Enham Trust

Enham Trust - Care Home Services (Michael/Elizabeth & William Houses)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Enham Care Homes is a residential care home providing personal care to 52 people with learning and / or physical disabilities at the time of the inspection. The service can support up to 60 people in three purpose-built properties on a campus site. Each of the homes has accessible facilities and can accommodate up to 20 people all of whom have flat or bedsit style accommodation.

The service was a large home, bigger than domestic sized properties. This is larger than current best practice guidance. The homes were identifiable as care homes with intercoms, CCTV cameras and their location on a campus where the Trust head office was based alongside a supported living service and a number of other properties owned by Enham Trust. Staff did not wear uniforms to work in the care homes.
The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons; the premises were large and did not fit with current best practice guidance and were on a campus where only people requiring support resided providing minimal access to the wider community.

People's experience of using this service and what we found
Medicines were not safely managed, and people were at risk of harm as a result. This was a breach of regulations. Staff understood the principles of safeguarding and whistle-blowing and would not hesitate to speak with their house managers about concerns. Staff were not confident that they would be listened to by the senior leadership team. Support plans were not consistent and omitted information, lacked detail and could pose a risk to people if information was not already known by staff. Recruitment was safe and either all necessary checks were completed prior to commencement in post or a risk assessment implemented to cover staff shadowing colleagues. The houses were clean and there were no malodours. A quality team monitored incidents and distributed learning from them.

Assessments of needs were not always accurate and as with care plans, they omitted information or did not hold supporting guidelines. Latest good practice guidance for modified diets had yet to be adopted by the provider. Generally, feedback about meals was positive however the mealtime experience could be improved. Referrals were made to health and social care professionals as required and people were supported to attend appointments if staffing permitted. The premises were accessible, and people had bespoke access to their flats such as card or pressure mat controls. Maintenance was not always carried out in a timely way.
Mental Capacity Act 2005 information on support plans was confused. Additional work was needed to complete MCA assessments and best interest decisions to support current practice. We found the provider to be in breach of Regulation 11, the need for consent.
Staff completed an induction and attended regular training sessions. Staff told us they received regular supervision sessions.

Staff were caring and we received some positive feedback from people and their relatives about them. At times, people did not receive support when needed and this had a negative impact on their dignity and was

not respectful of them. Most people praised staff for their care and for the respect they showed them. One person was distressed as they felt that once some staff members knew their sexuality, they treated them less favourably. People felt that due to staff being very busy they were not able to get to know them well. People could contribute to their support plans and were involved in care reviews.

People were mostly happy with the choices they could make such as when to get up however one person believed that they had missed an activity as their support was not on time. There was some information in people's support plans about their interests which would benefit from being added to but due to the more experienced staff knowing people well there was little impact from this. The provider supported people to use a variety of communication methods however not all staff had knowledge of signing which was used by some people using the service. People told us they spent a lot of time in their rooms and there were few activities organised in the care homes. Most activities took place at Choices, an Enham day opportunity that people could pay to attend.
There was a complaints procedure and we received mixed feedback about its efficacy.
End of life care was not a focus for most people living at Enham however the manager told us that everyone had been asked if they wanted to consider starting an end of life plan.

The service was not always well-led and there was a continuing breach of regulations due to a lack of oversight of peoples support plans which, due to the lack of accuracy within them, posed a risk of harm. The associate director of care had applied to become the registered manager of the service, there had only been a registered manager for three months since January 2018. There were house managers in each of the homes responsible for the day-to-day management of each service and people told us they did not see the overall manager often.
We inspected during a consultation on the future of the services and received mixed feedback about the process. The provider issued regular quality assurance surveys however the numbers of people completing them had significantly reduced.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The service didn't apply the principles and values of Registering the Right Support and other best practice guidance. These 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.

