SHC Rapkyns Group Limited

Wisteria Lodge

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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service:
Wisteria Lodge is a residential care service that is registered to provide accommodation, nursing and personal care for up to 20 people with the following support needs; learning disabilities or autistic spectrum disorder, physical disabilities, younger adults. At the time of our inspection there were 17 people living at the service. Accommodation is provided across two lodges called Wisteria Lodge and Stable Lodge. Each lodge has a separate living room, dining room and kitchenette. Rooms are of single occupancy and have en-suite facilities.

Wisteria Lodge is owned and operated by the provider Sussex Healthcare. Services operated by Sussex Healthcare have been subject to a period of increased monitoring and support by local authority commissioners. Due to concerns raised about the provider, Sussex Healthcare is currently subject to a police investigation in relation to incidents that occurred between 2016 and 2018. The investigation is on-going, and no conclusions have yet been reached.

Wisteria Lodge had been built and registered before the Care Quality Commission (CQC) policy for providers of learning disability or autism services 'Registering the Right Support' (RRS) had been published. The guidance and values included in the RRS policy advocate choice and promotion of independence and inclusion, so people using learning disability or autism services can live as ordinary a life as any other citizen.

The service did not consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons; People did not always receive personalised care. Staff did not always plan, review or develop people's individual support needs and wishes with them. People did not always have support to access the wider community.

People's experience of using this service and what we found:
Risks relating to people's care and safety was not always assessed or monitored. Risks relating to behaviours which challenge, and epilepsy management were not consistently mitigated. Further work was required to make the care planning process holistic and further involve people within the design and formation of their care plan.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support as engagement in the community needed improvement. People did not always have personalised goals to help increase their independence or participation in community activities. Further work was required to ensure people's communication needs were met.

People were not always 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 always support this practice. We have made a recommendation for improvement. The care planning process failed to reflect and consider best practice guidance.

Quality assurance frameworks were in place; these were not consistently effective in driving improvement or identifying shortfalls. Links and engagement with the local community required strengthening.

Staff felt supported and had access to a range of training. The building was purpose built and met people's needs, with wide corridors, en-suite shower rooms, and ceiling hoists. People could access outside areas and were observed using the grounds. The service was clean, and the risk of infections was mitigated by a dedicated and effective housekeeping team. Complaints were dealt with in line with the provider's policy.

Staffing levels appeared to be safe from our observations and staff and relatives confirmed that the service had enough staff available to meet people's needs. Staff received ongoing supervisions and competency assessments were completed to ensure staff had the right skills and knowledge.

People had enough food and drink to maintain their health. Fluid charts had been completed accurately and peoples recommended daily amounts were met. Staff worked in partnership with external healthcare professionals to promote positive outcomes for people. Relatives told us staff were kind, caring and treated their loved ones respectfully and we observed this to be the case.

People were safeguarded from abuse as far as reasonably possible and staff knew how to recognise and respond to any allegations of abuse. Medicines were being managed safely. There were safe recruitment practices. Relatives spoke highly of the care provided to their loved ones. One relative commented, "My relative is extremely well cared for."

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

Rating at last inspection:
We last inspected Wisteria Lodge on 20 and 21 December 2018. The rating for the service was Requires Improvement (report published 5 March 2019). The service was found to be in breach of two regulations. Regulation 12 – Safe Care and Treatment and Regulation 17 – Good Governance. At this inspection, some improvements had been made but the provider remained in breach of Regulation 12 and 17 and a new breach of Regulation 9 – Person Centred Care was identified.

This service has been rated Requires Improvement for the last three consecutive inspections.

Why we inspected:
This was a planned inspection based on the previous rating.

Enforcement:
At this inspection, we have identified two continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regulations 12 (Safe Care and Treatment), and 17 (Good Governance). We also identified a new breach of Regulation 9 (Person Centred Care).

We imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider, including Wisteria Lodge. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider.

The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

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 request an action plan from the provider to understand what they will do to improve the standards of quality. We will also meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority and care commissioners 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?

Good

The service was 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.

Wisteria Lodge

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:
On 28 January 2020 the inspection team consisted of one inspector, a registered nurse specialist advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

On 29 January 2020 the inspection team consisted of two inspectors and a registered nurse specialist advisor.

Service and service type:
Wisteria Lodge is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was unannounced.

What we did before the inspection:
Before the inspection, we reviewed information we held about the service. We considered the information which had been shared with us by the provider as well as the local authority, other agencies and health and social care professionals. We looked at safeguarding alerts which had been made and notifications which had been submitted by the provider. A notification is information about important events the provider is

required to tell us about by law. This is necessary so that, where needed, the Care Quality Commission (CQC) can take follow up action.

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:
Due to people's communication needs, not everyone was able to verbally communicate with us. We therefore 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 observed the provision of care provided to people in the communal areas and observed how staff interacted with people.

