SHC Rapkyns Group Limited

Wisteria Lodge

Inspection report

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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 to 20 people with learning disabilities, physical disabilities and a range of neurological conditions such as autism. The service comprises of two separate buildings: Wisteria Lodge, and Stable Lodge. At the time of this inspection there were 19 people living at the service. The service is located in a rural setting and is purpose built to provide ground floor accessible accommodation for people with complex health needs and disabilities.

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. The investigation is on-going, and no conclusions have yet been reached.

People's experience of using this service and what we found
There was unsafe monitoring and management of risks around behaviours that may challenge others, deteriorating health needs, choking risks, access to assessed levels of physiotherapy, risks around constipation care and skin integrity. People were not being protected from abuse or neglect at Wisteria Lodge.

There was a lack of learning when things went wrong. Incidents had not been managed well so that staff and people could learn from them and prevent them reoccurring. There was a lack of effective governance and systems and audits did not highlight all concerns or remedy shortfalls that were identified.

The culture in the service was not person centred, for example people who were communicating distress were not supported to use communication aids and their support did not change despite their distress being recorded regularly.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of Safe and Well led the service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.
Right support:
• Model of care and setting did not maximise people's choice, control and independence
• The service was rural and located in private grounds. Opportunities for people to access the community were limited as the drivers were absent from work and not adequately replaced.

Right care:
• Care was not person-centred and did not promote people's dignity, privacy and human rights
• People did not receive person centred support. For example, activities were in groups and not personalised or individualised so some people became bored or distressed.
• Staff did not always know when people may be in pain or distress.

Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services lead confident, inclusive and empowered lives
• The service did not have a positive culture and people were not supported to be as independent as they could. Some people were not receiving the correct level of support with physiotherapy putting them at risk of reduced physical movement.

Rating at last inspection and update.
The last rating for this service was Inadequate (published 19 February 2021).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

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

We carried out an unannounced focused inspection of this service on 25 and 26 November 2020. Breaches of legal requirements were found. 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, safeguarding people from abuse and improper treatment, good governance, and staffing.

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 stayed at 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, good governance and staffing. We previously identified a breach relating to person centred care, but this has not been reviewed at

our last inspection or this current 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.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

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 by two inspectors on both days of the inspection.

Service and service type
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.

The service did not have a manager who was registered with the Care Quality Commission. This means that the provider was 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 that had been shared with us since the last inspection by the provider, the local authority and other partner agencies and health and social care professionals. We used all of this information to plan our 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 took this into account when we inspected the service and made the judgements in this report.

During the inspection-
We spoke with three people who used the service and two relatives about their experience of the care provided. We spoke with eleven members of staff including the provider, manager, clinical lead, physiotherapist, nurses, senior care workers and care workers. 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 seven people's care records and multiple medication records. We looked at 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 care records and quality assurance records. We spoke with some staff and relatives by 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 Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management, and learning lessons when things go wrong
At our last inspection in November 2020 the provider had failed to robustly assess, monitor and mitigate risks in relation to risks around people's behaviours of concern, constipation, epilepsy, positioning, unexplained injuries, choking, and monitoring people's health needs. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- People who were prone to deteriorating health were monitored with a tool called the RESTORE2. RESTORE2 is a tool for care and nursing homes to help staff recognise when a person's health is deteriorating, or they might be at risk of physical deterioration. This involves taking a baseline for a person's normal temperature, pulse rate and oxygen saturations. The RESTORE2 tool then states what actions should happen if results are recorded outside of the baseline.
- Some people's baseline scores were not being totalled meaning staff would not know when their health changed, or what action they should take to reduce the risk of harm to their physical wellbeing. There were times when people showed signs of physical decline and would have scored above their baseline, but the necessary checks and observations had not been completed. This put people at risk of poor health or serious illness.
- Risks around Positive Behavioural Support (PBS) had not been managed safely. PBS is an approach that seeks to understand the reason for inappropriate or challenging behaviour and reduce the behaviours. The provider had appointed a PBS practitioner, but they had not reviewed people's support at the time of our inspection.
- One person had a PBS plan that had been written by a specialist PBS provider. However, none of the recommendations made to reduce behaviours were being implemented by staff. There was not an effective review of the persons support around their behaviours. Failure to review behavioural support meant the person was at an increased risk of repeatedly experiencing distress.
- Another person had an intervention that staff used to reduce risk of injury to their hands. However, this had not been care planned and there was no PBS plan for staff to follow despite the persons care plan directing staff to a PBS plan to safely manage the risk. Staff did not have guidance about how to use the intervention safely, or when it should be used.
- A third person did not have risks safely managed around PBS. Their care plan did not cover all of the known risks including hitting staff. The person had ABC charts completed. ABC charts record what happens before, during and after an incident of behaviour that may challenge. The support the person was receiving, as recorded in their ABC charts, was not care planned or risk assessed safely.
- People's ABC charts were not being systematically reviewed to reduce incidents. The manager had

reviewed some ABC charts but had not been trained in PBS and was waiting for a trained practitioner to review people's charts. This left people at risk of repeated agitation.

