Avenues South East

Chelsham Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out this unannounced inspection to Chelsham Lodge on 13 March 2018. This inspection was brought forward due to concerns we had received from Surrey County Council's quality assurance team. Chelsham Lodge is registered to provide accommodation with personal care for up to six people with physical and learning disabilities. At the time of our visit five people lived at the service.

There was no registered manager in post. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager (the manager) had started at the service in November 2017 and they were in the process of registering with CQC.

People were at risk of harm living at Chelsham Lodge. This was because there was a lack of robust medicines management processes and infection control procedures followed by staff. People lived in premises that were not fit for purpose and although staff had identified risks to people staff did not always follow written guidance. Alleged safeguarding concerns had not been escalated by staff and as such not notified to CQC which is a statutory requirement of any registered service. In the event of a fire or evacuation there was insufficient information relating to people available for staff.

Staff did not have access to regular refresher training and although staff had national guidance in place to follow they lacked knowledge in relation to some of this. Staff did not always encourage people to eat healthy and nutritious foods and referrals to health care professionals were not always made in a timely manner.

People were not shown respect or dignity by staff. People's rooms lacked personalisation and care and we found staff did not always show care or regard to people. We did however see some individual examples of attentive care from staff. Although guidance was in place for people staff were not always aware of it and people were not always being supported to participate in individualised, meaningful activities.

The registered provider had failed to ensure there was a registered manager in post manager for 11 months. This is a statutory requirement for a service registered with CQC.

There was a lack of management oversight at the service and by the registered provider and a lack of robust governance arrangements. Regular audits were not being completed to help ensure people received a good service and those that were carried out had not identified shortfalls. The manager had developed an overarching action plan since joining the service and was working on the culture within the staff team. Staff meetings were held and as such staff felt supported by the manager and told us they felt the service was improving. People were cared for by a sufficient number of staff and good recruitment processes were in place.

Staff were aware of the principals of the Mental Capacity Act. Although people could make a complaint the manager was unable to find all documentation relating to complaints.

During our inspection we found two continued breaches and seven new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The failure to have a registered manager in post was a Section 33 offence of the Health and Social Care Act. We also made three recommendations to the registered provider. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service has therefore been placed in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent
enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

There were poor medicines management processes in place. Staff did not follow guidance in relation to risks to people and accidents and incidents were not always recorded or followed up.

Not all staff could tell us how to escalate safeguarding concerns.

The premises were not suitable for people and there was a lack of infection control procedures by staff. In the event of an emergency staff did not have access to information to assist them with an evacuation.

People were cared for by a sufficient number of staff and staff working at the service had gone through a recruitment process.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were not always supported to access training to ensure they were working to best practice.

The service followed the principles of the mental capacity act.

People could choose what they ate and drank.

Staff had access to national guidance to follow.

The environment in which people lived was not suitable for them.

Is the service caring?

Requires Improvement

The service was not caring.

People were not shown respect or dignity by staff.

We found staff did not always show care or regard to people.

We did however see some individual examples of attentive care from staff. People were encouraged to help around the house and maintain relationships important to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always have access to individualised, meaningful activities.

People's support plans contained information about their care needs but some information had not been reviewed recently. There was evidence staff were monitoring people in relation to particular needs. Staff knew people however they were unaware of some guidance in place and as such had not acted on it.

There was a complaints process in place, however the manager was unable to find information relating to all complaints received.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of management oversight and robust governance in place.

Audits had not identified the shortfalls within the service.

There was no registered manager in post.

Staff felt supported by management and said they attended regular team meetings to discuss all aspects of the service. However, we did not always find staff displayed the values of the organisation.

Chelsham Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13 March 2018 and was unannounced. The inspection team consisted of two inspectors. We carried out this inspection due to concerns we had received from the local authority Quality Assurance (QA) team. In addition, the service was subject to a safeguarding concern following the death of someone who had lived at the service.

Before the inspection we gathered information about the service. We reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

As part of our inspection we were unable to speak to people due to their communication needs. Instead we carried out observations of interactions between people and staff to see how people responded. We spoke with the manager, six staff and the area manager as part of inspection. We reviewed the care plans for four people, medicines records and the records of accidents and incidents. Following the inspection we received feedback from two relative's about their views of the service.

We saw records of quality assurance audits and looked at other paperwork relevant to the running of the service. After the inspection we were provided with information from the manager relating to quality assurance and training and supervision of staff.

