Mannarest Limited

Dewi-Sant Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Dewi-Sant Residential Home (hereafter Dewi-Sant) is a residential care home providing accommodation in one adapted building across three floors for up to 34 older people who require personal care. The service specialises in supporting people living with dementia. At the time of the inspection 26 people were living at the home.

People's experience of using this service and what we found
People were not protected from the risk of avoidable harm. Risks to people were not always identified. Where risks had been identified, sufficient action had not been taken to mitigate those risks and keep people safe.

Safeguarding systems and processes were not always followed. The registered manager did not always report and investigate safeguarding concerns. As a result of this inspection we made 10 safeguarding referrals to the Local Authority to investigate and where appropriate, take any necessary action to mitigate risk to ensure people were safely protected from harm.

There were indications that a "closed culture" may be developing at Dewi Sant. A 'closed culture' is a poor culture that can lead to harm, including human rights breaches such as abuse. In these services, people are more likely to be at risk of deliberate or unintentional harm.
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. Meeting bathing and toileting needs were not based on individual needs but were carried out on a rota basis. People, relatives and care records evidenced people being left in undignified states for long periods of time.

There were insufficient numbers of competent or skilled staff on duty to meet people's needs safely. We were not assured the service was following safe infection prevention and control procedures.

People had been identified as displaying behaviours that may challenge others and themselves. There was limited information within these peoples care records to determine what the behaviours that may challenge others were and what staff should do to support people effectively through this.

Following our inspection we wrote to the provider who worked with The Local Authority to reduce some of the risks and concerns that we had with the service.

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

Rating at last inspection
The last rating for this service was Good (published on 24 January 2020).

Why we inspected
We received concerns in relation to poor standards of care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. However, further concerns and risks were identified so a decision was made to carry out a comprehensive inspection to include the key questions effective, caring and responsive.

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.

The overall rating for the service has changed from good to inadequate. 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, caring, responsive 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 Dewi-Sant Residential Home on our website at www.cqc.org.uk.

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 regulation in relation to safe care and treatment, safeguarding people from abuse, staffing, consent, dignity and respect, person centred care, notifications of other incidents and governance.

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 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not effective. Details are in our effective findings below	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Dewi-Sant Residential 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 team was made up of two inspectors, a medicines inspector, an assistant inspector 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.

Dewi-Sant is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Dewi-Sant is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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. We sought feedback from the local authority and professionals who work with the service.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spent time with and spoke with six people living at the service, 12 relatives, eight members of staff, registered manager and the providers representative. To help us assess and understand how people's care needs were being met we reviewed 26 people's care records.

We also reviewed a number of records relating to the running of the service. These included staff recruitment and training records, medicine records and records associated with the provider's quality assurance systems.

Inadequate

Is the service safe?

Our findings

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Safeguarding systems were established, however safeguarding processes failed to operate effectively.
- Staff were able to describe the actions they could take if they had safeguarding concerns for the people they supported. However records showed appropriate action had not been taken.
- One person made an allegation of financial abuse about a family member. The registered manager was aware of this but failed to report it to the local authority to investigate the matter further.
- We noted three examples of incidents where people had suffered injuries and/ or unexplained bruising. The registered manager had not recognised them as abuse, there was no evidence to demonstrate the registered manager had taken action to better understand the nature of bruising/injuries and failed to report them to the local authority for further investigation and follow up.
- Staff had recorded nine safeguarding incidents between July 2020 and April 2022 for one person. These incidents had been recorded in the persons care records; for example, the person had assaulted or had been assaulted by other people. However, the registered manager had not recognised them as abuse and failed to report them to the local authority for further investigation and follow up. Nor did they see this as an opportunity to understand and support people to manage their emotional distress and reduce the risk of reoccurrence.
- One person had experienced a fall. They were not discovered until the following morning by staff. On another occasion the same person was left in a chair overnight fully clothed. Day staff reported they had found the person in 'the same clothes as yesterday' and the persons clothes were soiled.

