SHC Rapkyns Group Limited

Wisteria Lodge

Inspection report

Horney Common
Nutley
Uckfield
East Sussex
TN22 3EA

Tel: 01825714080
Website: www.sussexhealthcare.co.uk

Date of inspection visit:
25 November 2020
26 November 2020

Date of publication:
19 February 2021

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Wisteria Lodge is a residential nursing home providing personal and nursing 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 19 people living at the service. There were two lodges (Wisteria Lodge and Stable Lodge) which made up the service. Each lodge had its own dining area, lounge, nursing station and medicines room and kitchenette. People had their own rooms and they were en-suite.

Wisteria Lodge is owned and operated by the provider Sussex Healthcare. Services operated by the provider had been subject to a period of increased monitoring and support by local authority commissioners. As a result of concerns previously raised, the provider is currently subject to a police investigation, though this does not specifically involve Wisteria Lodge. The investigation is on-going, and no conclusions have yet been reached.

People's experience of using this service and what we found
People were not receiving safe care and treatment. Risks around people's behaviours of concern, constipation, epilepsy, positioning, unexplained injuries, choking, and monitoring people's health needs were not being managed safely. Systems to protect people from possible neglect or abuse were not effective.

Medicines were not being managed safely, such as poor stock control for some medicines and people not receiving medicines as directed by their doctor. Staff did not have the competencies to support people with behaviours that may challenge others.

Lessons had not been learned consistently. There had been a high number of bruises and injuries to people, and this had not been picked up in audits or lessons learned. The culture at the service was not always person centred. Outcomes for people were not positive and there were times we saw people supported in a way that was not safe.

At the time of our inspection the registered manager was off sick, and the clinical lead was overseeing the service. Both left the provider's employ shortly after our inspection meaning there was no registered manager in day to day charge of the service. The clinical lead in post at the time of our inspection had also left shortly after our inspection. Following our inspection, we were informed that a registered manager had been seconded from the management post of another service, and the provider was actively recruiting to the vacant registered managers post.

Audits had not been effective in highlighting issues found at this inspection or improving the care and support people received. Management of the service was ineffective and had not ensured improvements were made.

The provider had not worked effectively with all partner agencies. There had been safeguarding incidents that had not been alerted to the local safeguarding adults team or notified to CQC. Local health teams had not always been made aware of people's changing needs.

The provider was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture at Wisteria Lodge. People's experience of care was not always person centred such as at mealtimes. The model of care and setting did not maximise people's choice, control and independence. Staff wore uniforms and name badges to say they were care staff when coming and going with people. The service is bigger than most domestic style properties. There were identifying signs on the road before the service's private drive, the service grounds and on the exterior of the service to indicate it was a care home.

Right care:
Care was not always person-centred or promoted people's dignity, privacy and human rights.

People were not supported safely.
People were not always listened to.
Staff did not always respond in a compassionate or appropriate way when people experienced pain or distress.

Right culture:
The management team had left shortly after our inspection and a new team had been put in place.
There were times we observed care and support that was not indicative of a person-centred culture, such as one person asking repeatedly for an extra drink and staff not responding to them.
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 requires improvement (published 9 September 2020).
At the last inspection we found multiple breaches of regulations. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

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

We carried out an unannounced comprehensive inspection of this service on 28 and 29 January 2020. Breaches of legal requirements were found, and we served a warning notice. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Wisteria

Lodge on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, safeguarding people from abuse, good governance, and staffing at this inspection.

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 continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not 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.

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

Inspection team
The inspection was carried out on both days by two inspectors.
Wisteria Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Service and service type:
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
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection-
We spoke with six people who used the service and four relatives about their experience of the care provided. We spoke with nine members of staff including the deputy manager, registered nurses, senior care workers, and care workers. We also spoke with the chief operating officer, the clinical lead and the provider's nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included two 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 policies and procedures were reviewed.

After the inspection
We reviewed copies of people's care plans and records, training records, rotas, incident reports and audits. We spoke with the chief operating officer, and the provider's nominated individual. We also spoke with two support workers, two registered nurses and four relatives of people using the service via telephone.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● At the last inspection in January 2020, we found a continued 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. At the last inspection we also served a warning notice in relation to risks around people's epilepsy and their behaviours that may challenge others. At this inspection the warning notice was not met.

● Some people were not kept safe from the risk of choking. We observed one lunch service where a person was given food in a way that was not in line with their current speech and language therapy (SaLT) guidance. By failing to follow guidance the person was at a higher risk of choking. We asked the provider to raise a safeguarding alert for this.

● Other people were not supported in the way set out in their SaLT guidance. For example, some people were given heaped spoons of food instead of level spoons. A level spoonful had been directed to reduce the risk of choking.

