclerosis or Parkinson's disease the care plans did not give sufficient information about the illness or how it may affect the person.
● Care plans contained little information on people's social needs. Care plans for people who had limited verbal communication did not give staff information about their previous lives, employment, hobbies and interests. There was no information about their family life or history to guide staff on the things the person might like to hear about.
● The new electronic care plans provided greater detail than the paper care plans and were up to date but not all staff had received training on the use of this system. Staff were not always accurately recording when tasks had been completed and therefore daily notes did not always provide evidence that care needs had been met.

Lack of adequate care plans and risk assessments has placed people at risk of harm or poor care. This is a breach of Regulation 12: (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Before this inspection the provider told us that, following changes in the management team, they had found some people did not have care plans while other care plans were either out of date or did not provide enough information to ensure staff understood the care people required.
● New people had been admitted without carrying out an assessment or completing a care plan. The acting manager told us that all new people admitted in future will have an assessment of their needs completed before they are admitted. The new electronic care planning system included a section for new assessments.
● The acting manager and senior staff team were working towards providing an electronic care plan for each person with enough up-to-date information to ensure people received safe and effective care. The

acting manager was inputting information on the electronic care planning system and had liaised with the staff team to ensure the information was up-to-date. They had drawn up care plans for those people for whom they had been unable to locate a care plan, including those people admitted in recent months.
● Staff told us they were aware care plans and risk assessments were being updated. When updates were completed staff were instructed to read them after each handover.

Adapting service, design, decoration to meet people's needs
● Lack of maintenance and management oversight had resulted in the decoration and maintenance deteriorating since the last inspection. Some areas of the home required maintenance and decoration to ensure the premises were safe and comfortable for people living there.
● At the last inspection we found some areas of the home appeared tired and dated. At this inspection we found very little improvements had been made. Scuffed and worn paintwork and decorations were found in most areas of the home. In one bedroom a ceiling had been damaged by a leak and had been re-plastered but had not been repainted. In another room ceiling tiles were damaged leaving a hole in the ceiling. Some carpets and flooring were worn. The provider told us some floor coverings were due to be replaced in the near future.
● At the last inspection sticky backed plastic had been used to cover a dining table which was torn and unhygienic. Although we were assured the sticky backed plastic had been replaced after the last inspection, during this visit we found that once again the plastic was torn, unsightly and unhygienic.
● A toilet and shower room on the top floor had been in construction at the last inspection. At this inspection we found it was still under construction and unusable.
● At the time of our last inspection a member of the care staff team also had responsibility for some maintenance tasks. At the time of this inspection this person had recently taken on the role as acting manager. This meant the home did not have a maintenance person who was able to carry out routine repairs and maintenance. The provider told us that the Covid-19 pandemic had meant they had been unable to find tradesmen to carry out maintenance tasks that were not urgent.
● At the last two inspections we found the layout and decoration of the home was not suitable for people living with dementia. We recommended improvements were made. Lack of action taken to address this has meant there was a possibility people with dementia may have difficulties finding their way around. There was a mixture of different floorings which may cause difficulties for people with dementia or visual impairment. There was little evidence of signage or decor to help people find their way around.

People were at risk of harm from unsuitable accommodation because the provider has failed to ensure the premises and equipment are properly maintained This is a breach of Regulation 15: Premises and equipment.

Staff support: induction, training, skills and experience
● Not all staff had received induction or ongoing training in essential topics to provide them with the knowledge and skills necessary to meet the needs of people living in the home.
● A member of staff told us they were involved in administering medicines. They could not remember when they had completed any training on this topic, or if their competency to administer medicines had been checked.
● Following changes in the management of the service the provider had been unable to find evidence of staff training. Staff were unable to confirm they had received training on essential topics. Records of some qualifications could not be verified by staff. Staff recruited prior to the management changes earlier in 2020 could not confirm they had received induction training.
● The training matrix showed seven staff (out of 29) had gained the Care Certificate in 2019 and early 2020. However, there were no records of staff employed since the beginning of 2020 having started this

qualification. The training matrix also showed only three out of 29 staff held a relevant qualification such as a National Vocational Qualification (NVQ).
● There was no evidence to show staff had received training on specific topics relevant to the needs of people living there. For example, there was no evidence that staff had received training on dysphagia, tissue viability, falls prevention, or illnesses such as Multiple Sclerosis.
● Staff had not received regular one-to-one supervision. The acting manager told us they had realised supervision records were lacking but they were offering one to one support to staff where possible. Staff told us they had not had any supervision for a while.