For more details, please see the full report which is on the CQC website at

Rating at last inspection and update
The last rating for this service was requires improvement (published 2 March 2019) and there was a breach of regulation. The service remains rated requires improvement. This service has been rated requires improvement for the last four consecutive inspections. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection improvements had been made but the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.
We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.
You can see what action we have asked the provider to take at the end of this full report.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Enham Trust - Care Home Services (Michael/Elizabeth & William Houses)

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 team consisted of four inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Enham Care Homes (William, Michael, Elizabeth House) are 'care homes'. People in care homes receive accommodation and 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 had a manager who had applied to be registered with the Care Quality Commission. This means that they will be, and the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we already held about the service including notifications and previous inspection reports. A notification is submitted by the provider to tell us about significant events that happen in the service. We sought feedback from the local authority.
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 11 people who use the service and eight relatives. We had email communication with four relatives. We spoke with 13 staff including house managers, senior personal assistants, personal assistants, members of the senior leadership team including the nominated individual, human resources staff members and a health and safety manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records including seven people's care records and multiple medication records. We looked at seven staff files in relation to safe recruitment and supervision and a range of records relating to the management of the service including policies, procedures and health and safety documents.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

• Peoples medicines were stored in locked cabinets in their rooms. Controlled medicines were stored in separate secured cabinets. We checked and found though that medicines were securely stored, temperature checks of cabinets had shown temperatures higher than 25^0 Celsius, the most common maximum temperature recommended for medicines. Medicines stored at higher than recommended temperatures may degrade or be less effective. There had been no follow up action to remedy the high temperature. This had not been risk assessed and no advice had been sought to find out if the medicines would continue to be effective. Medicines were not always safely managed.

• There were medicines in people's cabinets from October and November 2019. The pharmacy had been changed in December 2019 and the remaining medicines from the previous pharmacy had not been returned. In one of the houses, the medicines return's books showed no entries since October 2018, in another house, no returns had been recorded since August 2019. Staff packaged the waste medicines for return during our inspection. Whilst we are aware that retaining some as required or PRN medicines would be cost effective as new stock would not need to be ordered until the old stock were used, retaining medicines that were in people's blister packs could increase risks of people receiving double doses of medicines.

• Medicine administration records, (MAR's), did not show individual medicines but staff signed to say they had given the contents of the blister packet. This was not in line with current good practice guidelines. For example, if someone had six medicines to take at midday, the MAR would show one signature whether they took one tablet or six. The care home policy stated that notes should be completed to inform if any medicines were refused or omitted, however we saw several instances when this had not happened. We saw one tablet had been left in the blister pack for one person and there were no notes to say why it had not been given. Furthermore, the signed MAR had indicated that it had been given.

• When hand writing new or short-term medicines onto MAR sheets, current good practice guidance states that the new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used. We saw this had not happened and a number of medicines including antibiotics, analgesics and laxitives had been added to the MAR by one staff member only and not safeguarded with a second check by staff.

• Senior staff would sign an audit form to say that all MAR's had been completed and signed at the end of each day. We found a number of MAR's were not signed with no notes added to explain if medicines had not been administered or if they had been refused etc. However, senior staff had signed to indicate that all the MARs had been completed in full.

• We found out of date topical medicines and opened liquids and lotions that had not been labelled with the relevant dates of when opened and when to dispose of. Analgesics given to one person during a week away

from the home were out of date. This left them at risk of pain. Other examples included magnesium hydroxide, a laxative and Beconase, for hay fever, both of which should be used within three months with no 'opened on' date recorded and we also found expired Sudocrem and paracetamol. A medicine may not be safe or effective if it has passed its expiry date.

Whilst we found no evidence that anyone had been permanently harmed by the unsafe management of medicines, people had been placed at risk. The provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12, safe care and treatment, 12(2)(g) the proper and safe management of medicines.

Systems and processes to safeguard people from the risk of abuse
• Staff had an understanding of the signs and symptoms of possible abuse and told us they felt confident that if they raised a concern with a house manager, their immediate line manager, that it would be dealt with.
• Staff had access to and understood about whistle-blowing. They understood they could report concerns about other staff members and should not, as a result be treated unfairly as they would be protected by law.

• Staff told us about attempts to whistle-blow about an issue that had arisen that negatively affected staff members. The staff member told us the disclosure had not been acknowledged by the senior leadership team and the issues raised had not been addressed. Following our inspection, an investigation into the matter by the provider found that the senior leader was not aware of the matter. Staff were not confident that they would be listened to by the senior leadership team should they need to bring concerns to the fore in future.

