St David's Home For Disabled Soldiers, Sailors and Airmen

St. David's Home

Inspection report

12 Castlebar Hill
London
W5 1TE

Website: www.stdavidshomealing.org

Date of inspection visit:
22 February 2023
24 February 2023

Date of publication:
13 July 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
St David's Home is a care home with nursing providing personal and nursing care for up to 76 adults living in 4 units. 1 area is used to provide rehabilitation support to people with a range of physical disabilities with the aim of being able to live a more independent life and to return to their home or move to other accommodation. At the time of the inspection there were 63 people staying at the home. The home is operated by St David's Home For Disabled Soldiers, Sailors and Airmen, a registered charity.

People's experience of using this service and what we found
People and relatives said care staff treated them well. However, most people said the quality of the service needed to improve and it was not well-led. A relative told us, "I would tell people not to go there. I wouldn't recommend it to anyone." The culture of the service did not always promote supporting people to achieve good outcomes.

The provider had not always assessed, monitored and managed risks to people's safety and well-being. People's medicines were not always managed in a safe way. Some people had experienced an inconsistent approach to safeguarding them from avoidable harm.

Some people's care plans were not always up to date, sufficiently personalised or reflective of the care and support people received.

The systems in place to monitor the quality of the service and make improvements when required had not always been effective. The provider had not made enough improvements since the last inspection to address breaches of regulations.

The service provided a variety of weekday activities for people but this resource was not available to people who stayed in their rooms.

There were appropriate staff recruitment processes and infection prevention and control procedures in place. Staff, people and relatives had opportunities to comment on the running of the service. There were systems for recording and responding to complaints.

Staff worked with other agencies to provide people with joined up care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 8 August 2022). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations. The service remains rated requires

improvement. This service has been rated requires improvement for the last 4 consecutive inspections.

At our last inspection we recommended that the provider consider current guidance on assessing and monitoring safe staffing levels. At this inspection we found the registered manager had implemented a protocol for determining staffing levels.

Why we inspected
The inspection was prompted in part due to concerns received about staffing and providing people with safe care. A decision was made for us to inspect and examine those risks. We had also carried out an unannounced focused inspection of this service on 10 and 11 February 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve in relation to safe care and treatment, infection control and good governance. We undertook this focused inspection to also check they had followed their action plan and to confirm they now met legal requirements. As such, this report only covers our findings in relation to the Key Questions Safe, Responsive and Well-led.

We have found evidence that the provider needs to make improvements. Please see the Safe, Responsive and Well-led sections of this report.

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 COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained the same. This is based on the findings at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St David's Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, medicines management, person-centred care and good governance. We have made recommendations regarding the call bell system, activities provision, complaints handling and service culture.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an urgent action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

St. David's 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 Health and Social Care Act 2008.

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 conducted by 2 inspectors, a medicines specialist advisor, a nurse specialist advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
St David's Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under 1 contractual agreement dependent on their registration with us. St David's Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service had a manager registered with the CQC, who was on leave when we visited. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included speaking with a relative of a person who uses the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 8 people who used the service and 8 relatives about their experience of the care provided. We also spoke with 15 members of staff. This included care workers and senior care workers, nurses, a chef, an activities coordinator, laundry workers, the maintenance manager, the quality manager and the registered manager. The registered manager was also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with 6 professionals who have recently worked with the service. We viewed a variety of documents related to people's care and the running of the service. This included 11 people's care and risk manage plans, 5 people's medicines support records, complaints records, audits, meeting notes, and 5 staff recruitment records. After our visits we continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. 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
At our last inspection we found risks to people's safety were not always assessed, monitored and managed so they were supported to stay safe. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

While we found there had been improvements at this inspection, the provider was still in breach of regulation 12.

