Wings Care (North West) LLP

Lilac Cottage

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
Lilac Cottage is a residential care home providing personal care to five people at the time of inspection. The service can support up to seven people with different health and care needs, including learning disabilities and/ or autism, in one adapted building.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. There was some mixed feedback about the consistent implementation of the principles and the adaptation of the service to meet individual needs.

People's experience of using this service and what we found
People and staff told us that the service had gone through a period of unsettlement but was stabilising again. People and staff were pleased that the registered manager was back at Lilac Cottage full-time. The provider had seconded the registered manager elsewhere and made alternative management arrangements for the service. However, in the absence of the registered manager, there had been some inconsistencies in management arrangements and effective provider oversight had not always been ensured. This had led to a deterioration in some areas, including the safety and quality of people's care, but this was now improving. Staff comments included, "When I first came here, things were up the wall. With [registered manager] back, we are progressing a lot." The provider had identified these gaps; however, it was clear their lessons learned from events included the need to ensure more timely, robust oversight and prevent recurrence of issues.

The report highlights issues experienced by the service during an unsettled time and issues we identified at the start of our visit. We found a breach of regulations, as the Care Quality Commission (CQC) had not always been notified of specific events. However, we also took into consideration progress made and the reintroduction of stability with the presence of a dedicated registered manager. This provided mitigation to potential further breaches of regulation. We therefore made recommendations regarding safeguarding oversight, risk management and record-keeping, staffing and governance.

Record-keeping and quality processes had needed to be more effective, particularly to ensure safety and risk management information were up to date. We received some concerns regarding staffing. People felt that there were not always enough staff and that many had left. The registered manager was addressing this through recruitment. Staff felt that colleague numbers and reliability were stabilising again.

The service applied the principles the principles and values of Registering the Right Support and other best practice guidance, but some improvements were needed to the consistency of this. The principles ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. It was noted that an aspect of service adaptation did not

always meet the individual needs of a person. We considered that partnership working with people, families and stakeholders at times needed to be more robust. This was to ensure there was an agreement on how individual needs would be met appropriately and establish a shared vision of support and expectations.

However, following their recent full-time return the registered manager had brought back with them their passion to drive up the quality of people's care. Overall, people told us they felt safe living at Lilac Cottage and thought, "[Registered manager] is sound" or showed us in their own ways how much they liked them. Positive feedback from some relatives told us, "I generally think it is a great service, the staff are very supportive of [name] and their family" and "[Name] is safe and well looked after. At home they never settled, but we get to see a different side to them now."

Team meetings established a clear vision and expectation by the registered manager for all staff to be accountable and take responsibility for the quality of people's care. Between the two days of our visit, the registered manager had already acted to improve records and rectify issues. The provider had introduced additional checks to ensure more robust oversight going forward and management arrangements had been reviewed to promote greater stability.

Although at this visit we did not check this particular aspect of the service, at the last inspection we found that people were overall supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. We found that since the last inspection the service had made improvements to their recording and reflections following incidents.

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

Rating at last inspection
The last rating for this service was good (published 29 March 2019).

Why we inspected
We received concerns in relation to the safety, staffing and governance of the service. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.

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.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report. The overall rating for the service has changed from good to requires improvement. 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 Lilac Cottage on our website at www.cqc.org.uk.

Enforcement
We have identified a breach of registration regulations at this inspection, as CQC had not always been notified of specific events and related risks for people.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. To check on progress made or if we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Lilac Cottage

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors on 13 December 2019 and one inspector on 27 December 2019.

Service and service type
Lilac Cottage is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service 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.

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. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and five people close to them , including family members, to ask about their experience of the care provided. We spoke with five members of staff including the provider's operations manager, the registered manager, senior care workers and a care worker. 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 people's care records and medication records. We looked at staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including reports, safety and quality checks and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service had not always been safe.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong;
● During previous management arrangements, the provider had not always been informed of safeguarding investigations taking place within the service, including those by the local authority.
● The provider had identified this, however acknowledged that there needed to be more robust oversight to identify such gaps without delay. They introduced additional checks and agreed more robust communication with the local authority and the service, to prevent reoccurrence.

We recommend the provider continues to monitor their oversight of safeguarding alerts at the service, including ensuring robust communication with the local authority regarding concerns to prevent reoccurrence.

● People overall felt safe living at Lilac Cottage, although there was some mixed feedback. For example, people did not always feel safe when those they lived with had incidents of behaviours that challenge. However, there was also a sense of people using the service looking out for each other. One person used their individual way of communicating to tell us, "[Person I live with] and [staff name] look after me."
● Senior staff completed debrief meetings with people and staff following incidents. These helped to reflect on what had happened and what could be done next time to prevent reoccurrence. We discussed how at times actions staff identified in debriefs at times could be implemented more effectively.
● Positive examples of learning together with people had been identified and implemented to encourage more proactive support. The service had also introduced an additional monitoring chart, to check on people's safety and wellbeing following incidents.