The last inspection of this service took place in May 2017 when we rated the service as Requires Improvement.

Inadequate

Is the service safe?

Our findings

We asked staff if they felt Chelsham Lodge was a safe place for people. A staff member told us, "Yes, this home is safe because we always support the residents. Safety is always the key." A relative said, "He is not frightened of anything – if he was unhappy you would see it in his face." However we found concerns about the care people were receiving throughout our inspection.

People's medicines were not handled in a safe way. A staff member told us they followed medicines policies and procedures and recorded all the medicines they administered so other staff were aware of what a person had been given. However we found processes in relation to people's medicines were not robust. We saw that people had a medicine administration record (MAR). This had a photograph of the person as well as information on their allergies and how they liked to take their medicines. We also found in the case of one person they had been on a particular medicine for at least six months consistently. The manufacturer's instructions relating to this medicine state, '"not to be used for longer than 4 weeks". The manager told us following our inspection that they had contacted the GP to review this person's medicines and as such this person would need to be re-referred to their original consultant. However this should have been picked up by the service prior to us raising it and as such followed up previously. We also observed secondary dispensing of medicines. We saw one staff member dispensing medicines and a second take them to people. Once a person had taken their medicines the dispensing staff member signed the person's MAR. This meant that in the event of a medicine error the records were incorrect and signatures would not match those of the staff member giving the medicine. Two people had gaps in the medicine administration records with no explanation as to whether they had been administered their medicines as prescribed.

People were at risk of harm. A staff member told us they felt people were safe because staff put safety measures in place. However although risks to people were recorded in their support plans we found that staff did not always follow the guidance that was in place. We noted some people had risk assessments relating to the laundry room. These stated that the laundry room should be locked and people should only access it in the presence of a staff member. However, we found the laundry room unlocked during the morning and by later in the day the lock that had been on the door had been removed. We found a box of washing powder sitting on the floor in the room and cupboards unlocked which meant there was a potential for people to ingest unsafe products. One person's support plan stated, "COSHH (unsafe) substances to be stored as per company policy as I may consume them if left unattended". Two people had oil radiators in the bedrooms. One in particular was extremely hot to touch and yet we did not see a risk assessment in relation to this in the person's support plan. The radiator in the second person's room was missing a castor which meant it was leaning at an angle. As these radiators were filled with oil this meant it was potentially being used unsafely and as such posing a risk to the person. There was no risk assessment in place for this. We also found in this person's room an exposed screw in the top drawer of their chest of drawers where the handle had come off leaving them at risk of harm.

Accidents and incidents relating to people were not always recorded and it was unclear what action had been taken in response to them. For example, we read that one person became agitated and as a result of banging their head had received a small cut to their head. We did not find an accident report relating to this

and the manager was unaware of the incident. We also saw on a report of an accident that took place on 2 March 2018, that the manager had noted, "found in a drawer 10/3/18" which meant it had not been reported immediately to the manager. The manager told us they reviewed each accident form, however we found in all of the accident forms we looked at the manager's sign off page was blank. The manager then told us it was something they knew they should be doing.

In response to a current safeguarding concern staff had taken effective action to monitor one person who was experiencing some deteriorating health. The manager told us, "We measure his stomach every day, we are monitoring his bowel movements, encouraging him to drink 1.2 litres of water daily and his medicines have been increased. If there are no changes within three days we need to contact the GP again." We found staff were following these requirements and staff were aware of the reasons for monitoring this person, however staff had mixed views on how much someone should drink each day. For example, one staff member felt it was 1000ml and another 750ml. The second staff member told us they would report to the manager if someone had drunk 4000ml in a day. A third staff member told us they kept fluid charts to ensure people were dehydrated or over-hydrated. When we asked staff how much people should drink a day they told us 500mls and said that they never totalled how much people drank and would ask other staff for advice if they thought someone had drunk too much. This meant staff may not know at what point to escalate their concerns in relation to this person's fluid intake.

We found referrals to health care professionals were not always made in a timely manner for people. One person required a referral to the falls team and yet we saw this was not made immediately after this was recommended. In addition, during a meeting held on 8 January 2018 staff had reported concerns in relation to the distended stomach of one person. It was recorded, "to be followed up by the GP". However the GP was not asked to visit this person until 13 February 2018. Another person was noted as putting on 6kgs of weight during a period of two months and then losing 3kgs in another two months. There was no evidence that this had been addressed by staff and the manager was unable to provide us with any information relating to this which meant it was not clear whether or not professional advice had been sought.