The failure to ensure people were safe from abuse and improper treatment 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

Assessing risk, safety monitoring and management

- People were not always supported in line with their care plans to ensure risks associated with eating and drinking were managed. One person's care plan identified they required a specific consistency of food. We observed staff supporting this person to eat a meal that was not the correct consistency. This placed the person at an increased risk of choking. We brought this to the attention of the registered manager so they could mitigate the risk.
- Another person was assessed by a speech and language therapist (SALT) to be at risk of choking. During our observation we noted this person was being given fluids from a cup that was not in line with the recommendations specifically advised by SALT. We brought this to the attention of a staff member so they could mitigate the risk.
- One person had a history of epilepsy, the service had failed to carry out their own care plan or risk

assessment, to guide staff to support this person safely. This placed the person at increased risk of harm.
● Care plans and risk assessments were in place for people who had been assessed as at risk of pressure damage. However, the system designed to ensure people were repositioned regularly and appropriately was not consistent. For example, staff recorded information about repositioning however this was often recorded in different locations and forms within peoples care records. This increased the risk of people developing pressure ulcers because information to demonstrate the appropriate measures had been taken to keep people safe from harm were hard to review as and when need..
● Due to the increased risk of harm that people were exposed to in relation to choking and pressure care, The Care Quality Commission made three safeguarding referrals to Plymouth City Council Safeguarding Team.
● We noted the registered manager determined that 26 people required regular hourly checks, due to their care needs and/or inability to use a call bell. However, we noted that these checks ceased to be recorded at 19.00hrs when staff started their night shifts, therefore the registered manager and provider could not be assured that risks associated with people's on-going health needs, were monitored safely.
● During our inspection we observed one staff member carrying out a manual handling task, using an incorrect and unsafe technique. This placed the person at increased risk of harm. We brought this to the attention of senior staff and the registered manager immediately. We noted from the persons care records concerns relating to unexplained bruising. We could not be assured that these were not a result of unsafe manual handling techniques.

The failure to provide safe care and treatment for people with epilepsy, and the failure to reduce the risks associated with choking and manual handling put people at an increased risk of harm, This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staffing levels were not assessed using a recognised tool. Staff were not deployed in a way that met people's needs and kept them safe.
● The registered manager told us there was no formal tool to assess the changing needs of people in the service and determine the level of staffing required to meet those needs. This meant that when people's needs changed staffing levels were not reviewed to ensure their sufficient number of staff to meet people's needs safely.
● Staff described how low staffing impacted on their ability to provide person centred care. They told us "When we are fully staffed yes there is enough for people to do here but when we are not it is a struggle", and "It can impact the residents as we can't do activities".
● There were 6 members of staff on duty in the morning and 5 staff on duty in the afternoon for 24 people. Three people needed two staff to support them, two people whose behaviour was challenging to staff and two people who walked with purpose. However, there was on only two staff on duty at night.

The failure to deploy staff effectively was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had recruitment processes in place which supported safe recruitment decisions. This included pre-employment checks to ensure staff were suitable to work with people living at the service.

Using medicines safely
● Prescribed thickening agents were not always stored safely which put people at risk. For example, thickening agents were left on a drinks trolley and in an unlocked cupboard within an area of the home where people walked with purpose. We raised this with the registered manager who assured us this would

be addressed. When we returned four days later, action had not been taken and the thickening agents were in the same places.

● People's allergies to medicines were not recorded on their medicines administration record as recommended in NICE guidance SC1: managing medicines in care homes. Not having allergies recorded on a MAR means that information is not available if the record is shared with other healthcare professionals, for example during a hospital admission.

● Some people had medicines prescribed to be given when required. Staff did not always have guidance available to help them make consistent decisions about when these medicines might be needed. When guidance was in place, it was not person-centred and did not describe a person's individual needs.