Assessing risk, safety monitoring and management
• We saw care plans that were misleading and could cause people to be at risk of harm. One person's file for example, had a checklist to say if they were safe to be left alone. Staff completing the form had ticked to indicate that they could be left alone and that they could not be left alone. In the same care record we saw that well known assessments had been completed to ascertain risks about skin integrity, these had not been completed since May 2019 and June 2018. Both had assessed them as being at high risk however a risk assessment did not fully cover this, or indicate that, at the time we inspected, they had wounds to the skin.
• There was a choking assessment completed for the person which noted they were at risk of choking. There was no care plan attached and no details of what the signs and symptoms of choking would be for the individual or what first aid action to take. This was particularly relevant as the person used a wheelchair so basic first aid may need to be adapted to suit their needs.
• There were other discrepancies that could place people at risk of harm including one person being identified as having epilepsy at the start of their care record but this was not included on a care plan about altered states, which should include information about the presentation of their seizures. The provider has informed us that the epilepsy was in childhood only, an entry in the care record in the relevant part of the care plan would prevent misunderstandings. Other potential risks from discrepancies in care records will be addressed later in this report.
• Regular checks were completed of the premises. These included, for example, regular checks of the water system to minimise the risks from legionella and checks of the fire system.
• The provider had not completed all of the actions from a 2018 water hygiene risk assessment however had implemented a disinfection system they told us had alleviated some of the actions. When we inspected, the 'Written Scheme' for legionella had been drafted and was waiting to be approved by the senior leadership team. A written scheme is a comprehensive risk management plan identifying the measures to be taken to minimise the risk from exposure to legionella bacteria. This had been identified as a high priority in the 2018 risk assessment and was not completed until after the 2019 risk assessment.

• Though actions from the risk assessments had not been implemented as per the recommendations, we were confident that the new health and safety manager had taken all outstanding health and safety actions and had prioritised them and was completing them. They had good oversight of the service and we were confident they would continue to improve health and safety in the care homes. They told us, "They appreciate my input and listen to what I have to say. I'm well received here. They're taking note, looking to improve, there's no resistance."

Staffing and recruitment
• Staff were safely recruited. Most pre-employment checks required had been completed prior to staff commencing in post. If staff were to commence before a check was completed, a risk assessment was implemented and they would work under supervision until necessary clearances had been received.
• We received mixed feedback about staffing. People and their relatives were very happy with staff working at Enham and felt they supported them well.
• People, their relatives and staff reflected that at times there were not sufficient staff deployed to support people. Staff told us there were enough staff to support people with their health and personal care needs but not always to provide them with funded personal assistant, (PA) hours. At times, people would be supported to get to Choices, the on-site day service, and left without one-to-one support as there were not enough staff to cover the duty.
• Another staff member told us, "There are not really enough staff, we are always short after tea or breakfast. There can be lots of appointments to get people to. We need staff, but not every day, and at the weekend we cope with less staff as there are no activities to get people to,"
• One person told us, "They are always short staffed. When I need to change, the staff say I need to wait." Another person said, "There are a lot of agency staff, they don't like getting involved. There are some regulars but all random." Another person didn't think there were sufficient staff deployed to meet their needs. They told us, "No, I don't think there is [enough staff]. Sometimes they take a long time to come [when call bell pushed]. They say they are fully staffed but it doesn't feel like it."

Preventing and controlling infection
• Staff members told us they used personal protective equipment, (PPE), when supporting people with personal care. At lunchtime we saw staff wearing gloves and aprons when serving and supporting people with their meals.
• Cleaning schedules were in place and the communal areas of each of the three homes appeared to be clean and free from malodours.
• People gave mixed feedback about the cleanliness of their rooms. One person told us that the cleaner often didn't clean as they were not always able to be home at the time the cleaner wanted to access their flat. Another person told us the home was clean but could be tidier while other people either did not have a view on this or were happy with the situation.