Information to support people in the event of an evacuation was not readily available for the emergency services. We asked the manager where the fire folder was that contained personal evacuation plans for people and as such what support they may need in the event of an evacuation. The manager told us, "There isn't one. It's something I need to do." During the local authority's quality assurance visit they had identified that some areas of the home were not protected enough from the risk of fire. They told us they had found some doors were not self-closing and others were not fire doors. As a result they had requested that Surrey Fire Service carried out an inspection which the manager told us was taking place on 21 March 2018. We asked the manager what actions were being carried out in the meantime to ensure people were safe. They told us a fire drill was carried out last week, staff were ensuring pathways to fire escapes were kept clear and one door that was not self-closing had been repaired. We were told by the registered provider following the inspection that the fire visit was not due to happen until April but in the meantime they were carrying out a full health and safety and fire risk visit with an experienced consultant on 21 March 2018.

People were at risk of the spread of infection because of a lack of infection control practices being followed by staff. Only after we had entered the building and sat down to meet with the manager were we informed that three people living at the service were found to have marks on them and the GP suspected potential scabies. Although the deputy manager told us they were making sure that staff were aware and ensuring everyone washed their hands frequently, staff had failed to inform us of this potential outbreak. We also saw staff not encourage at least one person living at the service to wash their hands after they had been to the toilet. This showed a lack of understanding of best practice in responding to infectious diseases.

We found a number of areas in the service which were unclean. There were stains running down the outside of the toilets. Spots of faeces were found on the sink in a downstairs toilet and these remained there all day. In the corner of the kitchen on the floor there was a collection of dust and dried crumbs. The fire extinguishers sitting in the same corner were covered in dust. One bath had mildew around the top near the taps which indicated to us that staff were not following robust cleaning regimes as this bathroom had been refurbished just three months ago. We also found that floor mops were stored incorrectly in the laundry room in that they were stored mop-head down and there was no lid on the bin in the laundry room despite it containing used gloves.

Bathrooms and toilets did not have hand towels in the dispenser or toilet paper. We asked staff about this and were told this was because one person would block the toilet with them. We asked staff how people accessed these when using the bathroom. One staff member said they would show us where the toilet paper was, however it was clear they did not know because they took us to three separate rooms to find it. Another staff member was able to show us but we observed they had to find the manager first to get the key to the cupboard where they were stored. One person was seen using the toilet and we watched how when they had finished they left the bathroom without using toilet paper (because there was none in the toilet). Another person was noted in their support plan as, "I generally use the toilet myself during the night". However, this person would not have access to toilet paper. This meant there was a high risk of the potential of infections being transferred around the service.

This same person was recorded as requiring their general toiletries and shampoos locked away as this was a risk to them, however we found these sitting in their room accessible to the person. We spoke with the deputy manager about this who told us the information in the person's support plan was out of date. Where people had been weighed their weight was recorded, however staff were not filling in the column which highlighted any increase or decrease in weight which meant they may pick up concerns in relation to people more quickly.

The lack of robust medicines management processes, following risk assessments, following up on accidents and incidents, ensuring people were safe in an emergency and infection control procedures was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did observe staff following guidance in relation to individual risks to people such as in the case of one person who smoked a pipe. Their support plan stated, "when you are supporting me for my smoke, I must not be left alone" and we found this to be the case. We also found staff were able to describe risks for other people in line with what was written in the person's support plan. For example, where one people needed to wear a harness when in the car, staff were able to describe this to us in line with their care plan. Another person had experienced two falls in January and we saw the local learning disability service had visited to review this person and as such had recommendation a referral for this person to the falls team.