People are at risk of poor care because the provider has failed to ensure staff receive appropriate support, training, supervision and appraisal. This is a breach of Regulation 18: Staffing

● At the time of this inspection the provider had begun to address the lack of training. A new administrator had drawn up a training matrix showing the dates each member of staff had completed training on essential topics and identified where further training was overdue.
● In order to address the lack of training the staff team had been given training on topics the provider had identified as essential. Many of the topics were in the form of workbooks followed up by tests to check their skills and understanding.
● The provider told us they planned to put all new staff through the Care Certificate (a qualification for care workers new to the industry providing them with the basic knowledge needed to care for people safely) in future.
● A training company had been booked to provide face-to-face training in key topics such as moving and handling in the coming weeks. Local health and social care professionals had also offered to provide training on topics relating to people's health such as tissue viability. Training for all staff was in progress at the time of this inspection, with dates for further training on some topics identified for the coming weeks.
● Staff told us they worked closely with the acting manager and could ask for advice or support at any time. Staff told us they felt well supported

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Care plans did not provide evidence to show that people's mental capacity had been considered or assessed. The acting manager told us assessments will be completed in the coming weeks.
● Training records showed only two staff had completed training on the MCA.
● Four applications to restrict people's liberty had been submitted in 2015 and 2017 and were awaiting approval.

The provider did not have systems in place to ensure people's right to make important decisions about their care and treatment, and their daily lives was upheld. This is a breach of Regulation 11: (Need for consent) of

the Health and Social Care Act 2008.

Supporting people to eat and drink enough to maintain a balanced diet
● Care plans contained information about people's likes and dislikes regarding food and drinks.
● Staff recorded the food and drinks offered to people throughout the day and the amounts consumed.
People were offered a varied diet. If they did not like the main meals offered, they were able to choose a suitable alternative.

Supporting people to live healthier lives, access healthcare services and support. Staff working with other agencies to provide consistent, effective, timely care
● During the inspection we met two community nurses visiting the home. Before and after the inspection we spoke with health and social care professionals who had been involved with the home including the local authority Quality and Improvement Team (QAIT). We heard that external professionals were welcomed into the home, and that where advice and guidance were given the staff were always willing to follow their advice. However, we heard that staff did not always seek advice or treatment in a timely way.
● A new system of recording had been introduced shorty before this inspection to ensure that professionals completed a record of their visit before leaving the home. Recording sheets were placed in the entrance hall to ensure important information was always recorded and passed to the staff team.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
At the last inspection we found the service was in breach of Regulation 17: Good governance. The breaches had occurred because they had failed to adequately assess, monitor and improve the quality and safety of the services. Their monitoring processes had not identified failings in their risk assessment and monitoring procedures. The daily records did not provide an accurate, complete and contemporaneous daily record of the care and treatment each person received.

● At this inspection we found people continued to be at risk of poor or unsafe care because systems to monitor and improve the service had failed to identify serious failings in the service. The issues found at this inspection have shown that quality monitoring systems had not been effective. The provider had failed to identify that important records including care plans and staff training records were missing or incomplete
● There had been changes in the senior management team over the last year. The person who held the registered manager's post had submitted an application to de-register and was is no longer in this post. There had been a change of key persons within the provider's company Alban Quality Care Ltd. There had also been a high staff turnover. At the time of our inspection an acting manager was in post. The provider was in the process of trying to recruit a new registered manager.
● We received concerns before and after the inspection including lack of training, bullying and poor care practice. The high turnover of staff indicated the culture within the home had not always been open and there was some ongoing instability within the staff team.