- Risks to people's safety and well-being were not always assessed, monitored and managed.
- The service's approach to assessing and managing environmental and equipment-related risks remained inconsistent. We found two people had free-standing oxygen cylinders in their bedrooms. These had not been stored securely to minimise the risk of falling and created a fire hazard. We reported this to the registered manager so they could address this.
- Some people's care plans stated they required regular support to reposition their bodies in bed to mitigate the risk of developing pressure sores. Records of care indicated this support was not being provided as regularly as required. For example, 2 people's plans stated they needed turning every 2-3 hours but care records for the 4 weeks prior to our visit showed multiple occasions when this was not provided as required. 2 other people's plans stated they needed repositioning support every 4 hours but care records for the 4 week period indicated multiple times when this did not take place. This indicated the provider could not be assured these people were always receiving care as required to protect them from harm. The provider updated some people's care plans after our inspection to indicate when they may refuse this support.
- Some people's care plans did not always provide sufficient information for staff on how to support a person to manage or mitigate risks to their safety and well-being. A person required support to wear a brace on their body to promote the healing of a fracture. This was noted in their care plan but there was no information recorded for staff on how this should be worn properly. A relative said they had demonstrated this to staff but found at times the person not wearing the brace or it was fitted too loosely. Daily care records over 3 weeks noted the person may take the brace off but only referenced its use on 9 occasions. This indicated the provider could not be assured the person was always being supported safely.
- The person's care plan stated they were at risk of falls and 1 action to mitigate this was for staff to ensure the person used suitable chairs. Shortly before our visit the person experienced a fall from a chair without arms and needed hospital treatment. This indicated the person was not always supported in a way that lessened the risk of them experiencing avoidable harm.

These issues indicated that risks to people's safety were not always assessed, monitored and managed so they were supported to stay safe. This was an ongoing breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A healthcare professional told us staff supported some people to manage their pressure sores appropriately.
● Notwithstanding the above other people's care plans set out how staff should support them to manage or mitigate risks to their safety and well-being, such as from swallowing difficulties or diabetes.
● We observed staff supporting people to drink fluids throughout the day to ensure people were sufficiently hydrated.
● Staff we spoke with knew what actions to take in the event of a medical emergency.
● The provider was in the process of implementing a plan of works to improve fire safety measures in the home, such as repairing or replacing doors. The provider was in the process of refurbishing areas of the home. Repairs had been made to roofing since our last inspection, the dining hall had recently been redecorated and corridor flooring was replaced shortly after our visit.
● The maintenance team completed a variety of checks to maintain the home environment including water temperatures, lighting and mobility equipment, and took action to address issues these checks found. For example, we observed the maintenance manager address an issue with a person's pressure relieving mattress pump.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● Notwithstanding the medicines support issues we noted, we found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Conditions related to DoLS authorisations were being met.

Using medicines safely
● There were systems in place to support people to take their medicines, but we found these were not always implemented effectively. This meant people were at risk of harm from not safely receiving their medicines as prescribed. We raised these issues with the managers so they could address them.
● Medicines recording practices required improvement. For example, staff had not always recorded when people's medicines such as insulin pens were first opened for use. This meant it was not always clear by when such medicines should be used or discarded.
● The provider used a digital medicines management system to manage medicines. While staff used this to record when they administered medicines to people, managers reported connectivity issues at the home meant the system did not always effectively account for the amount of medicine being stored for people. For example, we found for 3 people the number of prescribed tablets being held at the service were different to the amounts recorded for them on the system. This meant the provider could not always be assured that accurate accounts of medicines stocks were being maintained.
● There were processes in place for the handling of controlled drugs, but these were not always

implemented appropriately. In the controlled drugs register for 1 person staff had written over a previous stock balance entry, which was an inappropriate recording practice. There was also a discrepancy in the stock balance entries that had not be identified and addressed.
● We observed staff crush multiple prescribed tablets together to be administered to a person. Their care plan was not up to date as it only listed some and not all the medicines to be crushed in this way. After our visit we saw the provider updated the person's care plan to clearly state which medicines were to be either crushed and administered individually, dissolved in water or added to food.
● We observed a person tell staff to leave their medicines out for them to take later. The person's care plan stated they liked to manage some medicines like eye drops on their own. However, they had also been left with other medicines, such as tablets, that were not set out for this support in their plan. Staff told us that when the person was left at times to take their medicines on their own staff would return later to check and record this had happened. There was no evidence the service had assessed and planned this with the person to ensure risks of them not receiving their medicines as prescribed were suitably mitigated. We saw evidence after our visit that staff had updated the person's care plan to reflect this care.