People may not always be kept safe from potential abuse. Despite staff receiving safeguarding training they did not understanding when to escalate incidents that may constitute safeguarding. We found the service had not always notified CQC of safeguarding concerns that had occurred. The deputy manager informed us, "I ensure that my team discussed safeguarding in our team meetings and in supervisions. I lead by example." A staff member told us, "Sometimes the residents will try to do things which will harm them and we can prevent that." However two staff we interviewed were unable to tell us how to raise a safeguarding concern. We found three accident reports dated 19 November 2017 and 7 December 2017 and 26 January 2018. One report recorded, "when I was giving [name] personal care this morning I noticed a big bruise on her side." We read that staff had asked the GP to visit. The second report recorded, "whilst supporting [name] with her personal care staff noticed unexplained bruise on her right cheek, also a scratch on her little

right finger". We did not see any action had been taken in relation to this. The third recorded a person waking up with their face and eye swollen on one side. The report noted, "I asked the shift leader/sleep in staff support worker about what happened to [name's] face. She said she did not notice it and she knew nothing about it. I am not sure when the incident took place and how". We read staff had notified the local safeguarding authority. But although staff had ticked the box, 'this incident requires further investigation and planning' there was no evidence that this had been done.

The lack of recognising all potential safeguarding concerns and not escalating them was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two people had recently been admitted to hospital with constipation. We found guidance for staff on the noticeboard entitled, "Understanding Constipation for People with a Learning Disability". This was attached to a staff list and staff had to sign to say they had read the guidance. We noted however that of the five staff on duty during our inspection only one had signed to say they had read the document. In addition, there was guidance for one of these people following their recent hospital admission. This was not signed as read by two staff on duty. This meant the provider could not assure themselves that staff would be providing appropriate care and as such keep people free from harm.

People lived in premises that were not suitable for purpose. We saw that the toilet paper dispensers were installed in a way that they would make it impractical for a person to use if they were on the toilet. Chairs in the dining room were office type chairs and had broken backs on them and a wooden chair was wobbly. The office type chairs were stained and unclean. We found the taps in two people's rooms were not working. We asked a staff member about this who told us, "That is not intentional (to not have the taps not working)."

Despite the service having been totally refurbished four months ago, we found curtains in people's rooms dirty, curtains hanging down and stained and torn furnishings. Where cupboards in people's bedrooms had been painted there had been a lack of care and attention and as such door hands were covered in paint. The lounge was sparse with two settees and a couple of chairs. There was a television on the wall, but there were no seats facing the television for people to sit on. People's rooms looked uncared for. We did speak to a maintenance person who was installing individual medicines cabinets in people's rooms. They told us that they had a programme of work to individualise people's bedrooms and we saw that one person's room had been more personalised with wallpaper and coloured paint. However we noticed after the medicines cabinets had been installed one had been placed on a person's dressing table area, rather than on the wall, which did not leave their table area free for their use.

During and following the inspection we were told by the manager and registered provider that a schedule of works to correct the omissions was in place. However we noted that some of this would not commence for four to six weeks.

The lack of suitability of premises was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for by a sufficient number of suitably deployed staff. We were told that everyone was on a one to one with staff and some people required two staff to support them when going out. We saw this happen consistently throughout the day and had no concerns that people were being left unattended. A relative told us, "Having enough staff so that he can go out frequently does seem to make a difference to him."

Robust recruitment procedures were in place to ensure staff employed were suitable to work at the service.

We had previously checked the provider's recruitment processes and did not have any concerns that they were not following correct procedures. The provider always undertook a Disclosure and Barring Service (DBS) check for staff before they started work. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. Potential staff were also asked to complete an application form, provide proof of identity, references from previous employers and evidence of their right to work in the UK.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found staff were following the legal requirements in relation to the MCA. We found in the case of people living at the service that appropriate procedures had been followed and mental capacity assessments, best interests discussions and DoLS applications were in place. This included in relation to living in a locked environment and having locked cupboards in the service. Staff had a mixed knowledge in relation to the MCA. One staff member told us, "Just because they can't do something one day doesn't mean they can't do it the next day." A third staff member told us however, "I always make sure to offer them a choice." However another staff member said, "As he hasn't got capacity I just do what's in his best interest. If I ever offer him anything he never declines or refuses it."

Staff did not have access to refresher training to ensure they were up to date with best practices in relation to their role. Although a staff member told us they had medicines training three weeks ago and another staff member said they had had their medicines training last month the training matrix sent to us by the manager showed that staff were overdue their training. For example, out of 17 staff, 10 staff's safeguarding training had expired before 2017, 10 staff's first aid or basic life support training had expired before 2017 and eight staff's health and safety training expired in 2017 and 10 staff did not have a record as having received this training. Staff did not always have access to training specific to people's needs. Staff did not receive training specific to the needs of the people they were caring for. We read that nine staff had received epilepsy training and only four staff had received autism training. However, we did read that the majority of staff had been provided with de-escalation and diffusion training.

