Enham Trust

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

Inspection report

Macallum Road
Enham Alamein
Andover
Hampshire
SP11 6JR

Tel: 01264345827
Website: www.enham.org.uk

Date of inspection visit:
07 January 2019
08 January 2019
09 January 2019

Date of publication:
01 March 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

What life is like for people using this service:
• People were supported by staff who had been trained in safeguarding and who would report any concerns they had about people.

• A new call bell system had improved response times when people needed support and provided statistics which were analysed to improve the service provided.

• People who had no capacity assessment in place had applications made to deprive them of their liberty. We recommended that the provider review all records concerning capacity assessments to ensure all are in order.

• Staff participated in mandatory training which was updated annually. Staff received regular supervision with their line managers. Staff told us they felt supported.

• People told us that staff were kind and caring and supported them in ways that maintained their dignity and were respectful.

• A reduction in the physiotherapy provision meant that some people no longer received input from visiting professionals. The impact of this decision and the fast implementation had left some people unable to source alternate provision in a timely way.

• Several people did not attend activities provided in the onsite day service as they did not believe them to be relevant. There were a number of different activities on offer that people could choose to attend.

• There had been improvements in the oversight of maintenance however there had been faulty emergency lighting for almost one year and action was only taken to obtain quotes to fix the problems after our inspection. 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.

• The provider had introduced robust audits within each of the houses which were regularly checked by managers and the senior leadership team.

• The service met the characteristics of Good in most areas. More information on our findings is in the full report.

Rating at last inspection: Requires Improvement (Published18 July 2018)

About the service: Enham Care Home Services – William, Michael and Elizabeth are residential care homes that can accommodate up to 60 people. When we inspected it was providing accommodation and personal

care to 54 people who had physical and / or learning disabilities.

Why we inspected: This was a scheduled inspection based on the providers previous rating.

Follow up: We will continue to monitor information we receive about the provider until we return as per our re-inspection programme.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was not always well-led Details are in our Well-Led findings below.	**Requires Improvement**

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 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.

Inspection team:
The inspection team consisted of two inspectors and two experts 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 Services are care homes. People in care homes receive both accommodation and personal care. CQC regulate both the care provided and the premises and both were looked at during this inspection.

Notice of inspection:
The inspection was unannounced. The inspection took place between 7 and 9 January 2019.

What we did:
• Before we inspected we looked at the information we already held about Enham Care Home Services. We looked at notifications. Notifications are sent by the provider to tell us about significant events.

• We reviewed the Provider Information Return (PIR). The PIR is sent to us by the provider every year and tells us what the service is doing well and about any improvements they hope to make.

• We requested feedback from external stakeholders including health and social care professionals and service commissioners.

• During our inspection we spoke with 20 people living in the homes, three visiting relatives, thirteen care staff, two domestic assistants, one maintenance staff member, one consultant, one manager, three house managers, and the chair of the board of trustees. We spoke with various support staff working in the Resource Centre.

• We received a great deal of feedback from family members following the inspection who were unable to meet us at the service.

• We looked at 12 care records, health and safety documents, training records, records of accidents, incidents and complaints and service audits.

• Following our inspection all additional documents we requested were sent by the provider.

Requires Improvement

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm

Requires Improvement: 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.

• At our last inspection in April 2018 the provider was in breach of four Regulations of the Health and Social Care Act. These related to fire safety, management of legionella and oversight of maintenance in the homes. Since we inspected in 2018 several improvements had been made. The following points address these breaches and the progress made towards meeting them.

• People, staff and relatives had expressed concerns about the length of waiting time when people used their call bells. This was a breach of Regulation 18 Health and Social Care Act Regulated Activities Regulations 2014 Staffing. At this inspection there were fewer concerns about response times and new call bell system had been installed which provided data about call response times. Most call bells were answered in under five minutes. The provider was no longer in breach of this Regulation.

• At our last inspection the provider was not meeting the requirements of its own fire safety policy and procedure. There was a lack of oversight about legionella and maintenance was not promptly completed. This was a breach of Regulation 17 Health and Social Care Act Regulated Activities Regulations 2014 Good Governance. At this inspection we saw there were many improvements including new fire doors in communal areas, fire resistant letter boxes to all flats, legionella training had taken place and there was a robust monitoring system and maintenance work was completed in a timely way.

