

Mr & Mrs S Wortley

Wisteria House Residential Home - Somerset

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Wisteria House Residential Home is a care home which is registered to provide personal care to 13 people. The home offers care to older people. Since the last inspection the provider has installed a passenger lift, which makes access to some areas easier. However, the house is an older style building set over two floors and some rooms may not be suitable for people with mobility difficulties. The management team considered the nature of the building when assessing people who wished to move in, to ensure their needs could be met. There were 11 people living at the service at the time of inspection.

People's experience of using this service and what we found

People and their relatives told us they felt the service was safe and people received a good standard of care. Comments included, "The care is very good, they look after us very well"; "We are looked after very well – almost as if we were family" and "The home runs very well and there is good communication between the home and the family". However, we found several areas that required improvement.

Staff were not using personal protective equipment (PPE) as per the Government guidance, which put people at risk of infection.

We identified the provider had not ensured all aspects of the environment were safe. For example, fire safety risks had not been addressed. Recruitment practices were not carried out robustly to ensure potential employees were suitable to work at the service. Some aspects of medicines management were not safe.

People were supported by staff who knew them well, however, we have recommended the provider review the number and deployment of staff on duty to ensure individual needs are met.

The premises were in need of some redecoration and refurbishment to ensure it met people's diverse care and support needs, especially those living with dementia.

The service was not always person centred. There was a lack of social opportunity and engagement for people, especially people living with dementia.

The registered provider did not have effective governance systems in place to maintain and improve the quality and safety of the service. Analysis of accidents and incidents were brief in detail and did not show clear evidence patterns or trends were being identified.

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

Rating at last inspection (and update)

The last rating for this service was good (Published 09 July 2019).

Why we inspected

This inspection was prompted due to concerns received about moving and handling practice; the management of pressure ulcers and continence care; concerns that nutritional needs were not being met; people not having access to call bells and overall management of the service. A decision was made for us to inspect and examine those risks. We found evidence during this inspection that people were at risk of harm from some of these concerns.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

This report only covers our findings in relation to the key questions of safe and well-led which contain those requirements and concerns. Prior to the inspection we reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We found evidence the provider needs to make improvement.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Wisteria House Residential Home on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified three breaches of regulation in relation to people's safety, infection control, recruitment and governance at this inspection.

We served the provider with a letter of intent under Section 31 of the Health and Social Care Act 2008, to warn them of possible urgent enforcement action in relation to infection prevention and control practice. We told the provider that we were considering whether to use our powers to urgently impose conditions on their registration. The effect of using Section 31 powers is serious and immediate. The provider was told to submit an action plan within four days that described how it was addressing the concerns. On receipt of the action plan we undertook a review and were assured by the actions the provider had taken.

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 for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

Wisteria House Residential Home - Somerset

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

This inspection was carried out by one inspector and an Expert by Experience.

An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Wisteria House 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.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

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 reviewed information we had received from the provider and feedback from local professionals. We used all of this information to plan our inspection.

During the inspection-

We met with most of the people living at the service and spoke with six people and three relatives about their experience of the care provided. We spoke with four members of staff including the registered manager, operations manager, and care workers. We also spoke with two visiting community nurses. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included three 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 continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We requested feedback from six professionals and received feedback from two who regularly visits the service. We contacted the Somerset Clinical Commissioning Group Infection Prevention & Control team, who offered support and advice to the registered manager and provider.



Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

- The provider had failed to ensure risks relating to infection prevention and control (IPC) including those relating to COVID-19 were being managed safely at Wisteria House. This put people at the risk of infection transmission.
- We were not assured that staff were using personal protective equipment (PPE) effectively and safely. Government guidance in respect of the use of PPE was not being followed.
- Staff were not wearing masks as recommended when in close contact with people using the service. The operations manager said masks had not been used for several months as they impacted on people's communication and general wellbeing. No risk assessment had been completed about how the decision had been made.
- The infection control policy was not appropriate for the service. The policy did not state that staff were always required to wear masks, as per current guidance.
- Most parts of the service were clean. However, records in relation to cleaning tasks were inconsistent, with several gaps. Records did not confirm that frequently touched points were regularly cleaned to prevent cross infection.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We issued an urgent letter to the provider requiring them to complete and send an action plan, setting out how they had already addressed the concerns identified in relation to the use of PPE, or how they intended to address them immediately. The provider confirmed that immediate action was taken and staff were wearing masks as per the Government guidance.
- We made a referral to the Somerset Clinical Commissioning Group Infection Prevention & Control team. They visited the service following the inspection to provide advice and support. We liaised with the local authority to ensure concerns were shared and the registered provider could be supported to implement and embed consistent and safe infection control principles.
- We were somewhat assured that the provider was meeting shielding and social distancing rules.
- We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was admitting people safely to the service.

- We were assured that the provider was accessing testing for people using the service and staff.
 - We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
- We have signposted the provider to resources to develop their approach.

Staffing and recruitment

- The provider had not followed safe recruitment practices to ensure prospective staff were suitable to work at the service.
- Satisfactory evidence of conduct in previous health and social employment had not been obtained. There were no references on file for one member of staff from their former employers.
- A record of a satisfactory Disclosure and Barring Service (DBS) check could not be found for one member of staff.

These findings evidence a breach of Regulation 19 Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People living at the service said the staffing levels mostly met their needs and requests in a timely way. Comments included, "I don't have to wait too long for someone to come and help" and "I am looked after very well really. I can get up whenever I want to but it's always early, I'm an early riser!"
- There were three care staff on duty from 7am until 2pm and two care staff from 2pm to 9pm. Care staff were responsible for daily cooking and laundry duties. Staff were also responsible for cleaning duties as the cleaner worked three hours per day, Monday to Friday. This meant at times, only two staff were available to provide care and support for 11 people.
- Three people required two staff to safely assist them with moving and handling and personal care. This meant, there was a lack of staff presence in communal areas at times.
- The activities person had left the service and care staff tried to offer some daily group activity. However, we saw that people were often unoccupied or sleeping in communal areas. One person told us, "We have the TV on but it is more to relieve the boredom as no one really watches except at certain times."
- Staff said the staffing levels "usually worked well" but added, "Some days can be manic." The service was recruiting for one vacant care staff post.

We recommend the provider review staffing levels and the deployment of staff to ensure people's needs were met in a timely way.

- Staff training was not fully up to date. The operations manager explained the training programme had been impacted by the pandemic. The operations manager was aware that staff required some refresher training, including moving and handling, medicines management, infection control and safeguarding. Planning to address this was underway.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Fire safety was not well managed. Weekly fire door checks had been carried out; however, we found several fire doors did not close properly, including the kitchen and laundry doors. One person's bedroom door was propped open with a commode. This meant the doors would not have prevented the spread of fire or smoke in the event of an emergency.
- Personal evacuation plans were in place; however, the main evacuation list had not been updated to ensure it contained accurate information.
- Many rooms did not have names or numbers, and some had been changed by hand, using a pen, making it confusing. This meant locating a certain room or resident in the event of an emergency could be difficult, especially for emergency services staff, who would not be familiar with the building.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the provider confirmed that several fire safety doors were being replaced.
- Prior to the inspection concerns were shared with us about unsafe moving and handling practice. Some staff training was overdue, but this was being planned and the service had two staff who were trained moving and handling trainers.
- Risks to people's health and wellbeing were assessed and integrated into individual care plans. However, where people required equipment to help them move safely, there was no assessment or record of what equipment was being used. For example, the hoist and sling type. However, staff were familiar with people's needs and we observed staff assisting people in a safe and unhurried way when moving about the premises or when transferring.
- To improve access for people living at the service, the provider had invested in a new passenger lift to replace the old one.
- Concerns were shared with us about the management of pressure ulcers. Two people had pressure damage at the time of the inspection. The operations manager said one person had developed pressure damage while in hospital.
- Where people were at risk, pressure relieving equipment was in place, for example mattresses and cushions. However, care records did not mention the use of the pressure relieving equipment or action for staff to take to reduce the risk of pressure damage. Mattresses were monitored by the community nurses to ensure they were set correctly.
- Concerns were shared with us about people's diet and nutrition and possible weight loss. Records showed most people's weight was stable or had increased. Two people were at risk of weight loss, both received supplements and their weight was monitored regularly. A health professional confirmed that any concerns about weight loss were discussed with the local GP team and action taken to address the risk.
- People confirmed they liked the food on offer. Comments included, "I enjoy the food. It is very nice, and they tell you what is for lunch and tea etc" and "The food is good."
- Accidents and incidents were recorded and checked by the registered manager or operations manager to see if changes needed to prevent re-occurrence. However, there was no overview of accidents and incidents to help identify any general trends or patterns.