● Other people were supported by staff who did not follow people's eating and drinking guidelines. For example, one person was supported using incorrect equipment, an unsafe portion size, was supported at an unsafe speed, had their head tipped back when given drink when their head should be level, had the drink given too quickly, and other people were given their meal before them. These actions increased the risk that people with swallowing difficulties may choke.

● One person received their food via feeding tubes. Their care plans did not effectively describe the risks of choking or breathing liquid in to their lungs. The person was supposed to be elevated to 30 degrees to reduce the risk of choking but there were instances where they were recorded as being at 15 degrees whilst receiving personal care. We spoke with staff who described the process but did not refer to any angle at which the person should be safely placed at. This left the person at risk from aspirating [breathing particles in to the lungs].

● The same person had a respiratory decision tool that identified them as low risk despite other care plans identifying the person was prone to aspiration, leading to chest infections. We discussed the respiratory decision tool with the providers' physiotherapist. They agreed that the form needed to be redesigned. This form was confirmed to have been redesigned after our inspection.

● Some people had behaviours that may challenge others. The risks associated with the safe management of these behaviours was not being managed effectively, or in line with best practice. For one person, noise had been identified as a reason they could become stressed and trigger an epileptic seizure. Staff were directed to ensure the person had a calm environment and follow the persons positive behaviour support (PBS) plan. A PBS plan is a document that explains how a person needs to be supported when they are

experiencing high anxiety and could be challenging, and how to reduce the chances of this happening in the future.

● We observed the person being supported in environments that were noisy and stressful. Staff we spoke with were not aware the person had a PBS plan. One staff said, "There is no PBS plan as we don't have behaviours with [name]". This put the person at risk of unsafe care around their epilepsy needs and behaviours of concern.

● Another person was observed to display distress indicators. They had a PBS plan, but we did not observe staff following the directions within that plan. This meant the person was at risk of being repeatedly distressed, or distressed for longer periods of time.

● The same person was given pain relief medicine when in distress. The nurse had not first checked that staff had followed the protocol for managing the person's behaviours. This meant the person may not have needed medicine for pain relief, but support with their distress. A third person was distressed during a lunch service and did not receive dignified or caring support from staff.

● People with a learning disability may be prone to constipation and at risk from the effects of poor bowel care. Some people at Wisteria Lodge did not receive safe care with their constipation needs. One person with constipation had been prescribed 'as required' medicines to relieve the condition.

● We spoke with the clinical lead about how the person's care documents were not clear about when to give this medicine. The clinical lead described a process for administering laxative medicines for this person that was different to what was written on the care plans and agreed the care plans needed to be changed. The person had not received their as required constipation medicine in line with the care plan or what the clinical lead described. This left the person at risk of suffering poor bowel care.

● A second person had 'as required' medicines to treat constipation and had not always received these as directed. On one occasion they received their medicine too early and on two occasions they had it later than directed. Not receiving constipation medicines as directed leaves people at risk of poor bowel care.

● Some people living at Wisteria Lodge were diagnosed with epilepsy. One person had experienced a type of seizure recently. Care plans did not say if the person should have their rescue medicine when they had this type of seizure, of how it should be given. We spoke with a registered nurse who told us they would give rescue medicine. This nurse also accepted that care plans were not clear.

● We raised this with the clinical lead who told us that the person would not be given rescue medicines for this type of seizure. The clinical lead acknowledged there was no direction around this and re-wrote the care plans. The lack of clear care plans and nurses telling us they would take different action meant the person was at risk of not receiving the correct care with seizures.

● There were many injuries to people. We reviewed incident and accident forms from July 2020 to November 2020 and there were 24 injuries such as bruises, scratches, cuts and marks. We asked the physiotherapist based at the service whether they felt this was a high amount, given that people were reliant on staff to move safely. The physiotherapist acknowledged the high number of the same kind of incidents happening and the need for a review of training with regard to manual handling, nursing, and how equipment was used.

● We raised these injuries and bruises as a concern with the provider who told us they would review them and check if any learning could be shared with staff.

● People who were prone to deteriorating health were assessed as needing to be monitored with a tool called the National Early Warning System (NEWS). NEWS is a standardised system for recording and assessing baseline observations of people to promote effective clinical care. This involves taking a baseline for a person's normal temperature, pulse rate and oxygen saturations. It then states what actions should happen if results are recorded outside of the baseline. Not all NEWS charts were followed up when people had scores above their baselines. An increased NEWS score could indicate a deterioration in health, so not following up an increased score left people at risk of not receiving assistance if their conditions deteriorated.