● Some people had their medicines given to them hidden in food or drink (covert administration). This should only ever happen when it is safe to do so and, in the person's, best interest. There were no assessments of people's mental capacity to make decisions about their medicines, no records of best interest decisions and no evidence of pharmaceutical input to ensure that medicines were safe to be crushed and mixed with food or drink.

We found no evidence people had been harmed. However, the provider had failed to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● Systems were either not in place or robust enough to demonstrate accidents and incidents were effectively monitored and reviewed.

● Staff did not record medicines errors, accidents and incidents, so there was no way of learning from incidents.

● The findings of our inspection identified a culture that was not based on learning. This meant that when things had gone wrong, the potential for re-occurrence was inevitable because there was no action taken to review, investigate and reflect on incidents.

Systems to assess and improve the quality and safety of the service were inadequate. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection

● People were not always protected from the risk of infection.

● We were not assured that the provider was preventing visitors from catching and spreading infections. The premises and the equipment were not always clean. Areas throughout the home were worn and damaged. This made it difficult for staff to thoroughly clean these areas and ensure they did not become reservoirs for bacteria to harbour.

● We were not assured the provider was supporting people living at the service to minimise the spread of infection. We noted that following an incident where a person left the service unattended a decision had been taken to close an access point in the service. This meant that staff had to transport dirty laundry through the kitchen area of the service.

● Linen used in care homes can become soiled with blood, faeces and other body fluids containing micro-organisms such as bacteria, viruses and fungi. This practice showed the register manager was not dealing with laundry in a way that managed cross contamination and put people at risk. This meant the provider was not promoting safety through the layout and hygiene practices of the premises.

● We carried out a targeted inspection in March 2022 looking at the infection prevention and control measures the provider had in place. As a result, we signposted the provider to resources to develop their approach. Due to our findings at this inspection we were not satisfied that the provider had taken the

necessary steps to address shortfalls in preventing and controlling infection.

The failure to ensure people were always protected from the risk of infection, was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● 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 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.

● The service facilitated visiting in line with national guidance.

Inadequate

Is the service effective?

Our findings

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's needs were not assessed. For example, one person who had recently moved to the service had not had their care needs adequately assessed.
- We identified another person who was diabetic and had a history off falls. However, their needs had not been adequately assessed. The registered manager had not ensured that staff had the knowledge and information to be able to meet their needs safely and effectively.
- The registered manager and provider had failed to ensure people's needs were regularly reviewed. The failure to regularly review people's needs meant the service could not be assured they could continue to offer effective support to people.

The failure to carry out adequate assessments and reviews of peoples care needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- Staff told us they had access to training and felt supported. However, the findings of our inspection demonstrated that staff support and training was not effective.
- People who were at risk of choking were put at further risk because staff had not received training and guidance on modified diets.
- Staff had not received sufficient training to support them to support people whose behaviours might challenge others, modified diets, capacity to consent and moving and handling.
- Whilst staff told us the registered manager had an open door policy, records, staff and the registered manager confirmed there was no formal supervision system in place to ensure regular meetings could take place for staff to discuss and reflect on practices relating to their roles.

The failure to provide adequate supervision and training to staff in order to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● People were not always supported to have maximum choice and control of their lives. Where people had been identified as needing equipment that restricts such as bedrails there was no record to demonstrate if they had consented or lacked capacity to consent.
● People's records did not always show that best interests processes had been followed. This indicated the home was not working in line with the principles of the MCA. For example, staff told us they would restrict access to the garden area following an incident where a person who was being deprived of their liberty had left the service unattended. A relative we spoke with told us, "The garden is locked as someone has absconded. We asked if we could sit in the garden and they told us we had to be locked out there and that is a problem. All the windows have locks on them and there is no freedom to go out in the garden. I can see the concerns for the safety of this one resident, but then it impacts on all the other residents". This blanket policy resulted in everyone living at the home having their movements restricted, by denying them access to the garden area. There was no consideration given to these people's freedoms and liberties.
● One person's care record showed a relative had made important decisions on the person's behalf. There was no mental capacity assessment or best interests' decision in place to support these decisions and there was no information within the persons care records to indicate that the relative had the legal authority to make this decision.