During the inspection we spoke with two registered nurses, the deputy manager, a senior care worker, three care staff, housekeeping staff, the registered manager, activity coordinator and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with three visiting relatives.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including staffing meeting minutes, activity programmes and complaints.

After the inspection:
We continued to seek clarification from the provider to validate evidence found. Additional information was emailed to the inspection team after the inspection. We contacted three relatives and one healthcare professional via email to gain their feedback.

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 Requires Improvement. This was because people did not consistently receive safe care. Risks associated with constipation management were not managed safely. At this inspection this key question has remained the same. Further work was required to ensure the ongoing safety of the care delivered. Risks associated with epilepsy management were not consistently managed safely. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management:

● At the last inspection in December 2018, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because risks associated with choking and aspiration were not consistently managed in a safe manner. At this inspection not enough improvement had been made and the provider remained in breach of Regulation 12.

● Risks to people with epilepsy at Wisteria Lodge were not always being monitored, assessed or managed safely, exposing them to risk of harm. People had epilepsy care plans; however, the risks associated with managing and responding to seizures at night time required further work. For example, one person's seizure management care plan referenced the need for 15-minute checks at night. However, the risk of the person having a seizure in-between those 15-minute checks at night had not been identified and no plan of care or risk assessment was in place.

● Support was provided to one person with audio equipment to help alert staff in the event of a seizure. However, guidance was not available on what staff should listen out for or how to recognise the sound of a seizure. The individual's epilepsy care plan also failed to reflect that an audio monitor was in place. One staff member told us that the person would often make noises during a seizure. This information was not documented in their epilepsy/seizure management care plan. Following the inspection, the registered manager advised that the person's risk assessment had been reviewed to demonstrate that they had no history of seizure activity whilst living at the service and therefore due to this, staff were unaware of the sounds which might indicate that the person was experiencing a seizure. The registered manager advised that the risk assessment had been reviewed which included guidance for staff to listen out for any unusual noise or activity.

● Seizure monitoring forms reflected that one person experienced cluster seizures in 2019. Their epilepsy seizure management care plan failed to give consideration on the management of cluster seizures. Guidance on the management of epilepsy was also inconsistent. For example, one epilepsy protocol referred to administering emergency medicine and stated to administer a second dose of the medicine to be administered along with calling 999. However, the person's emergency treatment plan stated that their GP did not recommend administering a second dose of the emergency medicine. The inconsistent guidance placed the person at risk of receiving unsafe support during a seizure.

● Risks relating to people's physical and non-physical challenging behaviours were not always assessed, monitored or managed safely, increasing the risk of harm to people. One person had received support from the provider's positive behaviour support lead and a positive behaviour care plan (PBS) had been

implemented. However, the actions and recommendations from this plan were not being followed.
● One person was observed biting their hand by the inspection team. We received conflicting information from staff on what this behaviour meant. One staff member told us that it meant the person was happy. Whereas another staff member told us that it meant the person was agitated and wanted whatever was happening to stop. Their care plan failed to identify or explore this behaviour and no functional assessment of this behaviour had been completed. The lack of detailed information meant there was an increased risk staff were not responding appropriately or consistently to protect the person from risk of self-harm.

The failure to provide safe care and treatment was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014

● Other risks were managed well. At the last inspection in December 2018, risks associated with constipation management were not managed safely. At this inspection improvements had been made.
● For people living with constipation, staff were clear on the steps to take in the event of a person not experiencing a bowel movement. One staff member told us, "We have new protocols in place which are really clear. For example, if one person hasn't experienced a bowel movement in three days we administer a suppository. We haven't had to administer any recently as they experience regular bowel movements."
● NEWS (National Early Warning Score charts) were used appropriately and acted as an effective tool in monitoring people's health. For example, one person was assessed as having a high NEWS score, medical attention was sourced, and the person was admitted to hospital for the treatment of an infection.
● The management of percutaneous endoscopic gastrostomy (PEG) care was safe. Documentation reflected that people received support to maintain their PEG in a safe and clean manner. Staff were knowledge about people's care and how to safely provide PEG care. However, documentation was not consistently in place to demonstrate that people were positioned at the correct angle. We have further reported on this in the 'Well-Led' domain.
● Relatives praised the care provided to their loved ones. One relative told us, "I know that my loved one is well cared for as otherwise they wouldn't be here. Staff have a good understanding of the risks surrounding their care and they know my loved one extremely well."

Systems and processes to safeguard people from the risk of abuse:
● People's relatives told us that their family members were safe living at Wisteria Lodge. One relative commented, "I know my relative is safe here. The staff communicate with us and I wouldn't leave them here if I wasn't confident that they weren't safe." Another relative told us, "I have never seen anything that has given me cause for concern."
● Staff had a good knowledge of local safeguarding arrangements and understood their role in protecting people from the risk of abuse and avoidable harm. One staff member told us, "I've not had to raise any recent safeguarding concerns, but I always monitor for any bruising, signs that the person might be disengaged or not their usual self."
● The registered manager was aware of the agreed procedures for reporting abuse allegations to the local authority safeguarding team and of the need to notify CQC in line with regulatory requirements.

