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

St. David's Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**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 nursing home providing personal and nursing care for up to 76 adults living in four units. One unit 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 71 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
People and relatives told us they felt safe living at the home. However, the provider had not always assessed, monitored and managed risks to people's safety in the home environment. The provider did not ensure the hydration needs of some people were always being met.
Most people and relatives said staff were caring and treated people with dignity and respect.

People's care plans provided some information about the care tasks they needed staff to complete. However, these plans did not provide personalised information about people, their background, their preferences for their care, or their communication needs. The provider had started to introduce a new care plan format to better record this information.

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; there were policies and systems in the service to support this practice but these were not implemented consistently.
There were systems in place to monitor the quality of the service and recognise when improvements were required. These were not sufficiently robust to have identified and addressed the issues we found at this inspection. The new manager had introduced some new systems to improve the quality of service.

Staff and volunteers provided people with a varied programme of activities throughout the day, which also included trips out into the local community.

Staff supported people to maintain their health and access other healthcare services when required. People were also supported by a team of occupational therapists and physiotherapists employed by the provider to help them to maintain their health and independence.
People were supported at the end of their life to have a comfortable and dignified death.

People knew how to make a complaint or raise a concern and the provider responded to these appropriately.

Staff received an induction, training and periodic supervision. Staff said the managers were approachable and told us they felt supported.

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 26 July 2017).

Why we inspected
The inspection was prompted in part due to concerns received about how people were supported to be safe from the risk of abuse and harm or poor care. A decision was made for us to inspect and examine those risks.

Enforcement
We have identified breaches in relation to providing safe care and treatment, medicines management, meeting people's nutritional needs, seeking people's consent appropriately, dignity and respect, person-centred care, and good governance.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider, the local authority and Clinical Commissioning Group 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 always 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 caring?

Requires Improvement

The service was not always caring.
Details are in our caring 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 Care Act 2014.
Inspection team
The inspection was carried out by two inspectors, a member of the CQC medicines team, a specialist nurse 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 or personal care as 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 CQC. A registered manager is a person who is legally responsible for how the service is run and for the quality and safety of the care provided. It is a requirement of the provider's registration that they have a registered manager. The manager had applied to register with the CQC.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We looked at the information we held about the provider, which included information about important events the provider had notified us about what had happened at the service, complaints and other information from members of the public. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 14 people who used the service and 10 visiting relatives. We spoke with a variety of staff on duty including, nurses, care staff, a catering assistant, an occupational therapist, a physiotherapist, and office staff. We met with the manager and clinical lead. We also spoke with a GP who visited the service. 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 also spoke with a visiting GP. We looked at the medicines support records for 12 people, the care records for 15 people and the recruitment records for seven members of staff.

After the inspection
We asked the provider to send us some additional information we were unable to view on the days of the visit and we sought further clarification from the provider to validate the evidence we found. We also spoke with three social care professionals who had worked with the service.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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

● Risks to people's safety were not always assessed, monitored and managed so they were supported to stay safe.

● On 22 October 2019 we saw several hazards to the health, safety and wellbeing of people using the service, staff and visitors. There were exposed hot water pipes which were hot to touch in the corridors between two units. We saw assorted cleaning products left unattended in trolleys in corridors and outside people's rooms. We discussed this with the manager. They acknowledged this could be a risk to some people, should not have happened and said they would address this with staff. We also found a bottle of odour neutraliser left in a downstairs toilet and more cleaning products stored on an open shelf in one of the unit's kitchens, both of which were accessible to residents and visitors.

● We found the doors to an electrical meter cupboard, sluice rooms and a boiler room were unlocked when they were meant to be locked to keep people safe. We saw that oxygen cylinders were not stored securely to prevent them from falling in the main and rehabilitation units. A fire door which needed to be kept closed as a fire safety measure had been propped open by a small table.

This indicated the provider had not identified and managed these risks to people's safety and wellbeing so they were supported to stay safe. 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.

● Staff completed risk management plans for people to reduce risks to their safety and well-being. These plans considered risks such as aspiration, pressure sores, nutrition, moving and handling, falls and self-neglect. The plans provided directions for staff on how to mitigate the risks to people. In some cases we saw from the dates of the original assessments of risks that they had not been reviewed, but staff had reviewed the actions to manage the risks on a monthly basis.

● The manager conducted a health & safety audit in May 2019 and an action plan had been used to make improvements, such as setting up regular health and safety meetings and completing staff risk assessments.

● The provider used a range of processes and checks to maintain the environment. These included health and safety, mobility equipment, water temperature, gas and electrical safety checks. We saw the provider had acted to address issues these checks had identified.