The failure to assess people's capacity and record best interest decisions risked compromising people's rights. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● Dewi-Sant was a large building set over three floors. The service did not have a homely feel and we noted areas throughout the service that were in disrepair. For example, missing skirting from bathrooms, damaged flooring, ripped carpets and doors that would not close properly.
● We saw one part of the service where a bay window was heavily damaged and stained. We told the provider to take immediate action to make this safe or restrict access to ensure people's safety. In other parts of the service door mechanisms designed to keep people safe in the event of a fire were missing.
● The service had a call bell system in place to alert staff to people who were able to use their alarms. However, the alarm could not be heard in one part of the home, which meant staff were not always able to hear when the alarm went off.
● The majority of people living at Dewi-Sant had a diagnosis of dementia. However, the environment was not dementia friendly. For example, there was a lack of reminiscence areas, for helping people living with dementia to be stimulated. Some parts of the environment consisted of bold and dark patterns which people with dementia can often interpret as very busy.
●There was a lack of colour and contrast within the environment which can be really helpful for people with dementia. Gardens can have a positive impact on people living with dementia. However, people could not access the garden as and when they wanted, due to restrictions and staffing levels.

● Equipment such as hoists and wheelchairs which were stored in lounge areas added to the dementia unfriendliness of the service.

This failure to ensure the premises was properly maintained and fit for use was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result of our concerns we made a referral to Devon & Somerset Fire and Rescue Service.

Supporting people to live healthier lives, access healthcare services and support, staff working with other agencies to provide consistent, effective, timely care

● One person had been identified as being at risk of choking by the service. The service had taken the decision to change the consistency of the persons food without taking advice from an appropriate healthcare professional to ensure it was safe.

● We cannot be assured that all reasonable steps to ensure joint timely care planning was being carried out. People who had experienced falls had conflicting information recorded as to whether or not the person had been referred to specialist healthcare professionals in order to reduce the risks associated with falling. We asked the registered manager on the first and second day of our inspection to demonstrate this. To date we have not received this information.

● Because of our findings in relation to the management of falls and choking risks we could not be satisfied the provider was always working with other agencies in a timely and consistent way to support people to have healthier lives and to access healthcare services, as is their right.

The failure to ensure that timely care planning took place with appropriate professionals was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We observed and saw from records that staff worked with a local GP service which visited weekly to carryout health checks.

Supporting people to eat and drink enough to maintain a balanced diet

● People told us they enjoyed the food. One person told us "The food is brilliant".

● Some people chose to have meals in their rooms and staff respected that. Alternative menus were available.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity, Respecting and promoting people's privacy, dignity and independence

● We found 'Toileting charts' and 'bathing charts' in the service, on which were recorded set regimes and times for taking people to the toilet or when they were scheduled to have a bath.
These institutionalised practices had contributed the risk of developing a 'closed culture' at Dewi-Sant.

● We noted that some people who could use emergency call bells and should have call bells in their rooms, did not. We noted one person who had a call bell which did not work.

● A recent note written by the registered manager in a book used to communicate with staff, recorded 'Staff to stop removing batteries from call bells and /or hiding them'.

● We observed how staff interrupted one person's meal to administer the persons eye drops in a dining area, where everyone else was eating. This meant care was not always given in a considerate and dignified way.

● In some of our observations we witnessed some staff being compassionate towards the people they supported. However, four observations also demonstrated people's right to have their dignity protected was not always supported. Unsafe moving and handling techniques and people being left for long periods of time in a manner that did not respect their dignity, was evidence that people were not always treated and supported well.

The failure to treat people with dignity and respect at all times was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Some relatives told us they considered the service to be caring. Comments included "The care is spot on", "I think they are terrific" and "They all seem gentle". However, people's lived experiences and our observations was not always reflective of this view.