Staffing and recruitment:
● Staffing levels were based on people's individual needs alongside the skill mix of staff. The registered manager completed a shift planner for each shift which considered the deployment of staff and that staff with the right skills and training were deployed. Relatives commented that they felt staffing levels were sufficient. One relative told us, "I've got no concerns over staffing levels."
● Observations of care demonstrated that staff were able to respond to people's needs in a timely and responsive manner. Staff told us that they felt staffing levels were safe. One staff member told us, "I have no

worries about the staffing levels. We get time to spend with people and do activities."

● There were safe systems and processes for the recruitment of staff to ensure they were suitable for their roles. This included undertaking appropriate checks with the Disclosure and Barring Service (DBS) and obtaining suitable references. Nurses deployed were checked by the registered manager and provider that they were registered with the Nursing and Midwifery Council (NMC) and were fit to practice.

● The provider employed five permanent nurses. Agency nursing staff were required to cover staff shortfalls and whilst the provider recruited to all nursing staff vacancies. When agency nursing staff were required to ensure safe staffing levels, a comprehensive agency staff induction process was in place. Before agency staff completed their first shift at the service, the provider obtained a copy of their profile to ensure they had required skills and training to provide safe care. The profiles of agency nursing staff demonstrated that they received training on epilepsy awareness, PEG care and learning disability training. The registered manager confirmed that the same agency staff were booked for continuity purposes.

Using medicines safely:

● Medicines were safely managed. They were stored securely and only accessible to trained staff who had been assessed as being competent to administer medicines. Staff carried out routine temperature checks of the medicines storage area to ensure they were maintained within a range that meant they were safe for effective use.

● People had medicine administration records (MARs) which included a copy of their photograph to help reduce the risk of misadministration. The MARs had been signed by staff to confirm they had administered people's medicines in line with the prescriber's instructions. There was guidance in place for staff on how and when they should look to administer any medicines which had been prescribed to people to be taken 'as required'.

● The provider had systems in place for receiving and disposing of any unused medicines. Medicine audits were completed on a weekly and monthly basis and helped to drive improvement with safe medicine management.

● Nursing staff were observed administering medicines in a kind and dignified manner. Medicines were administered in line with best practice guidance. They explained to the person what their medicine was for, ensured they had a drink to hand and stayed with the person whilst they took their medicine.

Preventing and controlling infection:

● There was an infection control policy and cleaning schedule to ensure that risks to people, staff and visitors from infection were minimised. Staff had received infection control training and understood their responsibilities in this area. The provider employed dedicated housekeeping staff who supported the staff to ensure the service remained clean and hygienic.

● There were hand washing facilities throughout the home and staff had access to personal protective equipment such as disposable gloves and aprons. One relative told us, "The staff are using gloves and washing hands and they're very well trained."

Learning lessons when things go wrong:

● Accident and incidents were monitored monthly by the registered manager to monitor for any trends, themes or patterns. A monthly report was also produced which considered the number of unplanned hospital admissions, infections acquired, pressure ulcers and safeguarding concerns. The registered manager was open and honest with staff and learning from incidents and accidents was shared with the wider staff team to prevent reoccurrence.

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 Requires Improvement. This was because further work was required to embed and sustain compliance with the Mental Capacity Act 2005 (MCA) and ensure staff's skills, competency and training enabled them to carry out the duties they were employed to perform. At this inspection this key question has remained the same. The principles of the MCA 2005 were still not consistently being met and further work was required to ensure staff had the right skills and training. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 MCA Code of Practice 2005 advises that capacity assessments should be time and decision specific. We found that some capacity assessments were not always decision specific. For example, several people had capacity assessments in place around making major decisions. The capacity assessment failed to identify what was meant by the term 'major decision'.
- People's involvement in the capacity assessment was not always reflected. Several capacity assessments stated that all methods had been tried to involve the person, but the person was unable to express their opinion. One person's communication care plan stated that they could communicate using facial expressions. However, their capacity assessment failed to reflect what steps had been taken to involve and empower the person to make the decision. We have further discussed the failure to maintain accurate documentation within the 'Well-Led' domain of the report.

We recommend that the provider seeks guidance from a reputable source on how to accurately complete mental capacity assessments and how to effectively involve people in the process.

- Staff understood the importance of gaining consent from people and this was observed in practice. Staff

were observed supporting people to make day to day decisions, such as to what to eat and drink. Staff told us that they had received training on the MCA 2005 and understood the importance of supporting people to make their own decisions.