Learning lessons when things go wrong
• The provider had a quality team who reviewed accidents and incidents and gave feedback to the senior leadership team. Learning was subsequently shared with house managers who cascaded it to staff teams.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

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 they 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• Some aspects of MCA recording were confused. Each person's support plan started with statements about their mental capacity and whether there was a deputy appointed by the court of protection in place. In some files people had indicated they lacked capacity but that there were no active MCA assessments. Effectively they lacked capacity but this had not been assessed.
• When asked what they would do should a person refuse their medication, one staff member told us they would wait then offer again but it was their right to refuse. They did not consider whether the person had capacity to make the decision. Reporting the refusal to senior staff, assessing capacity and involving healthcare professionals for advice to try other more palatable treatments could have been considered rather than just omitting the medicine.
• One risk assessment detailed that a person had learning disabilities and probably capacity issues leaving them at risk of abuse and possibly not having the capacity to give informed consent to a sexual relationship. We found that no MCA assessment had been completed about this risk.

The lack of understanding shown by staff and the lack of detailed and accurate MCA records means that the provider is in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11, need for consent.

• DoLS authorisations had been sought. One had expired but there was no evidence that a timely application

had been made to renew the authorisation. We saw in one of the homes, a tracker for DoLS authorisations and applications which would benefit from being introduced in all of the homes.
• More work was needed in terms of completing mental capacity assessments, evidencing how decisions were made and ensuring that records properly reflected actions taken by people and staff.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Information about people's needs was not always accurate. We saw, as previously mentioned, that information had been omitted or was not accurate. For example, one person had hearing loss and needed staff to stand on a particular side and speak loudly to effectively communicate. The person had a personal emergency evacuation plan, (PEEP) in place for situations such as a fire. The PEEP did not mention how best to communicate with the person and, in an emergency, having this information would be essential.
• A person who had difficulties swallowing had this in their care plan which mentioned there were guidelines from speech and language therapy, (SaLT). The SaLT plan was hard to locate in the persons file. The guidelines were not recorded in the care plan.
• The use of national descriptors for modified diets had not been embedded within the service and we were concerned this could lead to lack of clarity for staff and place people at risk of receiving the wrong type of diet. All services should have implemented these by April 2019 as per the guidance issued by the International Dysphagia Diet Standardisation Initiative (IDDSI) in 2013.
• People told us that they, or their relative if appropriate had been involved in their care plan. One person told us, "We had a review yesterday with my social worker. That went quite well. The care is always changing. It works out fine I get an input." A relative told us they had reviewed the care plan recently.

Staff support: induction, training, skills and experience
• Staff completed an induction and mandatory training courses before commencing in post.
• Staff members told us they participated in regular supervision. One staff member said, "I see [house manager] every three months but if I have a problem, I just see them and talk. I don't wait, if I have issues or feel uncomfortable I go and speak to them." A second staff member told us that supervision was useful, they said, "I can raise issues and have them taken seriously."
• One staff member was less positive about supervision. They were concerned they had to repeatedly raise the same issues and that there was no action as a result.

Supporting people to eat and drink enough to maintain a balanced diet
• We found additional discrepancies in care plans. The ticked boxes in one person's nutrition care plan indicated that drinks were not thickened but the text of the care plan stated two scoops of thickener in 200mls of fluid.
• Meals were mostly served in communal dining areas in each house. Tables were adjustable and people sat at which ever table best met their needs.
• People were mostly happy with the food provided to them. One person told us, "I eat downstairs, the food's good. I've recently gone dairy free because of my delicate stomach. We've worked out a menu and they stick to it. They use an outside company." Another person said, "It's a lot better than it used to be, it has improved. We do a weekly menu."
• Tables were set with adapted drinking cups and specialist cutlery to enable people to be as independent as possible with their meals. We saw a person requesting salt for their meal. Staff said there had been no salt for a while and had to leave the dining room to find some. Another person wanted ketchup with their meal. They were given a sachet by staff. The person did not have full use of both hands and needed to open the sachet with their teeth. Aspects of mealtimes were inclusive however improvements such as having bottles of condiments rather than sachets would enable people to maximise their independence.
• People were weighed and malnutrition universal screening tool, (MUST), scores calculated. We saw in two care records that staff had recorded people as being obese when this was not required on the form. We

asked senior staff to review the records, they did and staff were reminded of what should be recorded.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People were supported to make and access healthcare appointments. Medicines were ordered by senior staff and checked into the homes and stored in people's individual medicines cabinets.
• If people needed support from specialists such as speech and language therapy, (SaLT), this was arranged by the provider through peoples GP's.
• At times, adequate support with healthcare was not provided. One person's relative contacted us with regard to some specialist leg wraps required by the person. These had to be renewed every six months and on two occasions had not been ordered in time.