● Personal records about people were stored securely and only accessed by staff on a need to know basis. Staff understood their responsibilities for keeping personal information about people confidential.

Supporting people to express their views and be involved in making decisions about their care

● There was limited information in how people had been involved in making decisions about their care.

● Care plans were not individualised or did not reflect peoples voice and preferences. This is indicative of a 'closed culture'. The wording used in peoples care plans was the same as information held in other people's care plans and did not reflect individual views and opinions on their care.

The failure to ensure people were fully involved in their care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

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 Good. At this inspection the rating has changed to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The service failed to meet AIS in that the service did not identify, record, share and meet the communication needs of people living at Dewi-Sant. For example, one person used a hearing aid, however staff failed to ensure this person was consistently supported to use their hearing aid. Neither did the person have a personalised care plan for staff to support them to ensure the person's communication needs were met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support
● There was an absence of person-centred information within peoples care records. Relatives routinely spoke of how they had not been included within the care planning and care review process. They told us "No, a review of his care has never been discussed with me" and "No I've never been asked for my opinion before today".
● Some relatives we spoke with were not aware that people had care plans. Involving families in care planning is particularly important for people living with dementia because relatives can play a key role in ensuring care is personalised.
● There was evidence of some advanced care plans in place for some people, but these were not detailed. This information is important so that people's individual wishes are considered and planned for.

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
● People and their relatives routinely described Dewi-Sant as lacking in stimulation and meaningful activity. They told us "I don't see them doing the extra stuff like interaction with the residents", "I don't think there is much stimulation" and "I have to say there are no real activities".
● There was a lack of purposefulness to people's days. Staff told us they were unable to support people in a meaningful way due to low numbers of staff. Staff told us, "We have not always got the time to sit down and do activities or sit down and have chats."
● We noted that people were left for long periods of time without much contact from staff. This was because staff were task orientated. This meant staff were continuously focused on their next duty and did not have time to spend quality time with people and deliver individualised care and support.

The failure to deliver personalised care that met people's individual needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improving care quality in response to complaints or concerns

● Relatives had mixed views as to how their complaints or concerns were responded to. Some told us they found it difficult to get a response if they raised any queries. Others were more positive.

● We asked the registered manager for a copy of the providers complaint procedure to ensure this complaint had been dealt with in line with the providers policies and procedures. We requested this verbally on 30 September and 4 October and in writing on 6 October 2022. To date we have not received a response from the registered manager.

● Some relatives described how they had made complaints to the service, however there were no records of complaints other than the one recorded. Therefore, we could not be satisfied the providers system was effective in investigating and acting on complaints.

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 our last inspection we rated this key question Good. At this inspection the rating has changed 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The registered manager was registered with CQC in August 2013. The service was inspected in September 2022 and at this inspection 10 breaches of regulations were found. The service has deteriorated from good to inadequate.
- At this inspection the registered manager did not demonstrate the competencies required to manage the regulated activity.
- At this inspection the registered manager did not demonstrate they had sufficient oversight of the service to ensure people received the care and support they needed that promoted their health and wellbeing along with protecting them from the risk of avoidable harm. For example the quality assurance systems were not robust or implemented to positive effect.
- Poor decision making potentially placed people at risk of harm for example, in relation to staffing and risk management. The registered manager was aware of their regulatory responsibilities such as submitting statutory notifications but failed to carry this out. This meant people were at risk of living in a service where there is inadequate leadership and regulatory requirements not being met as required by law.
- As a result of this inspection we made a number of safeguarding referrals to the local authority.