● A number of mental capacity assessments had been completed in line with the requirements of the MCA and code of practice. For example, people's capacity to consent to bed rails had been assessed. The registered manager was also in the process of holding best interest meetings with relatives and healthcare professionals.

● Everybody living at Wisteria Lodge either had an active DoLS in place or was awaiting authorisation. An appropriate assessment process had been carried out for each person. The registered manager kept an overview of DoLS application status for each person, including when it was applied for, granted and expired. Where renewals of DoLS authorisations were needed, these had been applied for in a timely manner.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:

● Care plans were in the process of being reviewed and updated. The registered manager told us, "We've been revising the template of care plans and re-writing them to ensure they are person centred and reflective of people's needs."

● Further work was required to ensure all care plans were reflective of best practice guidelines and to ensure the care planning process was holistic and considered people's overall mental, social, psychological and physical care needs.

● Guidance produced by Skills for Care explains that everyone has to the right to explore their sexuality and develop meaningful relationships. The care planning process failed to consider people's sexuality and how people might be supported to develop and maintain relationships. The registered manager acknowledged that this was an area of practice they were working on and were due to attend training in March 2020 on personal relationship and sexuality. Subsequent to the inspection, the registered manager also added that a sexuality toolkit was in the process of being rolled out. The implementation of the toolkit would enable staff to explore sexuality and relationships and support people with developing and devising care plans in this subject area.

● The provider was using nationally recognised, evidence-based guidance to track and monitor people's health outcomes, such as Waterlow charts to ensure people's skin was healthy and MUST (malnutrition universal screening tool) tools to monitor people's nutritional needs

● For people living with a learning disability and a neurological condition, a DISDAT (disability distress assessment tool) was completed to help staff understand when people may be upset or in pain. Staff were knowledgeable about the signs and symptoms that might indicate a person was in pain or experiencing discomfort

Staff support: induction, training, skills and experience:

● At the last inspection in December 2018, the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as not all staff had received supervision in line with the provider's policy, not all staff had completed mandatory training and some staff lacked the necessary knowledge to communicate effectively with people.

● At this inspection, some improvements had been made. Staff were now receiving regular supervision and all staff were up to date with their mandatory training. However, ongoing work was required to ensure staff communicated with people in an effective and responsive manner. We have further reported on this in the 'Responsive' domain.

● Staff told us that they felt supported and received appropriate training and supervisions to enable them to fulfil their roles. One staff member commented, "We have regular access to training and the manager is always identifying courses that might be beneficial."

● The registered manager recognised the importance of training and ongoing development. The registered

manager told us, "I think it's important that staff have access to a wide range of training, not just training provided by the company."

● There was a clear induction programme for new staff to follow which included shadow shifts and practical competency checks in line with the Care Certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training.

● Systems were in place to assess the competency of staff including agency nursing staff. Clinical supervision was also offered to agency nursing staff and the registered manager was working in partnership with the provider's quality team to ensure nursing staff had the right skills and competency to carry out their clinical duties effectively.

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

● Staff worked in partnership with healthcare professionals such as dieticians and Speech and Language Therapists (SaLT). Specialist diets were catered for and where people were at risk of malnutrition, nutritional supplements were provided, and the chef provided fortified food to promote calorie intake.

● People's weight was monitored on a regular basis and with pride staff told us how people had gained weight since moving into the service.

● People were given choices of what they wished to eat, and this was provided in pictorial and written format to help people choose and decide. People were also provided alternatives if they requested this.

● Where people were at risk of dehydration, this was closely monitored. Fluid intake charts were maintained which included guidance on the person's recommended daily fluid intake. Fluid charts reflected that people were regularly supported to achieve their recommended fluid intake.

● The registered manager and provider had designed booklets for staff and the kitchen team which included key information on people's dietary's needs, SaLT guidelines alongside images on how to safely support the person during mealtimes. For example, ensuring that they were sitting in the correct position.

● The service had implemented an initiative at lunchtime. This included the use of a staggered lunch time which meant some people were supported with activities whilst other people were supported with their lunch time meal. However, we observed that this approach was not always effective. For example, one person was being supported with an activity in the dining room whilst other people were being supported with their lunchtime meal. They were observed becoming distressed and their care plan identified that food was extremely important to them. We discussed these concerns with the registered manager subsequent to the inspection who advised that further consideration would take place on how best to support people when other people are having their lunchtime meal.

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

● Staff monitored people's day to day health and well-being. Staff and management also sought support from external healthcare professionals. The registered manager was passionate about working in partnership with external healthcare professionals. They commented, "I think it's really important that support is accessed from outside professionals. I'm keen to work with community physiotherapists, occupational therapists and SaLT." One healthcare professional told us, "Staff members are knowledgeable surrounding the patients' needs, past and present and are able to adequately update me."