Adapting service, design, decoration to meet people's needs
• The premises were purpose built and were accessible. Each home had wide corridors and passenger lifts to the first floor. Elizabeth House had external, level access from both floors. Doors were automated and people accessed their rooms by the most appropriate way. One person had card access which unlocked their door, another person used a pressure mat.
• Each home had a communal dining area with tables set to specific heights for wheelchair users. We saw that this was isolating for some people as the only table they could access was some way from anyone else at lunch.
• People and their relatives told us that maintenance was not always completed in a timely way. One person told us, "I've had a leaky toilet…. It's been going on for ages, I've given up saying anything now. I just leave it there in a puddle of water." Another person said, "My bed was broken for four months, my hoist broken for about a year. Staff emailed maintenance and nothing got done." There had been improvements in maintenance systems and we did not have a time scale to determine when exactly the concerns people raised had taken place.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question had deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
• When we were inspecting, we spoke with a person who had wet clothing. We asked if they needed support and they told us they had rung the bell and staff had told them to wait until after lunch as they were unable to support them at that time. We rang the call bell again and when staff attended to the person a second time, they were supported to have a clothing change.
• We spoke with the manager and a senior personal assistant about this and they investigated the matter as we had seen there were staff available in an office when this happened.
• Another person told us, "Two members of night staff, sometimes one night staff and one sleep in. In the morning about 05:40 they both need to be getting people up. If I have an accident, I will ring the bell, they will come and say they can't deal with me, they will send another staff. They will change the bed but not dry me or change me. I will wait for day staff, one starts at 07:00 and one at 08:00." We checked when this had last happened and they told us a week ago. Leaving a person in soiled clothing for more than two hours can affect their skin and is both disrespectful of the person and undignified for the person.
• People told us that staff were respectful of their dignity when supporting them with personal care. One person told us, "They will come up to you, take you aside and ask." Another person said staff made sure curtains were pulled and doors closed before supporting them.
• People were supported to maintain and develop their independence. A person said, "I will do as much as I can. Most of the people [staff] here will ask if I can do it myself. They don't rush me." Three other people confirmed that staff encouraged them to be independent when appropriate.
• Staff told us that when supporting people with personal care they would ask them what they wanted, a bath or a shower for example, and would encourage them to choose clothing.

Ensuring people are well treated and supported; respecting equality and diversity
• Most people and their relatives were positive about staff providing support. One person told us, "The majority of the people [staff] go that extra mile." Another person told us that following a difficult personal situation, staff had been 'there for her'.
• Staff were also respectful of people. A person told us, "Yes, obviously it's a 2-way street." They thought staff treated people and other staff members with respect.
• People were less positive about how issues concerning equality had been dealt with. When asked if staff were aware of their cultural needs, three people said they were not. One person said that some people were supported to go to church.
• A person told us they felt treated differently at times due to their sexual orientation. We asked if staff were kind and they told us, "Some of them are… they can be very uppity especially if I let them know my sexual

orientation. The younger ones are alright but some of the older ones aren't." They told us they felt that once some staff knew, they were treated differently and said, "Some staff say to me I shouldn't be like that." They told us they had spoken to a manager about it but nothing had changed.
• People didn't always feel like staff could get to know them well. One person told us, "No I don't get time to know people [staff] unless they have PA [one-to-one] hours." Another person told us, "They don't have time to spend time with you. At Christmas, when people went home, it was easier as not so many people. At other times they can't, [spend time getting to know people], not that they don't want to, they don't have the time."