The registered managers inability to carry out their role effectively and adequately in line with the regulations was a breach of Regulation 7 of the Care Quality Commission (Registration) Regulations 2009

- Oversight of the service in respect of staffing had not been effective, as highlighted in the safe section of this report. This lack of oversight also impacted on the service's ability to deliver personalised, care as highlighted in the responsive section of this report.
- Governance processes were not effective in keeping people safe, protecting people's rights and providing good quality care and support.
- The providers oversight and governance of the service was inadequate in identifying the serious failings in relation to the safety, quality and standard of the service as detailed in the safe, effective, caring and responsive sections of this report. The provider told us they had not visited the service to carry out governance checks.
- Records and checks undertaken by the registered manager and staff were not always accurate and as such could not be relied upon. For example, people's care plans were incomplete or inaccurate. They did not always describe people's needs and did not always give staff instructions on how to meet those needs safely.

The lack of effective governance and oversight of the service placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC), of important events that happen in the service. The registered manager was aware of their responsibilities, however had failed to inform CQC about reportable events.

Failure to inform CQC of notifiable events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People were not involved in a meaningful way in the development of their care and support in a way which met people's individual communication needs. A poor staff culture created a lack of professional challenge, for example unsafe moving and handling techniques impacted on people's safety. All of this reinforced the risk of development of a closed culture within the service.

● Institutionalised practices, in the form of bathing and toileting times had helped to create a potential 'closed culture' at Dewi-Sant. A 'closed culture' is a poor culture that can lead to harm, including human rights breaches such as abuse. In these services, people are more likely to be at risk of deliberate or unintentional harm.

● The culture of the service did not reflect best practice guidance for supporting people living with dementia. The provider and registered manager failed undertake their responsibilities in the line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider failed to have systems and processes in place to ensure people received their care in a dignified and respectful way. This meant people's care was provided in a way that was sometimes not appropriate and disrespectful.

● Staff were clear about their aim of providing person centred care. They had a good knowledge of the service and wanted to provide good quality care. However, the ability to deliver person-centred care was often hindered due to a lack of management oversight, staffing levels and ineffective training.

The registered manager and provider had not ensured the quality and safety of the service had been adequately assessed, monitored or improved to ensure it met with regulatory requirements and best practice guidance. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw some examples of where the registered manager and provider worked closely in partnership with GPs and district nurses. However, we could not be assured that partnership working was fully embedded because of our findings in the safe, effective and responsive sections of this report.

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 CQC sets out specific requirements that providers must follow when things go wrong with care and treatment. This includes informing people and their relatives about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

● The registered manager understood their responsibility under the duty of candour to be open and honest when things went wrong. However due to the findings of the inspection we could not be satisfied that the correct procedures associated with duty of candour would be actioned and followed through.

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 registered manager and provider failed to carry out adequate assessments and reviews of peoples care needs, provide an environment that supported people with dementia, fully involve people in their care and deliver personalised care that met people's individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider and registered manager failed to ensure people were treated with dignity and respect at all times.

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers The registered managers failed to carryout there role effectively and adequately in line with the regulations.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider and registered manager failed to deploy staff effectively, provide adequate supervision and training in order to meet people's needs.

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 18 Registration Regulations 2009 Notifications of other incidents The register manager and provider failed to inform CQC of notifiable events

The enforcement action we took:

Fixed penalty notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider and registered manager failed to assess people's capacity and record best interest decisions which risked compromising people's rights.

The enforcement action we took:

Cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager failed to provide safe care and treatment for people with epilepsy. They failed to reduce the risks associated with choking and manual handling which put people at an increased risk of harm, The provider and registered manager had failed to ensure the proper and safe management of medicines. They failed to ensure people were always protected from the risk of infection and that timely care planning took place with appropriate professionals.

The enforcement action we took:

Cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider and registered manager failed to ensure people were safe from abuse and improper treatment.

The enforcement action we took:

Cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess and improve the quality and safety of the service were inadequate. The lack of effective governance and oversight of the service placed people at risk of harm. The registered manager and provider had not ensured the quality and safety of the service had been adequately assessed, monitored or improved to ensure it met with regulatory requirements and best practice guidance.

The enforcement action we took:

Cancellation of registration.