We had asked the manager to provide us with evidence that staff had received supervisions in line with the provider's policy. They sent us this information following our inspection. We noted that staff had received at least two supervisions in the last six months. Supervision is important as it gives staff the opportunity to meet with their line manager to discuss all aspects of their role, any concerns and any training requirements. However, although these were taking place they were not effective as we had seen poor practices during our inspection.

There was evidence of national guidance in place for staff. For example, NICE guidance on managing medicines for adults receiving social care in the community and the British National Formulary for medicines. In addition, the manager told us they used Public Health England's infection control and hand

washing guidance as well as other national guidance. However, staff may not always following this guidance as we found medicines were not always administered safely and visitors were not alerted to potential infectious diseases.

The lack of support for staff in relation to training and as such following best practice was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to a range of food and were able to choose the food they ate as a pictorial menu was displayed on a board in the kitchen. One person had a particular diet due to religious needs and this was adhered to by staff. Where one person had difficulty swallowing we saw information to staff to ensure their food was cut into small pieces. People were provided with drinks throughout the day and there was fresh fruit available for people.

People had access to healthcare professionals. We saw evidence of people being supported to see the doctor and other external professionals. A relative told us, "Last year I had concern about [name's] weight, but I saw him recently and he had lost weight which meant staff have been doing something about it." And another said, "Even when his activities have become more limited he has not become overweight."

People had their own individual hospital passports. This is a document that contains important information about a person should they have to go into hospital. We noted in the case of one person important information that was specific to them was included in this. For example, it noted they were at risk of choking and as such needed their food cut up into small pieces.

Requires Improvement

Is the service caring?

Our findings

We asked relative's if they felt the service was caring. One relative told us, "I am very happy with [name] living there. The staff are very good. He is very happy in himself. Let's face it it's his home." Another relative said, "He seems cheerful and healthy when we visit him."

A staff member told us, "My main goal is to help them live comfortably and happy." Another staff member said, "The best thing is supporting the residents and allowing them to lead their lives as they need."

Despite this the service was not caring because we found staff displayed a lack of person-centred approach towards people. At our inspection in May 2017 we made a recommendation to the registered provider in relation to the homeliness of the service and the interaction from staff. We found similar concerns at this inspection.

During the day we observed a large wooden pallet sitting on the floor of the lounge area. This contained new medicines cabinets that were being installed in people's rooms. This pallet remained in the lounge despite people participating in a musical activity in the morning. Not only did the pallet present a risk to people because the wood was rough but there was a lack of respect shown by staff by placing this item in people's lounge. Throughout the day we found doors and windows around the premises wide open, this was despite the heating being on which demonstrated a lack of attention by staff.

People were treated with a lack of respect by staff. Although we noted that people did not have access to toilet paper and paper towels we found that the toilet staff used contained both. This demonstrated to us a lack of respect or consideration staff members had towards people. We noted the toilet door on a downstairs toilet could not be shut properly or locked. We saw one person enter the toilet and leave the door open. We informed a staff member and observed the staff member go to the toilet and open the door wide and say, "Are you done?" We also heard staff refer to one person throughout the day by their initials, rather than their name.

During the morning we saw one person sitting outside having a snack. They had a puzzle in front of them. A staff member was with them; however they sat on a table top in front of the person, rather on a chair beside them. This gave an impression of 'patrolling', rather than engaging with the person. For the time we observed the staff member (approximately 10 minutes) we did not see them engage with the person once.

Information was not always presented to people in a way they would understand. We read a letter from the provider informing people about the impending refurbishment of the service and as such that they would be moving out for a period of time. However, this was a word document without pictures or symbols to help people understand.

The lack of dignity and respect shown to people was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did observe some individual staff show people care and attention. During the afternoon a staff member sat with one person prompting them to do some colouring. When they coloured the staff member said, "Wow! Look at that. Well done!" There was lively music playing in the background and the person looked relaxed and at ease. After another person drank some juice a staff member gently coaxed them to wipe their mouth. A relative told us, "They (staff) always speak to him in a kindly 'adult' way and take his requests or likes and dislikes into consideration."

Although people did not follow their religion there was evidence in their support plans of their particular faith and as such staff adhered to one person's in relation to the foods they gave them. People were supported to maintain relationships with those close to them. Relatives told us they could visit the service at any time. A relative told us, "We do feel that (he is shown respect and dignity) and would agree these are important but they also show him friendship and liking, which are important too."