These issues indicated people's medicines were not always managed in a safe way. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite the system recording issues we found, the service had maintained sufficient stocks of people's medicines when we visited. We saw the service was working with a local pharmacist to review people's medicines.
● Staff maintained suitable records of medicines that had been returned for destruction.
● Staff regularly checked and recorded the medicines room and medicines fridge temperatures and these were within appropriate ranges for storing medicines safely. Staff who administered medicines had completed training for this and their competency to do so was assessed.

Systems and processes to safeguard people from the risk of abuse
● Some people had experienced an inconsistent approach to safeguarding them from avoidable harm.
● At the time of the inspection we received information suggesting a person was not always safe and protected from avoidable harm or abuse. We passed this information to the local authority and these concerns were being investigated when this report was being written. Complaints records indicated the home was in the process of investigating a concern that an item of jewellery had gone missing.
● Staff had training on how to recognise and report abuse and staff we spoke with knew how to apply this.
● We saw the registered manager worked with statutory services to respond to and investigate concerns. A professional we spoke with confirmed this.

Staffing and recruitment
At our last inspection we recommended the provider consider current guidance on assessing and monitoring safe staffing levels in care homes and take action to update their practice accordingly.
The provider had made some improvements.
● The registered manager used a staff 'dependency protocol' to determine safe staffing levels in each unit and they stated staffing levels were adjusted based on this. We observed there were sufficient numbers of staff to meet people's care needs. However, we were not assured staff were always deployed effectively to meet all people's care and support needs at all times.
● A person told us that sometimes after using the call system to request staff support they had needed to wait half an hour to be attended to. These waits had created personal care issues for them. A relative also told us another person had experienced the same thing.

● Information displayed in the home stated the service aimed to attend to 70% of care calls within 7 minutes. However, feedback from some relatives indicated they felt people did not always experience timely care. A relative told us, "They say waiting times are down, but it's not true."
● We observed the call bell system sounding almost continuously throughout our visits, although sometimes this was due to the use of external doors, for visitors or deliveries, rather than people requesting staff support. A person told us, "You tune them out after a while." On 1 occasion we saw the call bell system go silent but it was not clear if people had been attended to. We raised this and issues with the system with the registered manager so they could investigate. The provider was in the process of reviewing the call bell system to ensure it was fit for purpose.

We recommend the provider monitor and assess the use of the call bell system to identify if there are issues with not answering the call bells on time, and if so to identify what these are so they could be addressed.

● Staff told us they felt the staffing levels were safe although 1 commented they would welcome more staff on shift. Staff and a relative said the home used less temporary agency staff on shift so people experienced more continuity of care from the same staff. The relative said this was "a big positive."
● People and relatives told us there was a reduced in-house physiotherapy service due to staff vacancies. The registered manager told us they trying to recruit staff for this and a new part-time physiotherapist had recently been engaged.
● The provider had appropriate recruitment processes to help make sure they only employed suitable staff.

Preventing and controlling infection
At our last inspection we found that the prevention and control of infections was not always managed in a safe way. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 regarding the prevention and control of infections.

● We were assured that the provider was preventing visitors from catching and spreading infections. A professional told us infection prevention and control practice had improved since our last inspection.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● 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 responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. Feedback from relatives indicated that cleanliness in some people's rooms had been a concern since our last inspection but this had been addressed.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

Visiting in care homes
● Visitors were allowed into the home in line with national guidance.

Learning lessons when things go wrong
● There was a system for staff to record incidents and accidents. These were discussed in daily 'flash' meetings to ensure unit leads were aware and actions taken. The quality manager monitored the recording

of these.

● The registered manager investigated concerns when things may have gone wrong. For example, when there were concerns about the safety of a person's care.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support
At our inspection in November 2021 we found care was not always planned in a way to reflect people's individual needs and preferences. This was a breach of Regulation 9 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 9.

● The provider's arrangements to ensure people always received care in a planned way that met their needs, or recognised and reflected their individual needs and personal preferences, were not always applied consistently.
● A person's eating and drinking care plan stated they were "on a special diet" but there was no information about what this was or about their food and drink likes and preferences.
● Another person's plan stated they should be offered use of the home's 'sensory room', but we found this room had not been in use for a number of years. This meant this aspect of their planned care could not be met.
● A person described experiencing a significant delay to getting a new wheelchair they needed to better promote their posture, safety and independent mobility. Staff informed us the provider was reviewing arrangements with the wheelchair service contractor to improve this.
● Some people gave mixed feedback about their care experience. One person stated, "Some of the carers are good and some are not so good."
● Some people's care plans did not always set out information about their end of life care. We found 1 person had a palliative care plan in place that set out basic care requirements, such as to manage the person's pain and discomfort and liaise with healthcare professionals and relatives. However, there was no recorded information about advance care planning with the person and the family, such as their wishes, values and care preferences, regarding their end of life care, or signs of deterioration related to their health conditions for staff to note.