Supporting people to express their views and be involved in making decisions about their care
• People were involved in making decisions about their care both through involvement with devising their care plans and on a day-to-day basis when care was provided.
• People were encouraged to speak with their key workers however not everyone we spoke with saw their keyworker regularly.
• An annual review was held which included people, their relatives, representatives of the service and the commissioning authority.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• People mainly told us they were in control of their lives. One person told us, "I get up when I want to and go to bed when I want to." Another person said they also decided when to get up and go to bed. One person said, "I may have missed an activity because they get me up late as they have done everyone else before me."

• Staff knew people well and provided person centred support. People were encouraged to make choices about day-to-day things such as meals or a bath or shower.

• There was some information on people's interests and the activities they liked to join in. More information could be included such as for example, people's food preferences in the nutrition section of the support plan, however as staff knew people well there was minimal impact from this.

• Daily records were completed and evidenced staff interactions with people and comments about their wellbeing.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• People had communication support plans detailing their various requirements to achieve effective communication. Methods included use of equipment such as light writers, communication cards, reading information to people and use of signing such as Makaton or finger spelling.

• One relative told us that at times their family member was frustrated as staff are not always able to use Makaton or finger spelling which are their chosen ways to enhance their verbal communication.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

• We asked people how they spent their days. One person told us, "Talking and watching television", another said, "I like drama but there is very little at my level, it is mostly aimed at the younger person." One person recalled that they used to have movie nights in each of the homes and another told us that there was nothing to do in the evenings.

• Activities at Enham Care Homes were mainly provided by Choices, an Enham run day service provider. This was separate to the care homes and people had to pay to access most activities. There were a few activities

taking place in the care homes however people did not choose to access these, attending one or two sessions then not returning.
• There was a sense of community in the service. Many people had lived at Enham for long periods of ten years or more and had long standing friendships with peers. People told us they were worried as planned changes may mean they would need to move from their current accommodation into a different home on the same site. When we inspected, a consultation was underway considering a number of different future options for the care homes.
• People were mainly independent in occupying their time. Peoples accommodation was in the form of flats or bedsit type rooms and had TV's, game consoles and other entertainment items.

Improving care quality in response to complaints or concerns
• There was a complaints procedure in place and all formal complaints should be investigated within a 28-day period.
• We asked people if they had made a complaint. One person told us they had because there was not always anyone available to take them to their work placement. They thought the complaint had been resolved. Another person would approach the house manager should they want to raise a concern.
• A person told us they had made a compliant and knew how to go about it. They told us, "There are posters up telling you who your 'rep' is. It's like talking to a brick wall, nothing happens. We are listened to within the house but if you expect anything to change it is sadly lacking. The individual houses seem to do a really good job but with the management there is no cohesion."

End of life care and support
• Some people had end of life care plans however most people did not. Most people living in Enham care homes were younger and end of life plans would not be a high priority unless they had a life shortening diagnosis.
• One person had an end of life plan in their care record. It was a work in progress and had clearly been added to at different times. They had chosen what should happen to them after they died, who should be informed, where they wanted to be interred and were even considering the music they wanted at their funeral.
• The manager told us that everyone had been asked if they wanted to commence an end of life plan but so far there were only a few people who had done so.

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 the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care

At our last inspection there was a continuing breach of Regulation 17 (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance. This was due to insufficient actions being taken to fix emergency lighting following faults being identified on two separate occasions. At this inspection, though there were outstanding actions from legionella risk assessments that had not been carried out, improvements had been made. The recruitment of a competent health and safety manager had an impact on progress and since they commenced in post, monitoring and recording had improved.

We saw that peoples care records held inaccuracies that could place people at risk of harm. Information about modified diets, epilepsy and communication had not been accurately recorded throughout peoples support plans. This could result in people not receiving appropriate support and, in significant risks to their health.