There was also some evidence of people being enabled to get involved in the house do tasks by themselves. One person was encouraged to assist a staff member with the laundry and another helped themselves to juice. We saw a staff member engaged in puzzles with one person. Another person went for a walk with two staff members. They had the person between them and staff were holding the persons hands as they walked, talking to them and making sure they looked both ways along the road. This same person came into a room when we were talking to staff. We watched how a staff member offered the person a cup of tea and invited them to sit down with us, which they did. A short while after a second staff member came in and again offered the person a cup of tea, supporting them to pour in their own milk. The person drank their tea in our company and then left the room.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in May 2017 we had concerns that staff were not always delivering person-centred care to people. We found similar concerns at this inspection.

People had access to activities, but further work was required to ensure these were individualised and meaningful. Although people had individual weekly activities planners, these lacked imagination and meaningfulness for people. We read one person's planner. This consisted of having lunch out three times a week, attending day services twice a week, wiping the table after lunch, smoking their pipe and preparing lunch. The manager told us they were aware that work was needed to develop activities and that they had introduced a bowling session once a week which staff encouraged people to participate in. A staff member said they needed to have better plans for the summer in terms of holiday and they were putting work into organising this. We heard from staff that the biggest recent improvement was having more drivers available to take people out and a staff member told us one person attended church twice a week, went to horse and cart sessions and music sessions. A further person went to the local farm and out for walks. A staff member told us, "We are trying to achieve integration for him into the community." They told us that they were organising a barbeque for this person for their birthday and would be inviting people from others of the provider's services. When we arrived at Chelsham Lodge we heard people participating in a music session.

People's support plans covered all aspects of their care needs such as people's physical, communication, personal care and daily routines although we did find that some support plans had not been reviewed recently. One person's support plan was last updated in January 2017, although their risk assessments had been reviewed more recently. There was evidence in people's support plans that demonstrated staff were monitoring people's fluid intake and bowel movements which was important due to the two recent hospital admissions. There was also information to staff on when to escalate concerns. We did find that staff knew people. One person was recorded as not eating pork for religious reasons and staff we spoke with were all aware of this. Another person had guidance in place for staff on how to identify it they wanted something, for example, they would tap on their mouth. One staff member described one person to us and what they told us matched what we read in the person's support plan. A second member of staff was knowledgeable in relation to another person. They knew that this person had eczema at present and that their increase weight was a concern. As such they told us they were taking this person for walks on a more regular basis. Another staff member told us that one person had not been responsive to some staff and as such they had changed their approach to this person and started taking them for walks to a pond. As a result other staff adopted their approach and this was taken on board as an activity for this person.

However, staff were unaware of guidance in place for one person and as such had not responded to recommendations made by a healthcare professional. We noted one person was described as, "displaying usual behaviours, crying and sobbing" every day for six months and staff told us at our inspection that this person "sobbed" every day. However staff had not considered that the noises the person made may have been their form of communication. We read Speech and Language Therapy (SaLT) guidance which stated, "[name] uses vocalisations to communicate. Staff interpret these to be negative sounds however as [name] had very limited intonation". We read SaLT recommended to provide resources to staff in order to make a

communication passport, a visual timetable, picture choice board and a list of communication recommendations for any staff working with the person. None of these recommendations had been taken forward by staff despite receiving this guidance early December 2017 which meant this person had not been supported to help them communicate their needs with staff .

People had keyworkers allocated to them. The role of the keyworker is to take a holistic approach towards a person, looking at their care needs overall, supporting them to reach goals and taking a specific interest in the person. However, despite this we found that keyworkers were not fulfilling this role. We found that the last meetings people had with their keyworkers were in June 2017.

The lack of person-centred care was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a staff member diffuse a situation in a skilled and responsive way. One person was becoming agitated in the kitchen as they were trying to grab a jug of juice. A staff member was patiently trying to ascertain what the person wanted and offered them different options. We saw the person take an empty jug from the staff member. The member of staff asked if they wanted coffee and proceeded to put coffee and milk into the jug by which time the person had calmed down.

Although there was no one on palliative care living at the service staff had noted people's individual end of life wishes in their plans. One person was recorded as wanting a funeral in the Muslim tradition. The manager told us they would speak to social services about people's end of life wishes as they had review meetings coming up.