These issues indicated care was not always planned in a way to reflect people's individual needs and preferences and there was a risk that staff would not always know how to support people in a way that reflected their needs and personal preferences. This was an ongoing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was some personalised end of life care information in other people's care plans. Staff referred

people to the local palliative care team when required. A professional told us staff worked with them to support these assessments.

● We found some staff could not demonstrate they knew how to use the digital care planning systems ably and efficiently when we visited; other staff could. However, staff we spoke with appeared to know people living at the home well. Professionals told us this was also their experience of working with the home's nurses and care staff.

● Some people's plans gave a clear indication of their care needs and preferences, such as if a person preferred male or female staff to support them, and information about their background. Relatives were involved in people's care, but this involvement was not always clearly documented in people's plans. A relative told us the provider had informed relatives they would be provided with access to a person's digital care plan but this had not happened.

● Some people and relatives spoke positively about people's care experiences. For example, a relative told us, "The carers can't do enough for [the person]."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Activities coordinators supported people with a range of activities on weekdays, but not at weekends, in a spacious, well-lit activity room. We observed activities such as a group crossword, table tennis and painting taking place and people appeared to enjoy this. There was a good range of equipment for different activities including craft materials and soft toys.

● There was not planned activities support for people who stayed in their rooms, either by choice or as they were cared for in bed. An activities coordinator told us, "We pop in and say hello, but can't do more than that." Care staff told us they did not actively encourage people to try new activities. However, we did see staff chatting with people in their rooms at times.

We recommend the provider consider current guidance on the provision of meaningful activities to promote people's wellbeing and review their practices accordingly.

● There was an on-site chapel that some people accessed. People had attended a ceremony there when we visited. Sometimes activities staff supported people with trips to hospital or to access the community, such as a local pub. We were told boat and museum trips were also being arranged.

● Friends and relatives were able to visit people during the day but visits after 8pm were discouraged, unless people were very ill or in an end of life care situation. We saw visiting arrangements were set out in an admissions protocol but 1 relative told us this wasn't made clear to them when a person started using the service.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● We saw care plans set out if a person had communication or sensory needs and how staff were to support them with these. For example, where a person had difficulty speaking or a visual impairment.

● A person described a delay in getting new prescription glasses they needed. We discussed this with the registered manager and saw staff contacted healthcare professionals to support the person with this.

Improving care quality in response to complaints or concerns

● The provider had processes in place for recording and responding to complaints, but it was not always clear if this was managed effectively.

● The managers informed us that nurses on each unit were responsible for responding to complaints in the first instance, but on some units we could not always find records of complaints handling. However, we saw complaints records the quality manager held in their office. Some of these showed recent complaints had been noted and were being looked into. 1 record logged a complaint on 30 December 2022 and that this was being investigated at the time of the inspection. This indicated the complaint had not been responded to in a timely manner in line with the provider's complaints policy.

We recommend the provider consider current guidance on complaints handling and review their practices accordingly.

● When the provider responded to complainants, this was generally comprehensive and in detail. We saw a response to a complainant which included setting out the findings of the investigation, actions taken to mitigate the risk of re-occurrence and an apology.

Requires Improvement

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
At our last inspection the provider had not always ensured systems were always either in place or robust enough to demonstrate safety and quality were effectively managed. This was a breach of regulation 17 (Good governance) 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 17.

● The registered manager used checks and audits to supervise the quality of the service. This system of monitoring had not always been effective as it had not enabled the provider to identify and take timely action to address some of the areas for improvement we had found.
● These systems had not ensured that people always received safe treatment and care and that people's care always met their needs and preferences in a planned way. This meant there was a lack of consistency in how the service managed risks to people and improved the quality of the service.
● These systems had not ensured that medicines support was always managed safely. Regular medicines support audits had not identified and addressed these issues we found. We were not assured the service operated appropriate procedures for identifying, recording and reviewing medicines support incidents and the learning from these. For example, the service had not always identified the stock discrepancies, recording issues and instances of missed medicines as incidents.
● We were not assured there were consistently effective systems in place to ensure staff always received an appropriate handover of information about people between shifts. We saw daily handover notes on two units were not always completed or had gaps where little or no information was recorded. This meant there was a risk staff would to be informed about incidents or changes in people's needs so as to ensure they received safe care. We raised this with the managers so they could make improvements.