Using medicines safely

- People received their medicines as prescribed. Medicines were stored securely and at the correct temperature.
- Handwritten entries on people's medicine administration records (MAR) were not signed and dated. This meant staff were not following best practice guidance.
- Protocols for the use of 'as required' (PRN) medicines were not in place to ensure these medicines were used effectively.
- Topical cream administration charts were in place but not always completed to demonstrate people had their cream applied as prescribed. There were limited instructions for the use of some creams, for example when, where and how to use.
- Medicines, such as creams, with a limited effectiveness once opened were dated on opening to ensure they were used appropriately. However, we found one cream preparation which was out of date. This was disposed of immediately.
- The last pharmacy advice visit, in May 2019, made some recommendations but no major issues were found.

We recommend the provider follow the National Institute for Health and Care Excellence (NICE) guidance for Managing medicines in care homes.

Systems and processes to safeguard people from the risk of abuse

- People said they felt safe at the service. Comments from people and their relatives included, "I have called for help and they have reassured me when I am struggling"; "The care is very good here. We have nothing to complain about as they look after us so well" and "I think Dad is very safe as he is always very happy and praises the staff".
- Records showed staff had received safeguarding training. Those spoken with were able to identify the types of abuse they may witness. They were aware of their responsibility to report any concerns to the registered manager. Staff were less sure of the external agencies to report any safeguarding issues to. For example, the local authority. However, they said if their concerns were not dealt with they would contact the Care Quality Commission or the police.

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The registered manager and provider did not have the required oversight of the service. The registered manager was registered with the CQC at another location. They divided their week between both services. They confirmed they spent one day a week at Wisteria House. They hoped to establish a more structured approach to managing the two services.
- To reduce the risk of the spread of infection during the COVID-19 pandemic, the provider had not visited the service as often as they usually did. They had relied on the information and audits completed by the registered manager or operations manager.
- Organisational policies and procedures and government guidance were not consistently followed to keep people safe and deliver high quality care. Checks and audits of the service had not been effective and did not identify the shortfalls found at this inspection. For example, the management of infection prevention and control; fire safety issues; the shortfalls in staff recruitment processes and medicines management.
- The registered manager shared a 'service improvement plan'. This was dated February 2020. This referred to refreshing and improving the décor and general maintenance, as well as maintenance of fire doors. The improvement plan aimed to "increase level of general maintenance; decrease time to resolve issues and improve the environment". There were no end dates on the improvement plan, just a comment saying, "on-going". Little work had been completed to improve the environment.
- Several areas of the environment required refurbishment and redecoration. Some flooring was stained and worn, including some carpets; the area at the main entrance and the area around the newly installed lift.
- Only one bathroom was in use for 11 people. The operations manager explained people did not like to use the first-floor bathroom. However, there was no explanation as to why and no work completed to make the bathroom more attractive and easier for people to use.
- Staff and one relative identified the general environment as needing some improvement. Comments included, "It is homely but looking a bit tired in places now" and "Redecorating would be good to bring it up to standard". A professional said, "It is very old fashioned - been going for years and hasn't changed the fabric of the building at all".
- Accident or incidents were recorded, however, there was limited evidence to suggest lessons were learned as the analysis of incidents was brief and did not identify patterns or trends. This meant opportunities for learning may have been missed.
- Not all records were accurate or contemporaneous. The duty rota did not reflect the hours worked at the

service by the registered manager or operations managers. This made it difficult to confirm accountability and who was working at the service on any given day.