A relative told us, "We have not made any complaints. Over the years while [name] has been at Chelsham Lodge we feel he has been very well looked after, during the good times and the not-so-good, when his behaviour has been really difficult. He seems happy now and is more communicative than he used to be."

The manager told us there was a complaints procedure in place and they had received one complaint since they had been in post. Although we saw action had been taken in response to the complaint, the manager was unable to provide us with all of the paperwork relating to it. We also found that the complaints procedure was not available to people in a way they would understand, for example, in pictorial format.

We recommend the registered provider ensures that information relating to complaints in available to people and that documentation relating to complaints is complete.

Inadequate

Is the service well-led?

Our findings

At our inspection in May 2017 we found a lack of robust governance and record keeping within the service. The area manager had provided us with an action plan and regular updates about the service following that inspection. As such we found similar continued concerns in this area during this inspection.

We found the manager had little management oversight of the service despite being in post for over four months. There were several occasions throughout the day when the manager was unable to provide us with documentation and they regularly had to refer to another senior staff member. During our initial discussions about people the manager was unable to answer some of our questions relating to the five people's needs . This demonstrated that the manager did not have a good understanding of the needs of the people that they were supporting.

The manager told us at the beginning of our inspection that they were aware of some shortfalls at the service, these included records and training. The manager told us they were still getting to know the service and had started to do some work around activities.

We also found there was a lack of clear management oversight and direction from the registered provider. This was despite senior management overseeing the service for some months in the absence of a manager. Following our inspection we raised our concerns with the registered provider who informed us, "We are aware of the issues at Chelsham Lodge and have been and will continue to give a lot of attention to the service". However, the registered provider had not taken prompt action to address the concerns they were already aware of. We were also informed that some shortfalls may take four to six weeks to address which meant people would continue to live in unsuitable premises.

The manager told us that the culture within the staff team was mixed and we found this on the day. One staff member told us, "I am happy to work here." They said there was teamwork in the home. Another member of staff said, "I like working here. It's a challenge. I look forward to coming to work." In turn a further staff member said, "I'm always on the go and it's enjoyable to support people." It was evident that some staff were extremely caring and wished to provide people with good care. However, other staff did not display these qualities. One staff member said, "At the last (staff) meeting we talked about teamwork, respect and the well-being of the residents." Yet we had not always seen this on the day.

The manager told us they had a strategy to improve the service. This included making people's rooms more homely, to have a feature wall in each room, to bring in more music and sensory lights and to arrange holidays for people. The manager said they had an 'employee and person we support' award each month to encourage cohesion and good examples. However, staff were not always aware of the manager's strategy. A staff member told us that the strategy going forward was care, respect and teamwork. However another staff member was unaware of the strategy moving forward. Avenues South East's are to respect people, provide excellent care and for staff to take pride in their work. However we did not see this during our inspection. This showed a lack of clear direction and leadership from management to staff.

There was a lack of robust governance taking place within the service. Although health and safety audits were carried out, there had been no recent external medicines audit and the manager was unable to provide us with evidence of any other audits they completed apart from in relation to information governance and holding records securely. The area manager informed us that a quarterly infection control audit was completed, however the manager was unable to find the most recent one. We did receive this following our inspection. Although the audit was not dated we noticed actions were to be completed by August 2017. We noted that it was recorded in the audit, "At Chelsham Lodge we have a cleaning rota in place to ensure that all areas are cleaned. All the personal care outlets such as bathrooms, toilets, bedrooms and laundry room have hand washing facilities with hand soap, antibacterial gel and paper towels are provided". Yet we had not found this to be the case. It also noted, "people visiting the home are asked to use antibacterial gel which is provided and as far as practicable people are involved in good hand hygiene". This was not the case as we had not been offered hand gel when we arrived at the service and we witnessed a person leaving a toilet without washing their hands and the staff member failing to encourage them to do so. The audit stated, "all staff are trained in their induction with yearly updates on infection control" however from the training matrix provided to us only seven staff had food and hygiene/infection control training and this had expired in 2016.

Staff had handover sheets which they were meant to complete between shifts, however we saw that this was not being done consistently. This meant that staff may not always record changes or incidents relating to a person that staff coming on duty should be aware of. We also noted in the handover sheet dated 13 February 2018, 'money in bank doesn't tally'. We asked the manager about this but they were unable to provide us with any more information although they thought the deputy manager was dealing with this.