● The manager acted earlier in the year to improve the fire safety arrangements at the home. This included asking the London Fire Brigade to audit these arrangements and identify where improvements were required. The manager had a comprehensive improvement plan in place and had taken significant steps to make these improvements. The fire service had told us previously the manager had responded promptly to address the issues they had identified at their visit.

● The staff told us they had recently undertaken fire safety training and practiced fire evacuation techniques. Staff knew what to do in the event of a fire and the procedures for safely evacuating people. They told us they now regularly practiced this and felt this helped with their confidence in knowing how to respond in an emergency. A relative told us there was an incident last year when staff on shift did not know how to respond to a fire alarm. However, they recognised the new manager had taken action to address this and that things had improved.

Using medicines safely

● Some people were at risk of not always receiving their medicines as prescribed.

● On 22 October 2019 we observed staff had signed a person's medicines administration chart (MAR) to indicate a person had received their medicine before they were actually offered or took it. This practice created a risk of recording errors and meant the provider could not always ensure people received their medicines as prescribed.

● Some people were prescribed medicines to take 'when required'. These are medicines given or taken only when needed, such as for pain relief. There were no medicines protocols or clear information to guide staff on when they should support a person to take such medicines. This meant the provider could not always ensure these people received these prescribed medicines as and when they needed them. We discussed this with the manager. On our second inspection day they created an 'as required' medicines form to be used to provide this information clearly to staff in future.

● Staff supported some people to use prescribed creams. However, there were no completed MARs in place to confirm the creams had been applied as prescribed.

● There was not always guidance available for staff about monitoring or managing the side effects of high-risk medicines, such as anticoagulants and insulin. Anticoagulant medicines help prevent blood clots and insulin helps regulate blood sugar levels.

● People's care plans did not always record information about their prescribed medicines. Where this was in place for some people, their plans did not always provide information about all the person's medicines. For example, one person was prescribed medicines for when they were at the end of their life, but there was no information or guidance for staff on when to use this medicine. This was not in line with National Institute for Health and Care Excellence (NICE) guidance for managing medicines in care homes.

● The provider did not always make sure medicines were stored securely. The medicine refrigerator in one of the units was not locked. The medicine storage room on this unit had a key code lock. There was no process in place to change the code and staff told us it had not been changed for over a decade. The room was used for office and kitchen facilities by non-nursing staff members. This meant there was a risk medicines could be accessed by unauthorised members of staff.

● Staff checked and recorded medicine refrigerator temperatures regularly to make sure medicines were stored correctly. However, temperature was not checked for the medicine storage room on one of the units. This meant there was a risk medicines were not always stored at recommended temperatures.

These issues indicated medicines support 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.

● MARs we reviewed set out the necessary information for the safe administration of people's medicines and staff had completed these records appropriately.

● There was written guidance or a protocol in place for staff on how and when to help people take a 'rescue' medicine as prescribed. This is medicine that be used for urgent treatment, such as to stop or reduce a person's seizure.

● One person was being given medicines covertly. Staff had completed a mental capacity assessment to

establish the person did not have the capacity to consent to this. A meeting had been held with the person's relative and GP to decide it was in the person's best interests to take their medicines in this way.
● The provider assessed staff to ensure they were competent to give the medicines support being asked of them.
● The provider worked with a local GP surgery's medicines management team which was led by a pharmacist who carried out regular medicine reviews with people. This helped to ensure people's prescribed medicines were reviewed regularly.
● The provider had safe systems in place for ordering, handling and disposing of medicines, including controlled drugs. □

Systems and processes to safeguard people from the risk of abuse
● Some people had experienced an inconsistent approach to safeguarding them from avoidable harm. This meant the provider had not always protected some individuals from risks to their well-being and safety.
● Staff received training in safeguarding adults. However, two members of staff had witnessed inappropriate practice and not reported this to the manager in a timely manner so safeguarding concerns could be always responded to promptly.
● When safeguarding concerns had been raised, the provider had engaged with local safeguarding systems and cooperated with the local authority to look into the concerns and ensure people were safe.
● At the time of the inspection we received information suggesting some people were 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.
● We saw the provider had taken steps earlier in the year to review and improve the safeguarding adults systems and processes at the home. These included commissioning an external consultant to audit the safeguarding arrangements and recommend improvements. The manager had implemented an action plan to improve the service's safeguarding systems and processes so they were effective, up to date and in line with local arrangements. We saw the manager also cooperated with statutory agencies to identify and make improvements to the provider's safeguarding policies.
● People also told us they felt safe with the care they received, with comments that included, "This home is my home, very safe," "I feel safe here" and "The home is very safe and clean."
● Staff we spoke with were able to tell us what they would do if they were concerned about a person's safety or wellbeing. There was information displayed in staff offices about how to report abuse.
● The manager had run safeguarding awareness sessions to support staff understanding of this and how to report concerns. We saw the manager was also arranging additional safeguarding training for senior staff and looking to appoint two staff safeguarding 'champions' to continue to raise staff awareness.