● People were at risk of skin breakdown. Some people slept on air mattresses, with pumps that are set to each person's weight, to reduce the risk of pressure damage to skin. We found three people's mattresses were set to the wrong weight. This put people at risk of skin breakdown.
● Two other people were at risk of skin breakdown and their care plans set out the frequency their continence pads should be changed. If people are left in used continence pads for too long they can be at risk of skin breakdown. Both people's care plans indicated they should have their pads changed every four hours, but this frequency was not being met. For one person they were left in one pad for between six and seven hours. This left people at risk of skin breakdown. Following our inspection, we were told by the provider that an additional staff member had been added to the rota to help with personal care.
● Other risks were not being managed safely. Some people needed to be positioned in a certain way .. One staff told us a person bent one knee under their other leg, so staff had to be very careful when turning them in bed. This was not in care plans and risk assessments. If the person was being supported by agency staff there is a risk the person could be injured.
● The same person had a risk of choking and needed to be at a certain angle when in bed, to reduce the risk of fluid entering their airways. Staff told us there were markings on the bed, so the correct angle was achieved, but when we went to check the person's room with the staff there were no markings or pictures to say how the head of the bed should look. The staff acknowledged this, and said they just raised the bed by eye rather than using the bed markings as there were no markings for staff to use. This placed the person at risk of choking from staff not raising the head of the bed enough.

Using medicines safely
● Medicines were not being managed safely. There was not an effective stock control in operation. Medicines in tablet form were not being counted and no staff knew how many tablets there were for some people. We spoke with a registered nurse about the tablets in stock for one person and whether they would know if any were missing. The nurse told us, "There is no way for anyone to know."
● A second person had been prescribed 'as required' medicines to treat constipation. The clinical lead was unable to explain why the stock in the medicines cupboard did not match the stock records that they had kept. Poor stock control leaves people at risk of not having their medicines when they need them.
● People were at risk of not having their medicines as directed by their doctor. One person with a diagnosis of reflux was prescribed a medicine to treat this condition. This medicine was directed to be taken after mealtimes. However, staff were giving it before meals. As this was against direction we raised this with a nurse, who said they would speak to the person's GP.

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

Staffing and recruitment
● Not all staff had the competencies and skills to support people safely. Staff had not received training in positive behaviour support. This had affected how people were supported. For example, during one lunch service we saw one person clearly displaying distress indicators. Their care plan confirmed this behaviour means they are distressed. However, staff dd not respond in the way set out in the person's care plans.
● We discussed the lack of PBS skills for staff with the provider's nominated individual who confirmed that staff had a basic understanding but not an in depth understanding. The nominated individual outlined the recruitment plans to bring PBS specialist staff in to the organisation and upskill staff. However, in the meantime, there was a risk that people's distress was not being managed safely and staff and people may be at risk of injury.
● We spoke with a professional involved with providing care for people in the service. They highlighted there was a lack of staff skills and training around understanding swallowing difficulties.

● Some people living at Wisteria Lodge were funded for physiotherapy and hydrotherapy. Hydrotherapy sessions were not taking place due to restrictions related to Covid-19. However, people were not receiving their assessed level of physiotherapy sessions. For example, one person was scheduled for four physiotherapy sessions a week but had only had seven in the whole of October 2020. We raised this with the provider's physiotherapist who told us, "We have a spreadsheet that says how many hours people need. Only some people are getting what is on the sheet." This was due to a lack of physio staff and the need for assessments to be completed.
● Following our inspection, we were told by the provider that an additional member of staff had been added to the rota in response to concerns raised. The additional staff was to be part of daytime support to assist with personal care.
The failure to deploy enough staff with relevant skills, competence and experience to care for people safely is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse, and learning lessons when things go wrong.
● Systems had not always been effective in keeping people safe from the risk of abuse. For example, we found an incident where a person alleged money had been stolen from them. This was not reported to CQC or the local authority at the time of the incident, as required. The incident form had not been completed fully or shared with the providers' quality team for review. This meant that any learning may not have been shared with staff. Following our inspection, we were told that the money had been found.
● Our inspection was prompted in part by concerns shared with us from whistle blowers.
During the inspection we found a high number of injuries and bruises to people that could indicate issues with moving and handling people. The provider was not aware of the high number of injuries, meaning patterns or learning had not been identified.
● The service was the subject of an organisational safeguarding enquiry to examine widespread concerns about people's safety that were identified at this inspection. The provider was working with the local authority and partner agencies to ensure people's safety.
● At our previous inspection we served a warning notice around positive behaviour support and epilepsy. At this inspection, despite some improvements in some people's epilepsy care, we found concerns remained for one person's epilepsy care and widespread concerns around people's behaviours. The lack of effective learning left people at a serious risk of neglect.
The failure to implement systems that effectively prevent abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

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

Inadequate

Is the service well-led?