Records in relation to people were not always up to date and we found people's support plans contained information going back to 2014. This meant some of the documentation in people's support plans was irrelevant. Annual health planners for people were not up to date. One persons recorded they had last seen a chiropodist in 2016 and yet we read later on in their support plan they had seen the podiatrist in January 2018. This same person's health action plan recorded they had a hearing problem but had last had a hearing test in 2012 and their last medicines review was in 2016. Another person's health action plan was blank apart from a visit from a well-being advisor in January 2017. A third person's health action plan had much of the information not completed.

Even though people had individual annual health planners in place these were not up to date and as such staff would be unable to accurately identify when a person last had a particular health intervention. This was despite us seeing evidence that people had accessed health care professionals.

The failure to have robust governance arrangements in place and lack of contemporaneous record keeping for people was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the manager had joined the service they had been creating an overarching action plan relating to areas that required work or improvement. We noted this included activities, purchasing sensory items and working with staff to improve culture and team work. In February the manager held a 'team building' session with staff as part of their work in relation to the culture within the team. They told us they felt it had some positive impact in that staff were starting to work more cohesively.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered provider was not aware of their statutory requirements to notify us of particular incidents. For example, serious injury or safeguarding

events. We found that although the accident and incident book recorded three such incidents of potential abuse we had not received notifications in this respect.

The lack of notification of other incidents within the service is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

As part of registration with CQC the registered provider has a statutory duty to have a registered manager in post. The registered provider was failing to meet this requirement. The registered manager for the service left Chelsham Lodge on 21 April 2017. Although the registered provider had recruited a subsequent manager they had failed to register with CQC and they had left the service in November 2017. There was a new manager in post, however it meant that this service had been without a registered manager for almost 11 months. Following our inspection the manager told us they had submitted their application to registered with CQC.

The failure to have a registered manager in post was a Section 33 offence of the Health and Social Care Act.

We received good feedback in relation to management. One staff member said, "The manager is very efficient. Things are improving." Another told us their view was that management was good. They said, "I tell them things and they listen to me. I would feel comfortable going to the manager's about anything." Another staff member said, "[Manager] is okay" and told us that they felt supported because, "If I need something for my clients they always provide it." Furthermore, another staff member described the manager as, "Very supportive and encouraging. If there's a problem we can go to her." A relative commented, "The house has seemed well run even when there have been quite a number of staff changes. New staff seem to get to know [name] and the other residents quickly and to have a good understanding of their needs and possible problems."

Following the inspection the manager sent us the additional documentation we had requested and provided us with an update on the some of the actions they had taken in response to our concerns. This included contacting the GP in relation to one person's medicines and speaking with staff about the unlocked laundry room door. They also told us they planned to order lockable cabinets to be installed in the bathrooms and toilets for toilet paper and hand towel supplies to be stored.

Staff held meetings to discuss aspects of the service. The last meeting was held on 9 January 2018. We noted seven staff had attended. A staff member described the team meetings as good. They said they got to know people about talking about them and what they needed. Staff discussed people living at the service and a staff member reported that the community psychiatric nurse (CPN) was pleased with the progress of one person who had put on weight since they had moved to the service. We also read this in a recent report the CPN had written. Staff also discussed the furniture and bedding that was needed for people's rooms. It was noted that Tizard practitioners would be observing staff in February. We asked the area manager about this who told us that Avenues South East as a whole was working in conjunction with the Tizard Centre which is part of the University of Kent. The registered provider confirmed to us following our inspection that the joint project undertaken with the Tizard Centre was in regard to Person Centred Active Support. For example in relation to the implementation of support and engagement that allows each individual to fulfil their potential to live an independent and fulfilling life.

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 registered provider had not submitted statutory notifications to CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to provide person-centred care to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had failed to show people respect and dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to have robust medicines management processes in place, follow up risk assessments and follow up on accidents and incidents. The registered provider could no assure themselves people were receiving safe care.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had failed to recognise potential safeguarding concerns or escalate them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider had failed to provide suitable premises for people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure staff had the skills to carry out their role.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to hold contemporaneous records for service users. The registered provider had a lack of good governance in place.

The enforcement action we took:

We have issued a warning notice to the registered provider in respect of Regulation 17 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have set timescales in which the registered provider must become compliant with this Regulation.