Staffing and recruitment
● The provider deployed enough staff to support people to stay safe.
● However, we received mixed feedback from people and relatives about the level of staffing. Some relatives thought people would benefit from more staff being available. For example, a relative told us, "Staffing is okay but I think there aren't enough otherwise they [would] have time for my [relative]." Other relatives said they had not seen staff rushed and commented, "There are probably times when they are 'stretched' [but] I've never seen a time when I thought they should have spent more time with my [relative]."
● Some people said staff did not always provide responsive care as they sometimes took a long time to answer the call bells in their rooms. During our visits, on several occasions we observed call bells sounding but not being responded to in a timely manner or not being turned off once staff had attended to a person. We discussed this with the manager who was aware of the issue and had recently conducted a review of the use of call bells. Meeting minutes confirmed this has been discussed with people and relatives. The manager told us they had recently introduced an extra staff shift during the day to provide additional support across

the units to help out at busy times. They had started to monitor call bell use to see if this would improve things.
● Staff told us there were enough staff on shift, although sometimes they were very busy and did not always get to take their breaks. They confirmed the manager had then introduced the extra shift and this had been beneficial.
● Some relatives were concerned a number of staff had left over the course of the year which meant the provider had engaged more temporary agency staff to cover vacancies. This meant people had not always been supported by staff who knew their care needs well. Staffing rotas for the month prior to our visit showed there had been regular use of some agency and bank staff to cover vacancies. The manager told us the provider had been actively recruiting to address this, which recruitment records confirmed.
● The provider completed necessary pre-employment checks, so it only offered roles to fit and proper applicants. These included detailing applicant's previous work history, gathering previous employment references and obtaining criminal records checks with the Disclosure and Barring Service.

Preventing and controlling infection
● There were arrangements for preventing and controlling infection.
● The local environmental health officer had recently inspected the home and awarded a two stars Food Hygiene Rating, finding improvement was required regarding food handling. The manager said they would be appealing this as they did not think it was accurate. However, we saw they had already developed an improvement plan in response to the report. The kitchens appeared clean and tidy when we visited. We saw there were processes in place for ensuring the kitchens were cleaned, food was labelled correctly, food and fridge/freezer temperatures were checked, and stocks were managed appropriately.
● The general environment was clean and free from unpleasant odours when we visited. We saw cleaning staff working throughout our visit in different parts of the building. One person told us, "The home is very safe and clean."
● The manager conducted an infection control audit earlier in the year and had developed an action plan to address any requirements this identified.
● Staff told us they had training regarding infection control access to gloves, aprons and other protective equipment to prevent and control infection. People who needed to use mobility equipment had their own slings for this, which promoted infection prevention.
● There were suitable arrangements for the disposal of waste. There were posters and other information available for staff reminding them of infection control practices.

Learning lessons when things go wrong
● Staff told us that following incidents there were 'lessons learnt' discussions in handover meetings to make sure staff were aware of what had happened and how to lessen the risk of incidents re-occurring.
● The manager discussed a review of incidents as a regular item at team meetings so the learning from these was communicated to staff to improve the service.
● We saw the manager reflected on safeguarding adults concerns and identified actions to take in response to these, such as re-training and supporting staff to report concerns.

Requires Improvement

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

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

- The provider did not ensure some people were drinking enough fluids so they always remained hydrated.
- Some people's care records indicated staff needed to monitor how much they drank so they remained well and hydrated. We looked at seven people's daily fluid balance charts for the days prior to our visit. Some of these charts did not record how much staff needed to support a person to drink each day. Where charts did record a target amount, often staff had not tallied up how much fluid a person had taken that day to monitor if the person has had enough to drink. Also, often there was no evidence further actions were taken or considered if a person had not reached their fluid intake target.
- For example, one person's nutrition care plan stated staff needed to promote their hydration and record their fluid intake. We viewed 12 of their daily fluid balance charts. Staff had only recorded a daily target of 1,500ml on three charts and a daily intake total on five other charts. Each of these totals was between 970ml and 1,150ml and there were no records of staff taking actions in response to the person's low fluid intake.
- Eight charts for another person stated they were prone to urinary tract infections and should be supported to drink 1,500ml a day. The charts recorded they had only taken a maximum of 1,450ml on one day and 900ml or less on four other days. The charts did not always record if the person's daily intake had been reviewed and if any action was required or taken in response to the reduced amount of fluid the person had.
- When we asked staff about a person's partially completed charts they told us they believed the person drank well but sometimes staff forgot to fill the chart in. Some relatives also told us staff did not always record the amounts of fluid their family member may have been supported to take.