● Support was provided to enable people to live healthier lives. Staff had been working in partnership with the tissue viability team for one person who was admitted to the service with a significant wound. Through partnership working, the wound healed, and staff now regularly monitor the person's skin integrity to observe for any signs of skin breakdown.

● Staff accompanied people to their healthcare appointments where needed. Records confirmed people had routines check-ups with their GP, dentist and optician and were supported to attend appointments with more specialist healthcare services when required such as with a neurologist or psychiatrist.

● Bereavement support was also accessed for one person and staff also supported this person to seek support from a psychologist to support their mental well-being.
● Since the last inspection in December 2018 staff and registered manager had implemented a health file for all people living at the service. This included clear guidance on all health appointments, when the appointment was and any follow up actions. One staff member told us, "The new health folder has made things so much easier. We can visibly see when a person last saw their GP or the dentist and helps us keep on top of their healthcare needs."

Adapting service, design, decoration to meet people's needs:
● The service was suitable for people's needs. The premises had been designed to accommodate people with physical disability support needs. There were wide doorways and corridors to allow for wheelchair access. Equipment such as ceiling track hoists had been installed in individual bathrooms and bedrooms to support people with transferring from one place to another. It was spread over two separate lodges. Access between the two lodges was via the back garden.
● People had their own personal bathrooms, which meant they could access and organise these spaces to their liking. People's bedrooms were personalised to their taste. With pride one person showed the inspection team their bedroom and pointed to the certificates on their bedroom wall which they were extremely proud of.
● There were garden areas for people to enjoy that were accessible and we saw people going for walks with staff and enjoying the outside spaces.
● The registered manager had been working in partnership with people to redecorate the lodges. The registered manager told us, "When I came into post I found that the lodges had no identity and were not reflective of the people's personalities. We therefore sought people's input on what colour they would like the lodges to be painted. We are also making the lounges more accessible for people. For example, the lounges have sofa's in and due to people's mobility needs they cannot access the sofas, so we are sourcing bean bags to place into the communal lounges to make better use of the space."

Good

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 Requires Improvement. This was because some staff were observed to be task oriented. At this inspection, improvements had been made and this key question has improved to Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- Staff were observed to interact with people in a kind and compassionate manner. However, further work was required to ensure people were routinely supported to access the wider community. Ongoing work was also required to ensure staff understood people's communication needs and the principles of registering the right support were not consistently being met. We have further reported on these concerns in the 'Effective', 'Responsive' and 'Well-Led' domains of the report.
- People appeared to be happy and their relatives spoke positively about the support people received from the staff. One relative told us, "The staff are absolutely fabulous. One of them absolutely walks on water for my loved one." One person commented, "I like it here the staff are brilliant."
- The atmosphere in the service was calm and relaxed. Staff acknowledged people as they walked past. This was observed to happen with all staff regardless of their position. One relative told us, "What I love is that all staff interact with people living here. One of the housekeeping staff is tremendous. They have the most infectious smile and my loved one always interacts well with them." Another relative told us, "They are very caring. If a person is upset they really try to find out what the problem is and sometimes its emotional and they give the time and help to deal with it."
- Staff were able to tell us about people's personalities, likes and dislikes, and demonstrated their knowledge about what was important to people. Staff told us how it was always vital to one person to have items of importance with them. This was observed throughout the inspection. One healthcare professional told us, "It is lovely to see service user's face light up during interactions with staff members, time has been taken to build good relationships."
- Staff supported people to maintain their sense of appearance. One person enjoyed having their hair done each morning. Another person enjoyed wearing jewellery and looking smart. This was observed on the inspection.
- People's cultural and spiritual needs were respected. People were supported to access their local church and services were also held at the service. Staff had received equality and diversity training to help them to better understand why it was important to understand and respect people's needs and choices, including those related to their protected and other characteristics under the Equality Act 2010.
- Staff recognised the importance of human touch and gently supported people, to provide comfort. One person enjoyed having their hair stroked, during activities or in passing, staff gently stroked the person's hair providing comfort and reassurance.
- Staff greeted people and checked on their wellbeing and comfort. Visitors to the service were welcomed and offered refreshments. People were supported to spend time with their family and maintain that

communication.

Supporting people to express their views and be involved in making decisions about their care:
● People were supported to make day to day decisions. For example, staff supported people to make decisions about to eat or drink through showing the person choices available.
● Relatives confirmed that they felt involved in their loved one's care. One relative told us, "The registered manager is holding regular meetings with us which enables us to feel updated. We've also gone through our loved one's care plan to ensure we are happy with it.
● Steps were being taken to involve people in decisions about the running of the service. The registered manager told us that had started trialling involving people in the interview process. People's views on the design and decoration of the service had been captured and people were supported to decide on how they wanted the service to be redecorated.