● Some people with behaviours that may challenge could display these behaviours when they were in pain. However, no pain charts had been completed, or other investigations into possible pain had been made. This left people at risk of increased incidents and of not receiving the support they needed with managing pain.

● Some people were at risk from choking and aspiration (food or saliva entering the airways) and had speech and language therapy (SaLT) guidelines for how to support them safely to eat. Not all people were supported to eat in the way set out in their SaLT plans.

● We saw one person being actively fed when their care plan stated they should hold their spoon to feed themselves. The person was also not being supported by staff in the way set out in their plan in terms of where the staff were seated. In addition, we saw that the person was being fed much larger amounts of food than recommended by SaLT plans. This put the person at risk of choking.

● Another person had food bought out to them prepared in a way that was not consistent with their SaLT guidance. The person liked to see their food before it was chopped but this did not happen, and the food was pre chopped. This could have deterred the person form eating or made them less willing to eat.

● People were not being provided with their assessed level of physiotherapy support. One person was assessed as needing four physiotherapy sessions a week for range of movement and stretching. We reviewed the eight-week period prior to our inspection and found the person had only received nine sessions out of 32 they should have received.

● Another person was scheduled to have six physiotherapy sessions a week but they had only received 17 sessions in the last eight weeks, instead of 48 sessions. A third person was assessed as needing to receive two physiotherapy sessions a week but had only received 10 in the last 12 weeks, when they should have received 24 sessions. The lack of physiotherapy being provided put people at risk of poor physical health and decreasing mobility.

● Other support risks were not being managed safely. For example, where known areas of concern were mentioned in a plan there was no action or risk assessment to reduce the possibility of harm. A person who required their bed to be positioned in a certain way and for a certain time after moving and eating did not have this set out clearly in their care plans. As a result, staff we spoke with about this support gave us different answers regarding the care they provided.

● One person was diagnosed with constipation and they had a bowel care plan. People with a learning disability may be prone to constipation and at risk from the effects of poor bowel care. However, this did not set out measures that would promote good bowel health such as, exercise, movement, fluids, foods to encourage or avoid or any other measures to promote healthy bowels.

● At our last inspection we raised concerns that people were being supported to receive their personal care on shower trollies, as this was not suitable for some people who had not been assessed, and therefore may pose a risk to their dignity as well as a choking risk. At this inspection we spoke with a physiotherapist who had only been asked to make referrals in June 2021. This was seven months after we raised concerns about this practice, and not a timely response. The provider gave assurances that people's choking risks in relation to the use of shower trollies had been reviewed.

● Lessons had not been learned nor enough improvements made when things had gone wrong. In the two months preceding our inspection there had been 21 incident reports relating to marks bruises and injuries. Follow up of incidents had not been robust. For example, there had been occasions when the providers quality team had requested further information, but this had not been provided. This increased the risk that incidents would reoccur.

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

Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider had failed to robustly assess the risks relating to systems to protect people from abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13
● Systems had not always been effective in keeping people safe from the risk of abuse. Wisteria Lodge had been subject to an extended Organisational Safeguarding Enquiry led by the local authority. The enquiry concluded that engagement from senior management and efficacy of systems were not sufficient to keep people safe from abuse. Repeated incidents of concern were highlighted during this enquiry.
● During our inspection we found further issues of concern in the same areas as covered in the organisational safeguarding enquiry. For example, risk management for choking, safe management of people's deteriorating health, and provision of physiotherapy. This left people at risk of experiencing neglect or abuse.

The failure to implement and operate systems that effectively prevent abuse was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of
the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Staffing and recruitment
At our last inspection the provider had failed to robustly assess the risks relating to suitably competent and qualified staff. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18
● The physiotherapist employed at Wisteria Lodge told us there was an additional physiotherapy worker who came to the service and provided physiotherapy support to people. We could not see this, and the manager told us there was not an additional physiotherapy worker.
● Both the manager and physiotherapist told us they thought people were receiving their assessed number of physiotherapy sessions. However, this was not the case for people we reviewed. The lack of additional physiotherapy staff meant some people were receiving far fewer sessions of physiotherapy support.
● Staff did not have the skills and competencies to support people effectively with their behaviours. Staff we spoke with regarding one person were not aware of communication methods used to help the person. Additionally, some staff used language that was not person centred when describing people's behaviours.
● Staff were not always being deployed effectively. Some people wore incontinence pads and required staff to change these at intervals to protect their skin and their dignity. However, there were times when people had gone long periods, sometimes double the recommended time, before having their pads changed. This put people at risk of skin breakdown.

The failure to ensure sufficient numbers of suitably qualified, competent and skilled staff to meet the needs of the people using the service is a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Using medicines safely
At our last inspection in October 2020 we found a continued breach of Regulation 12 as there had been a failure to ensure there was good stock control and people received medicines when they needed them. At this inspection we found improvements had been made and this part of the breach had been met.

● Stock control was being effectively overseen by the clinical lead, so that there were adequate stocks of people's prescribed medicines. People were given their medicines at the times they were directed by a doctor.
● We observed registered nurses administering medicines to people and this was done following good practice guidelines.