This indicated the staff were not ensuring people were supported to avoid the risk of dehydration and were not responding when people's care records showed their fluid intake was insufficient. This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff completed nutrition assessments to determine the care people needed with their food and drink. We saw these assessments were reviewed regularly.
- We saw drinks were available to people in their bedrooms and people were offered hot and cold drinks throughout the day.
- We observed people at lunchtime in the main dining hall being supported by staff in a calm and unrushed manner. People were given time to eat at their own pace.
- We observed staff also provide unhurried and attentive support to people having lunch in one of the unit's smaller dining areas. However, a radio in the room played pop music throughout the meal and it was not clear if anyone had chosen this and no one was offered the opportunity to change this.

● Meals were prepared on site using fresh ingredients. There was a choice of meal options each day, including cooked breakfasts and vegetarian alternatives. People could have snacks and drinks throughout the day and night. We saw lunch was also brought to people in their rooms. People and relatives mostly spoke positively about the food. However, one person said they had requested brown rice and bread and had been told this wasn't possible as other people preferred white versions.
● The kitchen staff we spoke with knew people's needs well. They had written information about individuals' dietary needs, including their cultural preferences, if a person was diabetic, and people's soft or pureed food requirements. The kitchen staff were involved in the service and received feedback at mealtimes so they knew if they needed to make improvements to the meals. The chef attended the regular morning meetings with the senior meetings to discuss any issues of the day.

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.
● The provider and staff had not always assessed people's ability to consent to their care in a way that met the requirements of the MCA.
● Staff had completed one mental capacity assessment form to consider if a person could understand and make four different decisions. After concluding the person lacked mental capacity, staff had only recorded making one of these decisions in the person's best interests. This meant there were no records to demonstrate other decisions regarding the person's care arrangements were in their best interests and the least restrictive on their liberty.
● Sections of another person's care and risk management plans had been signed and consented to on their behalf by a relative. However, there was no evidence the relative had the legal authority to do this, such as a Lasting Power of Attorney (LPA). An LPA is a legal document that lets a person (the 'donor') appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf.

This meant people's rights were not being respected as they were not being supported in line with the principles of the Mental Capacity Act. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw the provider supported other people in line with the principles of the MCA. For example, the manager had followed a mental capacity assessment and best interests decision process to determine the least restrictive approach to supporting a person with their personal care when they had a tendency to act in a distressed manner.
● The provider had worked with the local authority when it considered people lacked the capacity to agree to their care arrangements and these may have amounted to a deprivation of their liberty. We saw the provider obtained a copy of the legal authorisation when a person's deprivation of liberty had been authorised.
● The provider monitored the applications and authorisations for people's deprivations of liberty to make

sure it applied to the local authority when authorisations were due to expire. The records we saw during our visit did not always clearly demonstrate new applications were managed in a timely manner to make sure ongoing deprivations of people's liberty were legally authorised. We discussed this with the manager and clinical lead and after our visit they provided evidence that they had submitted the applications on time.
● Staff had received training regarding the MCA and understood people had the right to make their own day to day decisions about their care.

Staff support: induction, training, skills and experience
● Staff told us they thought they had enough training in their role. However, one member of staff told us they thought more staff needed dementia awareness training. A relative also told us they thought staff needed to attend dementia training. We discussed this with the manager who said they were looking into accessing this training from local statutory agencies.
● New staff completed an induction process to make sure they were competent in their role. A member of staff who had recently started told us they had completed this induction and felt supported by their colleagues.
● Some staff told us they did not always benefit from regular formal supervisions with a line manager, but they felt supported and could speak with their managers whenever they needed to. Records showed staff supervisions took place periodically and these were used to discuss staff development and address some staff performance issues.
● Some relatives told us when they had raised concerns about staff performance to senior staff they felt they had been listened to and this was responded to.
● The manager planned to develop nurses to become champions in different areas of practice such as tissue viability, bowel care, dementia and nutrition. This was to continue to improve the staff's understanding of these issues when providing safe care.
● We saw the provider regularly checked the Nursing and Midwifery Council (NMC) registration status of nurses to make sure they were legally able to practice. One of the nurses told us the induction, training and support they had been given had supported them to revalidate their NMC registration.