Respecting and promoting people's privacy, dignity and independence:
● Staff were knowledgeable about the care practice they delivered and understood how they contributed to people's health and wellbeing. We observed caring interactions where people's privacy, dignity and independence were respected.
● Steps were being taken to promote people's life skills and independence. The registered manager told us, "It is really important that as a staff team we support people to develop as many skills as possible. I'm currently looking into getting the kitchen adapted in one of the lodges so that the units are accessible at wheelchair level and we can start focusing on promoting people's independence with cooking."
● Staff were supporting people with day to day life skills. For example, staff were supporting people to fold laundry and staff had worked in partnership with one person who was now able to independently make their own cup of tea. One staff member told us, "We help them to develop the best skill to the best they can do."
● The registered manager and staff team recognised that ongoing work was required to embed a positive culture whereby life skills was part of every-day interactions.
● Confidentiality was supported. Information was locked away as necessary in a secure cupboard or filing cabinets. Computers and electronic devices used by the provider and staff were password protected to keep information secure.

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 Requires Improvement. This was because work was in progress to have a 'pool' of minibus drivers so that people could go out at times to suit them, for example, in the evenings. At this inspection this key question has remained the same. 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: 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:

- At the last inspection in December 2018, work remained in progress to ensure people had access to a pool of drivers to enable them to go out in the evenings. We advised that we would follow up this action at the next inspection. At this inspection, we found not enough improvement had been made.
- The service had a designated minibus and a driver who was employed five days a week. However, the service still only had access to a small pool of drivers which impacted on people's ability to access the local community in the evenings and weekends. The service was also located in a rural area which meant people could not readily access local transport and the availability of wheelchair access taxis was also limited. The registered manager told us, "It's really important that people access the community and we have been trying to source drivers, but it is difficult. Where possible we do book taxis in advance so that people's ability to access the community is not impacted upon."
- After the inspection, the registered manager advised that the service had sourced a new mini-bus. The registered manager commented that staff with a driving licence would be able to drive the new mini-bus as no additional driving qualifications were required. They advised that this would promote access to the wider community. Alongside this, the registered manager advised that the provider was now working with a dedicated transport company who provide wheelchair accessible taxis. The registered manager advised that the purpose of this company is to provide transportation to hospital appointments and social events. We will further report on these actions at our next inspection.
- Guidance produced by Social Care institute for Excellence advises that people living with a learning disability should be empowered to live ordinary lives and community inclusion should be promoted. People were still not routinely accessing the wider community in the evenings.
- Documentation reflected that people were supported to attend local church and hydrotherapy at one of the provider's other locations. However, people were not accessing the wider community on a regular basis. One person's care plan identified that they enjoyed going swimming, bowling, shopping and to the park. Their activity logs reflected that over a four-week period, they accessed the local community once.
- Three people received funded one to one support. Documentation and activity logs failed to demonstrate what support was provided during these allocated hours and activity logs demonstrated that despite the allocation of funded hours, access to the community remained limited. For example, one person who received funded one to one care was only accessing the community once a month. Another person with funded one to one care had their own mobility car. However, the lack of drivers at the service meant the person was unable to appreciate the benefits of having their own mobility car.

● We discussed the provision of funded one to one care with the registered manager after the inspection. The registered manager advised that due to one person's health condition, they could only sit out in their wheelchair for a couple of hours. The registered manager added that for another person they were prone to infections and if the person experienced a cold this prohibited their ability to access the wider community. Whilst the registered manager advised that certain barriers were in place, steps on what actions were being taken to overcome these barriers and ensure access to the wider community was promoted was not evidenced within the care planning process or within care documentation. Care documentation reflected over a three month period that staff supported these two people to access the wider community on less than six occasions, despite the provision of funded one to one care and despite one person having their own mobility car.

● The provider employed a dedicated activity coordinator who supported staff with the provision of activities and devised an activity programme. A range of external entertainers visited the service and on the first day of the inspection a country and western singer attended the service. Staff supported people to attend the music session, however, staff were unable to advise how people had been matched with the activity.

● People's level of participation in activities was not routinely captured or recorded. The activity coordinator told us, "If we try something new, we always seek people's feedback however that isn't always recorded." This information was therefore not readily available in the review of activities and social care plans.

● Guidance produced by NHS England and the Department of Health and Social Care 'Valuing People a New Strategy for Learning Disabilities for the 21st Century' advises that care and support should be personalised, enabling the person to achieve their hopes, goals and aspirations. The principles of registering the right support also focused on supporting people to set goals and achieve their potential. However, people living at Wisteria Lodge were not consistently supported to set goals or aspirations for the future.

● Before people moved into Wisteria Lodge, a pre-admission assessment took place, and this formulated the care plans. Care plans considered people's medical needs, social, physical and nutritional needs. Staff and the registered manager were in the process of updating and reviewing all care plans. Further work was required to ensure the care planning process was holistic, person centred and considered all of the person's needs.