Our findings

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

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

Continuous learning and improving care

● At the last inspection in January 2020, we found a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the provider's governance framework was not consistently 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. At the last inspection we also served a warning notice for a lack of good governance and quality auditing systems. At this inspection we found the warning notice was not met.

● Following our last inspection, we served a warning notice relating to risks around positive behaviour support and epilepsy. The provider sent us an action plan setting out how they would reduce these risks. Despite their being evidence that some concerns around two people's epilepsy had been addressed at this inspection we found that widespread concerns around behaviours remained, and one person identified in our warning notice still did not have care plans that met all the risks around their epilepsy, and so the warning notice was not met.

● The provider had sent a service improvement plan following the warning notices being served. It identified actions had been completed such as around peoples' behavioural plans and epilepsy care plans. At this inspection we found those actions had not been complete or effective as people's support was not safe in terms of behaviours or one person's epilepsy.

● Wisteria Lodge had not been rated as Good in well led for four previous consecutive inspections going back to 2016. This is the fourth consecutive inspection that the provider has been in breach of Regulations 12 and 17 relating to safe care and treatment and good governance. Following each of these inspections we were sent an action plan setting out how the provider would ensure improvements were made. At this inspection we found a deterioration in quality and safety and the service has been placed in special measures.

● People with behaviours that may challenge others had ABC charts. ABC charts are used to track what happens before, during and after an incident to learn from them and reduce future instances of behaviours of concern. We were not assured that ABC charts were being monitored effectively. There was no systematic review of incidents by managers, that would lead to a change in how a person was supported. This left people with behaviours that may challenge others at risk of not receiving safe support.

● At this inspection we found people were still not consistently safe from a range of risks, including risks related to constipation, epilepsy, behaviours that may challenge others, unexplained injuries, choking, and monitoring people's health needs. Staff did not have the competencies to support people with their behaviours, and people were not being protected from neglect or abuse, as systems to protect them from possible abuse were not effective.

● The provider's quality audits had not been effective in identifying areas of concern, or in responding to concerns we had previously identified. There had been an external quality audit commissioned by the provider in January 2020 that had highlighted concerns that we still found in place in November 2020.
● The external audit had highlighted a lack of analysing incidents to spot patterns and learn lessons. During our inspection we highlighted a high number of bruises and injuries to people that could indicate poor moving and handling. A tracking and analysis of this had not been completed despite a high number of injuries having been identified in one of the provider's risk and clinical governance meetings in August 2020.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● During our inspection the provider brought in additional management resource to the service in response to our concerns. Following our inspection, the registered manager left their post and had deregistered with CQC. This meant there was no registered manager in day to day control of the service.
● We spoke with the provider about the management of the service and they acknowledged that the audits were being completed but were not picking up issues and were not of the correct quality. The provider assured us that new management were overseeing the service and they were actively recruiting to the registered manager's post.
● Concerns about risks associated with: constipation, behaviours of concern, choking, epilepsy management, feeding tubes, staff competencies and auditing had all been highlighted to the provider previously at Wisteria Lodge and others of their services. This information had not been properly shared or used to improve safety and care at Wisteria Lodge.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Not all support was person centred or inclusive. We reviewed people being supported during lunch services and activities. One person was not responded to in a caring or person-centred way when they were distressed. They had been asking for a drink and were not responded to by staff in a positive way. In the end the person was removed from the lunch table without having the extra drink they were requesting.
● A second person did not have a positive experience when being supported with an activity. They were told they could not bring a certain item to the table and became distressed. This was then repeated to them causing further distress. This could have been managed in a more sensitive way to reduce the impact on the person.

Working in partnership with others
● We were told by a visiting health professional that they had been unaware of a significant deterioration in one person's presentation. During a visit to the person the professional had previously assessed the person in February 2020 and then noticed a significant deterioration during a visit in October 2020. This deterioration had not been fed back to the professional involved in their care over the summer. This put the person at risk of not receiving safe or effective care as their needs changed.

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.

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
● Relatives told us that they were contacted when there had been developments in their loved ones' care. One relative told us, "Yes we are [kept informed]. We get regular updates by emails." The relative told us

about how the service kept them involved and had difficult conversations with them when their loved one tested positive for Covid-19.

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

● We spoke with the provider's nominated individual about how families have been involved. The nominated individual told us, "We hold family meetings and some families have strong relationship with each other we have open forum." The provider had sent referrals to speech and language therapists and was working with families on the best way to support people with their communication.

● There were weekly meetings with people, and they were involved in meetings around health and safety. Plans were in place to involve people in risk and clinical governance meetings.

● Staff were involved in developing the service. The nominated individual told us, "We asked staff what would improve the service for them or people we support, and they came back with an upgraded sensory room and IT room. This has been provided now."