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.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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 Inadequate. At this inspection this key question has remained the same. 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, 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

At our last inspection the provider had failed to robustly assess the risks relating to quality assurance and continuous improvement. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- At our last inspection we raised concerns relating to people's behaviours of concern, constipation, epilepsy, positioning, unexplained injuries, choking, monitoring people's health needs and a lack of effective governance. At this inspection we found risks relating to monitoring peoples changing health, safe management of peoples behaviours of concern, positioning, learning from incidents, a lack of assessed physiotherapy sessions for some people and failure to sufficiently act on known risk such as constipation or the use of shower trollies.
- Our previous inspection found four breaches of regulations relating to safe care and treatment, safeguarding people from abuse, good governance and staffing. At this inspection all four breaches remained. Breaches of regulations 12 and 17 relating to safe care and treatment and good governance have been found at the last four inspections and remain in breach at this inspection.
- Wisteria Lodge has been subject to a prolonged organisational safeguarding enquiry led by the local authority. This enquiry involved input from partner agencies such as local safeguarding team and health professionals in order to drive improvement in the service. Despite this the provider was not able to engage effectively with the process and demonstrate that people were kept safe.
- Wisteria Lodge had not been rated as Good in Well-led for the last five inspections going back to October 2016. At our last inspection the ratings of the Safe and Well led domains had deteriorated to Inadequate and both remain rated Inadequate at this inspection. The provider has failed to make the necessary improvements ensure people were safe and there was effective governance of the service.
- In December 2018 we imposed conditions on the provider's registration. The conditions were therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at several services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about accidents and incidents, unplanned hospital admissions and staffing and how they are acting to resolve any risks to people's safety and wellbeing.
- In March 2021 we also imposed conditions on the location setting out the need for a monthly report on

how people's needs had been assessed and monitored in relation to the management of behaviours that may challenge others, epilepsy/seizure treatment, constipation, pain management, choking, injuries, medicine management, and safe moving and handling of people.

● The provider level conditions and location level conditions and reporting of information about themes of unsafe care for people being supported by the provider had not led to similar risks to people at Wisteria Lodge being reduced. For example, a care plan audit had identified that 95% of people had a communication care plan that was person centred. However, the audit also stated only 28% of plans outlined how the person may communicate pain, and under half of the plans set out how the person would communicate their likes and dislikes. Pain management was one of the areas of concern highlighted in the location level condition imposed by CQC. The communication plans could not therefore be person centred or effective.

● Quality audits had not been effective in highlighting areas of shortfall or in putting right things that had previously been identified as an issue. For example, it had been identified in an internal quality visit in March 2021 that incidents were not being managed when they occurred to ensure lessons were learned, including updating people's care records. Following this finding the next risk and clinical governance meeting did not address this issue. We found that incidents were not being managed effectively and peoples care records were not updated during this inspection in July 2021.

● The provider had a Service Improvement Plan (SIP). The SIP had identified that there was a lack of shared learning from incidents in the staff team. One action had been to record any trend or themes in risk and clinical governance meetings. This was completed in the March meeting and the action marked as complete on the SIP. However, there was no analysis of trends or themes in the meetings that followed in May, June and July 2021, and these were poorly attended. This meant that improvements were not being maintained or monitored.

● Concerns about risks associated with constipation, epilepsy, effective use of RESTORE2, behaviours that may challenge others, risk mitigation and incident management have all been repeatedly highlighted to the provider at other of their services. This information had not been effectively shared or used to improve the safety and quality of service for people at Wisteria Lodge.

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

● People were not empowered to engage effectively with communication. For example, one person was frequently described as communicating they were not happy. However, there was no change in their support from day to day. The person had communication aids, but staff were not using these prior to, or after an incident, to help the person understand the situation.

● People had Abbey Pain Chart. An Abbey Pain Chart is a tool designed to assist in the assessment of pain in people with communication problems. There had been no pain charts completed for people with behaviours that may challenge others. This put people of risk of not being able to communicate their pain or discomfort, such as from contracted muscles whilst seated in wheelchairs.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● There was not a registered manager in day to day charge of the service at Wisteria Lodge. The service had a newly appointed manager. This meant that the registered provider was legally responsible for how the service was run and for the quality and safety of the care provided.

● At our last five inspections the registered provider had told us they would take action to make improvements. We saw that improvements had not been made or evidenced. At this inspection not enough action had been taken to make improvements and breaches of Regulations remained. The registered provider has a duty as part of their registration with CQC to ensure the service was compliant with Health

and Social Care Act (Regulated Activities) Regulations 2014.

Working in partnership with others

● There had not been an effective relationship with all partner agencies. An extended organisational safeguarding enquiry found a lack of engagement from the providers senior managers. This left people at risk of unsafe care and practices.

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

● The registered provider has appointed a team of specialist management consultants to oversee the day to day management of the service.

● CQC have been meeting regularly with the new management consultants to ensure that audits are completed effectively, and staff have the support to carry out their role.

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

● The manager had been in post for three months at our inspection and had not had sufficient time to implement an effective key working system. The manager was able to describe their plans for staff to think about improvements for their clients and for champions roles to be given amongst the staff team, such as a first aid champion.