Assessing risk, safety monitoring and management
● The service needed to ensure more robustly that risk assessments reflected current support to keep people safe. Assessments of risks to individuals' health and safety had been completed. However, at times information in these assessments had not been fully completed or updated through regular review.
● The registered manager was aware of these improvement needs and was addressing them by working through all care plans.

We recommend the service, through establishing clear accountabilities and responsibilities, continues to ensure the quality and review of people's risk assessments, so they are completed fully and up-to-date.

● Training for a few staff within the service needed to be completed to fully meet risk-reducing actions identified in people's safety plans. This training was offered externally, and the registered manager was arranging this. Most staff had received relevant training and a fully trained staff team was always available in

an adjacent service.
● Checks of the building and service environment had been completed to help ensure people's safety. We discussed some areas for review, which the maintenance person rectified.
● We received some positive comments from relatives about how staff kept their family members safe. These included, "[Name] is very safe living at Lilac Cottage. The staff are very supportive of [name] and their family" and "[Name] is safe and well looked after. They are settled there. At home, [name] was never settled, but we see a different side to them now."

Staffing and recruitment
● We received mixed feedback from people and relatives about whether there was always enough staff to meet people's needs. One person told us, "Some staff have left, others are not always turning in." They told us they were aware the registered manager was addressing this through recruitment.
● Staff told us there had been staffing issues, but this was improving. Staff felt reliability and team work had got better. Staff felt colleagues from adjacent services were happy to cover shifts again, since the culture and atmosphere had improved.

We recommend the service continues to review staff planning and deployment and involves people in this, to ensure a good understanding of how people feel staffing arrangements meet their needs.

● New staff continued to be recruited using appropriate checks.

Using medicines safely
● Staff supported people with their medicines safely. Staff helped people to take their medicines as independently as possible.

Preventing and controlling infection
● The service appeared clean and hygienic and was in the process of being repainted and redecorated.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of service management had been inconsistent.

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

- The Care Quality Commission (CQC) had not been notified of some specific events regarding abuse or allegation thereof in line with legal obligations. This meant we had not been informed appropriately of safeguarding investigations or potential risks identified for people.

We considered the provider had mitigated the future risk of this reoccurring and the impact on people through reviewing management arrangements and oversight procedures. However, CQC had not been notified of these significant events in relation to understanding the safety of people using the service. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

- We considered that these events occurred during the secondment period of the registered manager. We discussed learning from these events and legal responsibilities with the provider's operations manager and registered manager. Events showed that at times more effective provider oversight and mutual support had been needed.
- Records needed to be reviewed and completed more effectively, to ensure person-centred information was up to date. The service's audit checks had identified this, however rectifying actions at times needed to be more effective. The registered manager was improving this.

We recommend the provider and registered manager continue to implement and assure the effectiveness of governance systems.

- Since our last inspection, the provider had developed forms to reflect on incidents and monitor people's safety. These helped people and staff to think together more effectively of how support could be improved and developed to be more proactive.
- The registered manager understood their responsibilities under the duty of candour. Ratings from our last inspection were displayed within the service as required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The service worked with a variety of health and social care stakeholders and there were some positive examples of how this supported people to achieve outcomes.

● However, examples highlighted that people's support would benefit from more robust partnership working with people, their families and stakeholders. Shared views of person-centred support and its ongoing development needed to be promoted further, to ensure people's care needs and goals to live a fulfilled life were appropriately met.

We recommend the service reviews their systems to involve people, their families or legal representatives, as well as stakeholders. These systems need to establish a robust, mutually agreeable vision of appropriate person-centred support in line with best practice guidance, as well as goals and acceptable time-frames for review.

● People described some positives of the service. One person was excited about what they had achieved with support and what they planned to do next. Another person told us, "I am happy here, the staff are nice. We [people who live here] get together, watch movies and have meals together."
● Family members gave positive feedback about people living together as well as the staff. Their comments included, "[Name] loves those people they live with", "They always keep me informed. If I ever had any concerns, everybody is really accommodating, I can speak to anyone" and "I think it is a great service."
● Staff meetings took place to keep everyone involved. The registered manager used these meetings to make clear that all staff were responsible and accountable for the quality of people's care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff spoke positively about the change in atmosphere and team work since the registered manager had returned to Lilac Cottage full-time. One said, "I have no concerns now, but when I first came here things were up the wall. Those staff have gone and with [registered manager] back, we are progressing a lot. She is so supportive, both with staff and service users."
● Staff praised the positivity, motivation and dedication of the registered manager. As at the last inspection, the registered manager was passionate about making a difference for people.
● The registered manager was honest about recognising how the service had deteriorated in their absence. They had a clear vision to reverse this and lift the service back to a good standard and above. This included developing a stronger person-centred and person-led service, with greater staff ownership and responsibility for supporting people's journeys.
● Staff described an improved atmosphere. They explained, "Visitors who have come to the service have noticed the change. People are wanting to come downstairs a lot more, they were spending a lot of time in their apartments."
● The registered manager gave us different examples of how the service supported, encouraged and embraced people's diversity. They showed us examples of how people were getting involved in the wider community, as well as opportunities to develop this further.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The Care Quality Commission had not always been notified of specific events, particularly those relating to abuse or the allegation thereof.