This was a continuing breach of Regulation 17 (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

• A quality team monitored accidents and incidents and provided the senior leadership team with an overview. A safeguarding team were responsible for defining and alerting safeguarding matters to both the local authority and CQC. Again, an overview of issues was presented to the senior leadership team.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• We received mixed feedback about the service from people, their relatives and staff. People were generally happy with the location of the care homes and people and their relatives were complimentary about staff.
• There were concerns that there were not enough staff to provide support to people. There were four staff providing support to up to 18 people in each house. Support for appointments and personal assistant hours were met using the four staff on duty.
• As mentioned in both the safe and effective sections of this report, there were concerns with regard to the accuracy of support plans. One statement in a plan read, 'Food must be fork mashed and with a gravy sauce', this did not reflect current good practice definitions of meal texture. In addition, a personal care plan stated that the person should have 'a Weetabix for breakfast with milk so it is soft'. This is insufficient

information as providing the food with insufficient milk would mean they were eating dry textured food, too much milk may be too liquid for their swallow.
• Another person's support plan showed they 'seldom needed support with personal care'. Later in the same persons care record it was stated that they had little warning they needed personal care and that they needed care support at night.
• At the time we inspected, there was no evidence that harm had been specifically caused by the errors and omissions in care plans. Due to the number of errors seen we are concerned that there is a lack of oversight and awareness of the importance of support plans in providing appropriate and person-centred 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 provider was aware of the duty of candour and acted should something go wrong. We were told by some relatives that information was not always available about their relatives when they asked about events and they had to wait for a response. House managers would follow up with staff to seek answers for people however the sharing of information with relatives could be improved.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The associate director of care had applied to be the registered manager of Enham Care Homes. They were already registered manager of Enham Care at Home. Since January 2018 there had only been a manager registered with CQC in post for three months.
• People did not know the manager well. People know their house manager but were less sure of who the overall manager was. One person told us, "There are changes, a lot, they bring them [managers] in." Another person said. "[The manager], that would be [name], they look very nice, that's about it. I've not seen the same management as last year." One person told us, "They had a shift around last year and a few people left." Since we last inspected four senior managers had left the organisation.
• People told us they did not see the manager in their houses often and if they did come to the houses they would remain in the office and did not work alongside staff.
• Each of the care homes had a house manager responsible for the day to day running of the home. They were supported by two senior personal assistants and a team of personal assistants who provided hands-on care and support to people.
• Accidents, incidents and safeguarding concerns were raised by staff in the homes and considered by a central team before notifying Care Quality Commission of events. They had identified thresholds at which they would alert CQC. We discussed two incidents that were not notified to ascertain why the provider had not informed us about them.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• When we inspected a consultation was underway about the future of the care homes. A number of options had been proposed by the provider including closing the homes, merging with another organisation and deregistering the homes and replacing them with a supported living type of service.
• People and their relatives were not happy about the method of consultation. The provider had carried out a brief survey of people's capacity by asking staff who they thought would understand. They had invited relatives of the people identified as being unable to understand to short meetings when they introduced the consultation to people.
• We received feedback about the initial consultation meetings from people and relatives. Both felt that information had been shared too quickly and that many attendees who did not have a relative or advocate present were confused by what they heard.
• Since the initial meeting there had been additional meetings with optional one-to-one sessions for people

and their relatives. Resources including an easy read version of the proposals had also been issued. These had gone someway to reassuring relatives in particular, however a number of people had taken away from the initial meeting the fact they may need to move from their home and had remained very focussed on this.

• Surveys had been issued to people. Most people remembered receiving them and one person told us it went directly to their relative. Only 18 responses had been received when the last survey was issued in October 2019. This had fallen from 64 responses a year earlier.

Working in partnership with others
• Enham Trust had contacted the local authority and CQC before commencing the consultation about proposed changes to their service provision.
• Local GP surgeries and district nurses supported people living at Enham and people also accessed a neurological rehabilitation service that provided them with occupational therapy, physiotherapy and some counselling as required.
• The Trust were well known in the area; a café and a charity shop were among the facilities they provided to the local community. Some people living in Enham Care Homes had voluntary work placements in the charity shop.

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 11 HSCA RA Regulations 2014 Need for consent There was a lack of accurate records around capacity and consent and staff understanding of MCA was not clear.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always safely managed and as a result people were at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's care records contained inaccuracies that could place them at risk of harm. Information about modified diets, epilepsy and communication had not been accurately and consistently recorded throughout peoples support plans. This could result in people not receiving appropriate support and in significant risks to their health.