The failure to provide centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other areas of care were responsive, and person centred. Staff and the registered manager had built links with the local barbers and hairdresser. People were supported to go into town to get their hair cut.

● Staff supported people to attend regular physiotherapy and hydrotherapy to ensure their mobility needs were maintained and promoted.

● Staff had built positive rapports with people and people responded to staff with smiles and laughter. One staff member was observed reading a book to a person. The person enjoyed the interaction and laughed along with the staff member.

● Staff were knowledge about people's interests and what was important to them. One person enjoyed listening to music and had a range of music instruments and items of importance to hand to engage with.

● Technology was utilised, and people enjoyed spending time using the computer. One person enjoyed looking at YouTube videos. The provider was in the process of developing a computer sensory room for people to use.

● The registered manager and activity coordinator were taking steps to ensure people lead meaningful lives. The registered manager told us, "We are still a work in progress, but the activity coordinator is now producing a report to identify how often people are going out and that will enable us to monitor how often people are accessing the community and if not, what action can be taken."

● Relatives spoke highly of the service and the provision of person-centred care. One relative told us, "My relative is very happy here. They enjoy the company of their peers and the staff and the activities that are on offer."

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 registered manager was passionate about ensuring people were empowered to learn new communication skills. The registered manager told us, "I've been working with SaLT to get people's communication skills assessed and consider what else we can be doing to promote people's communication abilities." Whilst people were beginning to receive input from SaLT to assess their communication needs, further work was required to ensure people's communication needs were consistently met.
● A number of people's care plans referred to the use of communication passports. Communication passports are a practical and person-centred way of supporting adults who cannot easily speak for themselves and require assistance with communication. We asked one staff member to show us one person's communication passport, they returned with the person's hospital passport. The staff members understanding of what the communication passport was and how to use it effectively was limited.
● One person was supported with a communication assessment in June 2019 which identified that staff could support the person with learning a couple of Makaton signs (form of sign language) and for staff to implement a communication tool. These recommendations had not been followed up. This was because staff were unable to demonstrate what steps had been taken to support the person to learn some new Makaton signs and not all staff had received training on the use of Makaton. Whilst steps had been taken to support the person to receive a communication assessment. The impact of that assessment was minimal as not all staff had the right training and the recommendations made were not being followed.
● Throughout the inspection, we observed several positive examples where staff interacted and communicated with people in a person-centred manner. This approach was not consistent. We observed one interaction whereby a staff member removed an item of importance from a person without explaining why. This caused the person distress. We also observed an interaction where a staff member removed a person's jumper without explaining why or asking if they would like their jumper taken off.
● Staff's knowledge of people's individual communication needs varied. One person's care plan identified that if they made an 'L' shape with their fingers that meant they were unhappy. Staff however, told us that if the person made an 'L' shape with their fingers that meant they were happy, and the sign of distress was the individual moving/flicking the 'L' shape at their temple. Staff's knowledge of how the person communicated varied to the information documented within their care plan. For new members of staff or agency staff this meant they would be unable to communicate with people in a responsive and effective manner.
● People's involvement with their care plan was limited. Whilst monthly care plan reviews took place, it was not always recorded how people were involved in that process and how information was provided in an accessible format. After the inspection, the registered manager advised that steps were being taken to involve family members and people in the design and formation of their care plan. Further work was required to embed and roll out this way of working.

The failure to meet people's communication needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Steps had been taken to display information in an accessible format throughout the service. This included

the activity programme being displayed in pictorial format alongside the daily menu. Meeting minutes were also made available in pictorial and easy read format.

Improving care quality in response to complaints or concerns:

● A complaints policy was available, and a copy was also available in a format which was accessible for people. There was a log of all complaints and the actions taken by the management team. Complaints received had been reviewed, investigated and feedback provided within a dedicated time-period.

● Relatives told us that they felt confident in raising any concerns and felt that any concerns raised would be acted upon. One relative told us, "I'd be happy to raise concerns. I know that the manager has nothing to hide and tells us how things are."

End of life care and support:

● No one was receiving end of life care at the service at the time of the inspection.

● Forward care planning meant staff had thought about people's wishes as they were growing older. Staff had developed end of life care plans which considered treatment people might wish to have and any specific needs staff needed to be aware of.