Adapting service, design, decoration to meet people's needs
● The home environment was not always decorated or adapted in a way to make it accessible to people and promote their independence. For example, there was very limited signage or distinction in the décor between the home's different areas in the home, which could help people to orientate themselves. Signs for the different units were small and positioned fairly high on the walls. There were information notice boards in various places, but these were not always prominently displayed and were sometimes obstructed from view, by a pot plant, for example.
● Some people's rooms were personalised with individual decorations. Other people's rooms appeared to have very little or no personalisation and their décor seemed blander and less stimulating. Most bedroom doors were not labelled with people's names and some room numbers were small and positioned higher than may have been comfortable for someone viewing from a wheelchair.
● The manager told us they were looking to commission dementia specialists to audit the premises and make recommendations to improve the physical environment to better suit people's needs.
● We noticed in some places some carpet tiles were worn and had started to fray at the edges. This could develop into a tripping hazard.
● The home was generally well lit and ventilated throughout. People could access the garden areas, on-site chapel and grounds.
● There were a number of different communal areas, quiet rooms and seating areas, which we saw some people using throughout the day. The communal areas were decorated with some homely features such as pictures, photographs, ornaments and books. The dining rooms were set with matching table cloths and

laid ready for lunch after breakfast had finished.
● There was a well-equipped therapy room and we saw people being supported to use this by physiotherapists.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The staff carried out assessments of people's needs before they moved to the home. We saw people's assessments involved gathering information about the person from the person, their relatives and other adult social care professionals. Assessments captured personalised information about people, for example a person's interests and hobbies. However, such information was not always then carried over to people's care plans. We saw staff reviewed people's assessments and care plans on a monthly basis.
● Staff explained how they had visited and spent a day with a person before they moved into the home so they could understand more about the person's care needs and how they communicated.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Staff supported people to maintain their health and access other healthcare services when required.
● Local GPs visited the home twice a week to monitor and support people's health. We spoke with one GP who said they thought staff provided people with a good service.
● Staff supported people who were at risk of pressure sores appropriately. There was basic information about this for staff in people's care plans. People were supported to use pressure relieving mattresses and records of care indicated staff helped people to turn regularly. Staff monitored people's pressure sores to track if they improved or deteriorated.
● The provider employed occupational therapists and physiotherapists who worked with people using the service, where there was an assessed need for this support. They had created therapy plans which included the use of equipment, addressing sensory needs and regular exercises. They worked directly with people and also developed interventions for the staff to carry out between therapy sessions. People's care plans included detailed plans from the therapists which had been regularly reviewed. The care staff told us they found this multi-disciplinary approach was beneficial for people using the service.
● Staff explained to us how they provided good oral care to people, usually in the mornings, although they were not aware of the NICE guidelines for promoting oral health for adults in care homes.
● Adult social care professionals told us staff worked collaboratively with them to provide joined-up care to people. For example, when people were receiving end of life care.
● When people transferred to hospital or A&E, the staff prepared appropriate transfer records to ensure hospital staff had the necessary information about a person to help make clinical decisions and treat them.

Requires Improvement

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
● Staff mostly treated people with dignity and respect and promoted their privacy, but we saw occasions when this was not consistent for everyone.
● On 22 October 2019 we observed a nurse support people to take their prescribed medicines, such as eye-drops, while they were eating their lunch in a shared dining room sat at a table with other people. Little consideration seemed to have been given to their comfort and the fact they were eating their meal. We discussed this with the manager who said they will address it.
● On 22 October 2019 we also noticed staff had left the door to a person's room open while they were supporting them. The person's bare legs and undergarments were exposed to the communal corridor when the door could have been closed to promote the person's dignity and privacy.
● On the same day we saw two staff move two people using wheelchairs from a lounge to the main activity room. The staff pulled the people's wheelchairs backwards to move them and did not explain what they were doing and did not speak with them while they were helping them to move.

The above shows people were not always treated with dignity or respect and their independence was not always promoted. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One relative told us in the past some staff had entered their family member's room without introducing themselves and had not explained what they were there and what they were doing. They said they reported this to senior staff who had then addressed this.
● Despite the above, we also observed instances of staff treating people with dignity and respect and in caring manner throughout our visits. For example, we saw staff knocking on bedroom doors and respecting people's dignity by closing curtains and doors for personal care. People had the option of having their door left open or closed whilst in their room. People told us staff were polite, respectful and protected their privacy. One person told us, "It's nice. They give you space, which I like."
● Staff explained how they promoted people's privacy and dignity when providing personal care. This included always speaking with the person, making sure the environment was private, ensuring the person was suitably covered while washing, and playing music for the person if this helped them to relax.
● The manager had held training sessions for staff on promoting Dignity in Care.
● We saw staff encouraged people to be independent. Staff working in the rehabilitation unit particularly described supporting people to do things themselves. The occupational therapists had developed therapy plans aimed at encouraging people to develop and maintain their independence. People used equipment,

such as plate guards, to help them eat more independently. We observed staff supported people who wanted to mobilise independently and slowly to do so. A relative told us they appreciated how staff supported and encouraged their family member to walk and be active at a pace that suited them.