These issues indicated systems were not consistent and robust enough to demonstrate safety and quality was always monitored, assessed and managed effectively. This placed people at risk of harm. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● However, despite recording issues, a care worker told us they received sufficient information about people

at shift handovers.
● The registered manager had implemented some improvements since our last inspection. For example, new audit tools to help make care plans more personalised, improve infection control, manage DoLS authorisations and monitor safeguarding concerns. Assorted refurbishments to the buildings had taken place or were planned and a new maintenance team had been employed. Also, they had introduced a senior care worker role on units. These staff completed training to be able to support nurses with managing aspects of care on a unit, such as checking people's bed equipment and ordering continence aids.
● The provider displayed the previous inspection ratings at the home and on their website, as required by regulations. This helped people to find out about the quality of the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● We received mixed feedback from people and relatives about the managers and leadership at the service and most relatives we spoke with did not think the service was well-led. Some relatives told us they felt there was not always a culture at the service that was positive, open, empowering and promoted person-centred care.
● Some relatives were upset when they told us they felt reluctant to raise issues or complaints for fear the provider would find ways to make their family member leave the service. Different relatives commented, "If there is a complaint from staff or family they will find a way to get rid of them" and "We were told that if anyone went to safeguarding or CQC your residents will be asked to leave." Another relative told us they were fearful about raising concerns as they didn't want staff "to take it out" on their family member, but they also said that had "never happened" when they had done this.
● We observed staff speaking abruptly to person after they had been ringing their call bell, stating, "We're coming, we're busy, we're feeding." We raised this with the registered manager so they could address this. A relative told us the service had recently made no effort to celebrate their family member's birthday. These issues indicated people did not always experience a culture that always promoted inclusive and empowering care.
● People and relatives told us there was a reduced in-house physiotherapy service due to staff vacancies. The registered manager told us they trying to recruit staff for this and a new part-time physiotherapist had recently been engaged.

We recommend the provider seek advice and guidance to review the culture at the service so care and treatment is always provided in a person centred way.

● We saw the service had also received some compliments since our last inspection from some relatives regarding improvements the managers had made. A relative told us the registered manager was good at communicating and talked "very openly" with people and relatives and improved this through weekly emails updates and regular meetings and 'drop-in surgeries'.
● We also received mostly positive feedback from staff about the leadership. Staff said they felt supported and told us the managers had made improvements at the service.
● We also observed staff providing kind and attentive care and support to people during our visit. Some relatives spoke positively about people's care experiences and the care staff. There comments included, "The staff do seem competent and confident" and "The carers can't do enough for [their family member]."

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
● The registered manager demonstrated a good awareness of their duty of candour responsibilities. They told us, "It's being open and transparent, apologising when things have gone wrong and take that onus if

not we have not delivered. I feel I am very much like that with family and residents."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People, relatives and staff had opportunities to comment on the running of the service.

● There were regular meetings with people and relatives. Records of these showed various topics had been discussed such as the reduced in-house physiotherapy provision, maintenance issues, the laundry service, activities support and service costs.

● There were regular staff meetings and records showed assorted matters were covered including learning from incidents, nurses supporting care staff and staff performance issues.

● Unit and service leads attended daily 'flash' meetings to discuss people's welfare, incidents and service provision. These provided staff and managers opportunities to raise issues and concerns. The quality manager monitored the recording of these.

Working in partnership with others

● The service worked with other professional services to help provide people with joined up care. This included social workers, podiatrists, speech and language therapists and GPs.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that service users' care and treatment was managed in a way that ensured it was always appropriate, met their needs or reflected their preferences. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always effectively operate systems and processes to assess, monitor and improve the quality of the service and to assess, monitor and mitigate risk Regulation 17(1)

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always ensure care and treatment was provided in a safe way for service users Regulation 12(1)

The enforcement action we took:

Warning Notice