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 Requires Improvement. This was because audits were not consistently robust in driving improvement and identifying shortfalls. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- At the last inspection in December 2018, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the providers governance framework was not consistently in robust in driving improvement and addressing shortfalls in the provision of care. At this inspection not, enough improvement had been made and the provider remained in breach of Regulation 17.
- Care plans were reviewed on a regular basis, however, these monthly reviews failed to identify shortfalls with documentation or identify how the care planning process could be improved.
- Care plans were not consistently detailed and lacked clear information on how to safely and effectively support people. One person's care plan referenced that they may self-harm. Guidance was not available on how that behaviour might present and the actions required of staff. Staff were unable to explain how the individual might self-harm. Incident and accident documentation reflected no recent incidents of self-harm. However, the lack of guidance meant staff may not recognise or respond to this behaviour appropriately.
- Robust systems were not in place to share learning at an organisational level. Concerns found at this inspection around epilepsy management, behaviours which challenge, and provision of community-based activities have been highlighted in inspection reports about many of the provider's other services. This information had not led to similar risks to people at Wisteria Lodge being reduced.
- The provider's wider governance system was not consistently robust in identifying shortfalls and driving improvement. Internal audits failed to identify a number of shortfalls. For example, the provider's service improvement plan failed to reflect the service's issues with lack of drivers and the steps being taken to address the concern. The service improvement plan also failed to reflect that not all staff had received Makaton training and that people were not routinely accessing the community.
- Service management and the provider's wider governance systems had not always ensured actions were taken to address any issues and risks in a timely manner. The provider's service improvement plan reflected that compliance with the MCA 2005 had been ongoing since November 2018. At this inspection, we found ongoing concerns with the provider's ability to sustain compliance with the Mental Capacity Act 2005.

The failure to ensure quality assurance and governance systems were effective was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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:

● Staff spoke highly of the improvements made at the service under the leadership of the new registered manager. One staff member told us, "I'm very thankful for the new manager. There has been a lot of improvements. People are now involved more in the running of the service and we are promoting life skills." Another staff member told us, "The manager is open to new ideas and giving things a go. I can go to her with suggestions and she's happy for me to try them."

● Relatives spoke highly of the registered manager's leadership skills. One relative commented, "The manager is brilliant. She tells it as it is and doesn't hide anything." Another relative commented, "The new manager is marvellous and against the odds had done very well. She has given the staff confidence, so they are more relaxed and happier and made clear what each person's job is and is good at delegating."

● The management team were committed to improving and developing the service. They were open and honest about the work still required but expressed dedication in improving the overall quality of care provided. The registered manager told us, "I've got a good strong team here and we've been focusing on revising the paperwork."

● Systems and forums had been implemented to involve people in the running of the service. The activity coordinator held regular meetings with people and supported people to make decisions on how they wanted the service to be decorated. The registered manager was exploring ways of involving people in the interview process for potential new staff.

● Forums were now in place to engage and involve relatives. The registered manager told us, "I've set up monthly relative meetings and have held them at various times as I recognise that during the day a number of relatives will be working." Relatives spoke highly of these meetings. One relative told us, "We definitely feel more involved since the manager came into post. She's a great manager and leads by example."

● Staff were empowered to bring forward ideas and make suggestions on the running of the service. Regular staff meetings were held and provided a forum for staff to discuss any concerns or raise new ideas.

● The provider had a mission statement and set of values in place which governed the day to day running of the service. Steps were being taken within the organisation to review these values and for staff to be involved in designing the new governing values. In November 2019, the registered manager held a staff meeting whereby staff were asked to discuss what values were important to them. Staff also considered their visions for the service for the next six months. The registered manager told us, "The staff have been great since I came into post. As a team they even wrote a poem about how they would support people, the poem was called 'our promise."

● People, relatives and staff spoke highly about the management of the service. Satisfaction surveys were sent out to relatives to gain their feedback. Recent feedback from relatives demonstrated that they were happy with the care provided. Comments included, 'The staff are devoted to the residents and make every effector to enable them to live in a varied and fulfilled life within their capabilities. We wouldn't want her to be anywhere else.' Another comment included, 'One thing for certain is that we would not entrust the care for our daughter to anyone else as she could not be in a better place.'

● The management team provided regular newsletters to relatives providing updates on recent activities and outings. Newsletters were also provided to the staff team providing key information on organisational updates.

● Links with the local community were in the process of being established. People were now accessing local hairdressers and barbers and the registered manager was trying to build local links with schools in the nearby area. Ongoing work was required to further strengthen community links.

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 management team understood their responsibilities under the duty of candour and had kept relatives informed when something had gone wrong.

● The CQC's rating of the home, awarded at the last inspection, was on display at the home and on the provider's website.

●The provider's chief executive officer and nominated individual told us about a new governance and quality assurance framework that was being developed to help ensure quality and safety issues would be identified and addressed effectively. There were plans to implement improved IT and technology resources for staff and management, to enable timely information sharing and good quality care delivery. Work was currently underway to invest in recruiting and retaining staff.

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
Treatment of disease, disorder or injury	The care and treatment of service users was not appropriate, did not reflect their preferences and did not meet their needs. Regulation 9 (1) (a) (b) (c)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Care and treatment was not provided in a safe way for service users. Regulation 12 (1) (2) (a) (b)

The enforcement action we took:

We served a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems and processes were not operated effectively to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) 2014. Regulation 17 (1) (2) (a) (b) (c)

The enforcement action we took:

We served a warning notice