Continuous learning and improving care
● The provider told us they had discovered earlier this year that a number of key records were either missing or incomplete. These included care plans and staff training records. The provider and acting manager had taken action immediately to begin to draw up new care plans and to implement a programme of staff training. However, the lack of a registered manager had slowed this process down. At the time of this inspection we found care plans were in place for each person, but some risks had not been fully identified or assessed and some information was out of date.
● Staff training was in progress but there were a number of staff who had not yet completed essential training topics. The acting manager was in the process of drawing up and updating care plans on a new electronic care planning system. At the time of this inspection approximately half of the care plans had been rewritten on the electronic care planning system.

● During our inspection we found some areas of the home appeared worn and in need of redecoration or replacement. The provider told us redecoration and routine maintenance of the home had been put on hold during the Covid-19 lockdown. This included some areas that had been identified at our last inspection that had not been completed.

Due to poor governance of the service people continued to be at risk of harm. This demonstrated a repeated breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008

● Staff we spoke with during and after the inspection were positive about the recent changes in the home. Comments from staff included, "Staff are valued, [the provider] often comes in later in the day, even to see night staff to check they are okay and happy with everything", "Things are getting better" and "We are now sitting down and talking as a team. We are slowly becoming a team".
● There were some plans in place to improve the premises, including the replacement of some floorings in the near future, and they hoped to engage a contractor to carry out some decorations and maintenance.

Working in partnership with others.
● The provider had received guidance and support from the local authority Quality and Improvement Team (QAIT) in recent months to help them draw up a service improvement plan. They had put in place monitoring systems to help them identify where issues had occurred and to ensure actions were put in place to prevent recurrence. Their records showed they reviewed progress in a number of key areas on a weekly basis including care plans, staffing levels and staff training. A weekly medication audit was completed by the acting manager. However, these systems had not yet been fully established. We are not yet confident that monitoring systems are effective and will ensure the service will be proactive in future to prevent issues occurring.
● Monitoring systems had been recently been introduced but these were not yet fully established to ensure the service will be proactive in future to prevent further issues occurring.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were no formal systems in place for gathering people's views on the service at the time of this inspection. However, the provider had been visiting the service most days since the end of lockdown and spoke with people each day. They knew people well and acted on any issues raised. The provider hoped that a new manager would be appointed in the near future who would put in place formal systems to involve people in the service, seek their views, and to make improvements to the service.
● During the Covid-19 pandemic relatives had been able to speak to people by looking through windows while standing outside of the home. A relative told us they used a mobile phone to talk to their loved-one through the closed window. Another relative told us they were able to speak to the person from the garden and speaking from a safe distance through patio doors. After the inspection the provider told us they planned to install a screen in one of the conservatory areas to allow visitors to see people inside the home rather than from the outside.
● A relative told us, "They are doing everything they can to make [person] happy. They have signed him up to Sky and are trying to improve the WIFI signal".

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Earlier this year we found the provider had not always notified the Commission promptly when serious issued had arisen. We spoke with the provider when these matters came to light and reminded them of their duty to notify all relevant authorities when things went wrong. In recent months the provider has notified us

promptly when issues have arisen.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider has failed to ensure people's ability to consent to their care and treatment was assessed. They had failed to ensure systems were in place to ensure people's right to make important decisions about their care and treatment, and their daily lives was upheld.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider has failed to ensure care and treatment are provided in a safe way for service users. They have failed to ensure risks to people's health and safety are fully assessed and measures put in place mitigate any such risks. They have failed to ensure staff have sufficient knowledge and skills to care for people safely. They have failed to ensure all areas of the premises and equipment are in good repair and safe. They have failed to ensure medicines were administered safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider has failed to ensure the premises and equipment are properly maintained.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

People are at risk of poor care because the provider has failed to ensure staff receive appropriate support, training, supervision and appraisal.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider has continued to fail to ensure risks to the environment, and to people who live in the home, are fully assessed, monitored and mitigated.

The enforcement action we took:

We have issued a warning notice in respect of regulation 17:Good governance