Ensuring people are well treated and supported; respecting equality and diversity

● We received mixed feedback from people and relatives about people's care. Some people described this positively and their comments ranged from, "The staff are very efficient, kind and polite", "The place is like our home," to "The place is excellent, we appreciate their kindness and I am thankful that they are looking after [the person]." However, some people and relatives also told us, "Some care workers are good, some are bad, it's natural," and "Some staff don't have any empathy."

● Whilst people experienced staff being individually caring towards them, the service was not always caring to people. The provider had not been caring enough to ensure people received their medicines safely, or that risks to people were identified and appropriately mitigated so people did not experience the risk of harm as a result. We saw that people's care plans lacked information about them as individuals so the plans did not clearly show how people should receive care personalised to their needs.

● People said that most staff who visited them regularly knew them well. Some people and relatives said this had not been the case earlier in the year when they felt the provider had engaged more temporary agency staff to cover staff vacancies. Staff we spoke with demonstrated a good understanding of the people they cared for and their individual needs and preferences. For example, a staff member described in detail how a person needed particular support and reassurance to turn in bed and to mobilise so they felt less anxious about this.

● People's assessments and care plans recorded information about their protected characteristics, including marital status and cultural and religious background. The home had a chapel on site and people were supported to attend two services a week if they chose. The manager explained how the activities coordinator was arranging for a piper to visit as part of plans to commemorate Remembrance Sunday.

● The manager told us they were looking to improve how the service recognised people's sexual orientations and relationships and promoted LGBT+ inclusive practices. 'LGBT' describes the lesbian, gay, bisexual, and transgender community. The '+' stands for other marginalised and minority sexuality or gender identities. The manager had developed and delivered a training session for staff on 'respecting and valuing difference'. This aimed to promote equality and human rights in people's care and was based on the United Nation's Principles for Older Persons.

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

● We saw that people were involved in planning and reviewing their care. Records showed people relatives, where appropriate, were involved as well. This gave people the opportunity to make decisions about their care and support arrangements.

● The manager told us they had recently introduced annual care plan review meetings to review people's care plan arrangements with their relatives. This gave people and relatives more opportunity to be involved in decisions about their care. Relatives we spoke with confirmed this and said these meetings were now taking place. Relatives told us the review meetings was clear, information was clearly communicated and people were involved. Their comments included, "[It was] done properly" and "[The meeting] went very well - very thorough."

● We observed staff supporting people to make day-to-day choices about their care. Staff took the time to talk with people and help them make decisions. For example, staff asked people if they could help them to wear an apron when eating.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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

- The provider did not make sure people always received personalised care that had been planned to meet their individual needs and preferences.
- People's care and risk management plans did not contain clear information about meeting people's needs and did not always reflect a person-centred approach to supporting people. Plans only gave basic, functional information about the care tasks staff needed to complete with people. They did not always include personalised information about people's preferences or the way they wanted to be cared for. For example, people's plans did not always record how they liked to be supported to wash or what products they might like to use for this.
- Some people's care plans lacked other personalised information, such as details of a person's life history, their hobbies, interests, likes and dislikes. Some of this information was recorded in profiles developed by the activities coordinator, but these were separate to people's care plans. This meant care plans did not provide staff with clear information about how to meet people's social and emotional needs.
- Although staff told us they supported people to clean their teeth and maintain good oral health, people's care plans did not set out how staff were to support them with this.

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 a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We discussed these issues with the manager. They had identified care plans needed more information on providing personalised care to people. They showed us the new care plan format they had developed and just started to introduce to better record this. A number of staff told us they felt the new manager was improving the service by introducing the new care planning documentation.

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.

- People's care plans did not always include clear information about their communication and sensory needs and how staff should meet those needs.
- For example, one person communicated with people in a particular way. While we saw staff engage

meaningfully with the person, their communication needs and the staff approach were not recorded in their care plan.
● This meant the service had not fully implemented the AIS to identify, record, flag, share and meet the information and communication needs of people with a disability or sensory loss.