The provider and registered manager had failed to operate effective systems to assess, monitor and improve the quality of the service people received. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

- Partnership working with some health care professionals had deteriorated. One professional described the "defensive" approach of the management team when issues were raised with them. They said, "We want to foster a good working relationship, but when issues are raised, they (managers) can be defensive."
- We discussed the importance of good working partnerships with the operation managers, who acknowledged improvements would be beneficial to ensure a consistent and pro-active approach.
- People had benefited from the support of various other professionals including the community mental health team; speech and language therapist and occupational therapist. A GP representative described good and effective working relationships. They confirmed any concerns were shared in a timely way and recommendations made by the GP and practice nurses were followed. They said they had no concerns about the service and added, "Wisteria House is a cottage type of home - older style residential home, more like a family".

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People we spoke with were happy with the care and support they received and we saw some positive and caring interactions. One person said, "We are looked after very well – almost as if we were family". Another said, "I don't have any reason to complain really...I am treated with dignity. Nothing is too much trouble for them". Relative's comments included, "The home runs very well and there is good communication between the home and the family" and "Staff are really friendly and Mum feels as though this is her home".
- There was no activities programme for people to enjoy. Activities were ad-hoc and usually group based activities. During the inspection, people were unoccupied for most of the day, except for one small group activity. One person described how TV relieved the boredom for them. A professional visitor told us, "People are all sat in the lounge watching TV; there's not a lot of stimulation compared to other services we visit".
- Staff said they were well supported by the operations manager and registered manager. Comments included, "There is good communication and we are a tight team"; and "I love working here very much. It is small and friendly".

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 provider understood their responsibility to be open and honest when incidents happen within the service. They accepted our findings following the inspection and took immediate action to reduce the risk of staff not following current guidance in relation to personal protective equipment.
- Relatives said the management team had been open and honest when incidents had happened. One relative told us, "(The operations manager) will call us if something happens with Mum or if there are any changes. Communication has been good. We have no concerns". Another said, "The home runs very well and there is good communication between the home and the family".
- The registered manager was aware of their responsibility to notify the Care Quality Commission (CQC) of any significant events and notifiable incidents. To the best of our knowledge, the registered manager has notified the CQC in line with their legal responsibilities. The most recent CQC rating was displayed in the

hallway area of the service.

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

- The provider used annual satisfaction surveys as one way to obtain feedback about the service and suggestions for improvement. The last survey was completed in October 2019. Results showed a high satisfaction rate in relation to the staff, home manager, procedure for making complaints, health care, the food, coffee and snacks available, the laundry service, the interior décor, bedroom areas and the gardens. Improvements were identified in relation to activities and occupation.
- A satisfaction survey had not been completed since 2019 due to the pandemic. The operations manager explained they met with people regularly and care reviews were held to give people an opportunity to feedback their experience of the service.
- People were consulted and involved in day to day decisions about how and where they spent their day. Relatives said they felt well informed about what was happening at the service.

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 | <p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had failed to ensure people were protected from the spread of infection. The provider had failed to ensure the premises were safe in relation fire safety issues.</p> |
| Regulated activity | Regulation |
| Accommodation for persons who require nursing or personal care | <p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Regulation 17 HSCA RA Regulations 2014 Good Governance</p> <p>The provider had failed to ensure systems for assessing and monitoring the service were robustly carried out to identify where improvements to the service were needed.</p> |
| Regulated activity | Regulation |
| Accommodation for persons who require nursing or personal care | <p>Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed</p> <p>Regulation 19 HSCA RA Regulations 2014 Fit and proper person employed.</p> <p>The provider had not ensured that robust recruitment processes had been followed to ensure prospective staff were suitable to work at the service.</p> |