We found no evidence that people had been harmed however, this evidence also indicated the provider had not ensured some people's care and treatment was always appropriate and met their needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed this with the manager. They had already identified people's care plans needed more information for staff on how some people communicated and how best to support them with this. We saw the manager had developed clear information sheets to better record this information in people's care plans in future.
● The manager had recently developed the provider's new AIS policy. This set out clear steps for staff when reviewing people's care arrangements so they could identify, record and share information about people's communication needs and how to meet them. The policy also included good practice tips for effective face-to-face and written communication.
● The service was meeting some people's communication needs. One person had a communication passport in place, which set out their communication needs and support. Some people living at the rehabilitation unit were supported to use communication aids.

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
● There was a programme of activities for people, provided by a team of activities staff and organised by an activities coordinator. We saw care staff and volunteers also support people to take part in activities throughout the day. This meant there were enough staff to help different people do different things. Activities included a quiz, table tennis, singing, colouring and exercising.
● People and relatives spoke highly of the activities on offer. Their comments included, "They always have activities; they celebrate festivals and [the person's] birthday", "The activities are amazing," and "A few weeks ago they had a fun day, there was lot of entertainment for the people and it was really fun."
● The activities coordinator had worked with people to develop personal profiles of their likes, dislikes and preferences. They used this to inform the activities they arranged so these could be more relevant to people's interests.
● The main activities room appeared well equipped with a range of different games, craft materials, a coffee machine, and a fish tank. There was also a computer which people could use to keep in contact with friends and relatives with online video calls.
● The activities team arranged for various entertainers to visit the home, such as musicians and a visiting farm service. The team organised trips out, for example to go shopping, boating or to Kew Gardens. One relative told us how the staff had helped them to support their family member to attend a show in the West End.
● There appeared to be less organised activities provision for people who did not want to go to the main activities room or who were unable to leave their rooms. We discussed this the manager who said they would be reviewing this support for people with the activities team.
● Relatives and activities staff told us they were fund-raising to purchase a 'magic table' for people to use. A 'magic table' uses technology to help provide visual stimulation and interactive opportunities, for people living with dementia, for example.

Improving care quality in response to complaints or concerns

● There provider had appropriate complaints handling processes in place.

● Relatives told us when they had raised issues with senior staff they felt they had been listened and responded to.

● Complaints records showed complaints had been investigated, responded to and learning identified. We saw the manager or clinical lead discussed complaints and learning from these at daily service meetings.

● One person told us they had complained about losing items of clothing in the laundry. We saw the manager had spoken with staff in team meetings to address this.

● One relative told us they were not always sure to whom they could raise issues or concerns about staff to. We discussed this with the manager who said they would address this and be clear to people they could bring all concerns to them.

End of life care and support

● People were supported at the end of their life to have a comfortable and dignified death.

● The service worked in partnership with a local palliative care nursing team to provide appropriate end of life care. Adult social care professionals told us the staff had worked with them to provide, monitor and adapt people's end of life care so it was effective and met their needs. A professional told us, "They provide palliative care very well" and "With palliative care we feel that the patients are safe in their hands." Professionals were confident staff sought their advice and assistance in a timely manner.

● Adult social care professionals said staff regularly attended end of life care training and their competency in this area was assessed.

● Staff were sensitive to the experiences of relatives when a person was receiving palliative care or in the last days of their life. They told us they had observed staff support people's families thoughtfully and respectfully at these times.

● We saw people had forms in place to state how they wished to be supported in the event of a sudden deterioration in their health. These were signed and endorsed by an appropriate healthcare professional and people, where appropriate, their relatives had been involved. The daily handover records staff used also clearly indicated which people had these forms in place.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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

- The provider carried out a range of checks and audits to monitor safety and quality and make improvements when needed. However, this system of checks had not been consistently effective as it had not identified or addressed the issues we found during the inspection.
- The provider's quality assurance systems had not identified or addressed risks to people's safety by ensuring people's hydration needs were always being met or by maintaining a safe environment. The provider had not identified and addressed that people's rights were not being respected in line with the principles of the MCA.
- Staff conducted regular medicines management audits. However, these had not identified and addressed the medicines management concerns we found.
- The provider's assurance systems had identified but not sufficiently addressed that some people's care plans did not provide personalised information about people's likes, dislikes, interests, their care preferences, or their communication needs.

These issues indicated systems were either not in place or robust enough to demonstrate safety and quality was effectively managed. This placed people at risk of harm. This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There had been a number of management changes at the home since our last inspection. Some relatives said they felt this inconsistency had had a destabilising effect on running of the service. The previous long-standing registered manager had left just over a year before our inspection, then a temporary manager had worked at the service for several months. The current manager started at the service six months before our inspection. They had applied to the CQC to be the registered manager by the time we visited.
- The new manager had a good knowledge of their legal requirements and of relevant good practice guidance, such as NICE guidelines for promoting oral health for adults in care homes.
- The manager had introduced new systems designed to improve and measure the quality of the service. For example, they had set up daily 'flash' meetings each morning with nurses and senior staff, a new Falls group to monitor and reduce the number of falls people experienced, and a new Health and Safety group.
- We saw the manager was in the process of developing a detailed service improvement plan, which was aligned to the CQC's five key questions. The manager reported on service improvements to the provider's board regularly. Members of the provider's board also conducted quarterly audits of the service.
- Staff we spoke with gave positive feedback about the new manager, said they had introduced new

changes which were better for the service, and said they felt the home had improved in the last few months. Staff told us the manager was approachable and we saw staff raise and discuss issues with the manager during our visits. One member of staff said, "It's not, 'I said, you do'; we discuss things."
● The manager was aware of the requirement to clearly display inspection ratings at the provider's office and on their website.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The manager described a clear vision and approach for managing the service. This included a commitment to ensuring people received good care that promoted their human rights, provided by nurses and staff teams who were supported to take responsibility for the care people experienced.
● We received mixed feedback from people and relatives about the culture and quality of service. Some people said they thought the service quality had declined over the last year. Some people said they felt the service quality had improved in recent months and commented, "We are very happy with the service," and, "It ticks all the boxes we want to see in a home." One relative said, "Everyone is lovely – [but] I think they need to come together and pull together."
● Staff told us they liked working at the service and with each other. They said there was good communication with colleagues. Staff told us the manager was approachable and we observed staff raise and discuss issues with manager during our visits.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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;
● We received mixed feedback from relatives about being involved in the service. Some relatives said they didn't think the provider had communicated with them well enough about management changes over the last year.
● Some relatives said they felt there used to be an 'open door policy' to be able to speak with the manager at any time and this was no longer the case. However, relatives also told us they could speak with the new manager when they asked to.
● The manager held regular 'resident and relatives' meetings to discuss the service and developments. Some relatives told us they found these meetings constructive and informative. One relative said, "[The manager] takes us through each of the action plans they have set and says where they are with [progress]..
● The manager told us some relatives contributed to running of the service in other ways, such as drafting a new resident handbook, fund-raising and helping with some activities, such as pantomimes.
● The provider had conducted a 'residents and relatives' survey in May 2019 as one method of finding out what people thought of the service. Of the survey responses received, 4% of people thought the service was outstanding, 65% saw it as good, and 31% said the service required improvement. The manager had developed an improvement plan in response to the findings, which included reviewing staff response times to people's call bells, recruiting permanent staff and reducing the use of temporary agency staff and reviewing staff training.
● Staff said they had regular team meetings where they could contribute to discussions about the service and we saw records of these taking place.
● The manager and senior staff held morning meetings each day to discuss the service, any concerns, complaints, incidents and share information so they could provide consistent care to people. There were regularly clinical review meetings to discuss particular health issues some people may be experiencing.
● The manager was aware of and understood the duty of candour and said they apologised to people when things did not go right. For example, we saw the manager had written to a relative to apologise for the

mishandling of a person's dentures and paid for these to be replaced. An adult social care professional also told us they provider had apologised to people when things had gone wrong.

Working in partnership with others

● Staff worked with other teams within the service, such as occupational therapists and physiotherapists, and external health and social care professionals to provide people with joined-up care. Professionals we spoke with confirmed this. For example, when providing palliative care to people, or when they were investigating safeguarding concerns.

● The activities coordinator worked to involve the service in the local community. For example, they had arranged for some people to visit local schools and a social event at a local synagogue. A small number of people from the community also visited the service weekly so they could take part in the varied activities being provided.

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 appropriate, met their needs or reflected their preferences. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure that service users were treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure that the care and treatment of people was only provided with the consent of the relevant person. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure care and treatment was provided in a safe way for service users because they did not always: : Assess the risks to the health and safety of service users receiving care : Do all that was reasonably practicable to

	mitigate such risks : Ensure the safe and proper management of medicines Regulation 12(1)(2)(a),(b),(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not ensure that the nutritional and hydration needs of service users were always met. Regulation 14(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 17 HSCA RA Regulations 2014 Good governance The provider was not always operating effective systems and processes to: - Assess, monitor and improve the quality and safety of the services provided in carrying on the regulated activity. - Assess, monitor and mitigate the risks relating to the health safety and welfare of service users. Regulation 17(1) and (2)(a),(b)

The enforcement action we took:

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