• At our last inspection there was no formal arrangement to account for who was present in the care homes, people did not sign in and out of the buildings. This was a breach of Regulation 12 Health and Social Care Act Regulated Activities Regulations 2014 Safe Care and Treatment. We saw new, easy to use name boards in each of the care homes and people could mark themselves as in or out as they entered and left the building providing an accurate record to inform staff in the event of an emergency. The provider was no longer in breach of this Regulation.

Assessing risk, safety monitoring and management
• The new call bell system had alleviated many of the concerns about call times however when installed the old call bell system had not been removed. In many areas in the homes both call points were fixed to the wall next to each other. One relative told us they had a phone call from the person living in the service at around 3am who needed care support and had waited some time. The relative telephoned the staff who attended to the person however had been unaware that they needed support due to them pushing the old call bell not the newly fitted one. We asked the provider to remove all the old call points which they have advised us has been completed.

• There was evidence that systems such as fire alarms and equipment and water safety were regularly

checked and maintained however, emergency lights that were serviced and found to be faulty in February 2018 were still not operational in November 2018. When we inspected in January 2019 there had been no action taken to remedy the situation. See further details about this in the Well-Led section below.

• Risks to people were assessed and regularly reviewed and residual risks were managed. Everyone living in the service had a personal emergency evacuation plan (PEEP) detailing supports needed to evacuate in the event of fire or other emergency.

Systems and processes
• We asked people if they felt Enham was a safe service. A relative told us, "I think so, if he wasn't I wouldn't leave him here". One person told us, "Yep, because I can tell the staff any concerns that I have and they will try and get onto it as quickly as they can", another said, "Yes. I know this place is my home, no harm or distress". A relative still had concerns about evacuating people from the homes when only two staff were on duty at night. Their relative could have moved to a larger room but had chosen to remain in the small room as there was an external door offering a safe exit in the event of fire.

• The provider had systems in place to safeguard people from harm and possible abuse. All staff had been trained in safeguarding and knew what to do if they were concerned someone could be experiencing abuse.

• We saw there were ongoing problems between two people living in one of the houses. Though the incidents that had happened involving them had been discussed with the local learning disability team and advice had been sought from psychology services, incidents had not been alerted to the safeguarding team and CQC had not been notified. Since our inspection the provider has begun to notify us of these incidents.

• Staff told us they were confident that any safeguarding concerns they raised would be addressed by management and if necessary would whistle-blow.

Staffing levels
• We received mixed feedback about staffing levels from staff, people living in the service and their relatives. We also observed staffing throughout our inspection.
• When we last inspected there had been a reduction in staffing, this had been evaluated and staffing, in some areas, had been increased again. We saw staff interacting well with people and as they passed them chatting with them. Staff were busy either providing direct support to people or completing necessary recording or tasks in the houses. We did not hear call bells sounding for long periods without being answered.

• A person in Elizabeth House told us, "The staff are kind. There should be more staff here. In the other house, there were more staff, there's not so many here, only two or three. They would come over to help if needed".

• Another person told us, "There's nowhere near enough staff for the amount of disabilities here. I've been here nearly 28 years and it's never been this bad. The ones here are nice though".

• We asked a person in William House if they thought there were enough staff. They said, "During the day yes. At night because there is one person who sleeps in and one who's awake I feel guilty about waking the sleeping person. I need two people to help me. It's supposed to be two, sometimes it has been one but I can't remember the last time it was one. They come quickly, and if they are busy they say, 'Please can you wait?'". We were told that overnight in all three homes staffing would be changed to two waking night staff which is being implemented as staff are recruited to the posts. This will address concerns people have about

waking staff for personal care.

• A relative told us, "There are 20 residents. On a shift there are six staff, they could do with more. The times I've been here, staff have been here in a minute (to answer call bell). Sometimes they have to wait, it depends who else is needed to be seen, I've never complained about it".
There were 18 people living in each house when we inspected supported by two staff at night, between five and seven staff in the morning and five or six staff in the afternoon and evening. Staffing was calculated according to the assessed needs of people living in each home.

• When asked if there were sufficient staff, a support worker told us, "It depends, most of the time". In addition to support workers, there were two senior support workers and a house manager in each of the houses, domestic staff provided support with cleaning and catering staff from the sites kitchen provided support in serving meals. When we inspected we saw sufficient staff working to provide support to people.

• The provider had been proactive in covering staff vacancies. Recently they had secured six regular agency staff members and provided them with accommodation for a fixed term so that cover could be readily available and be provided by staff who had time to get to know people.

• Staff were safely recruited. A recently recruited support worker told us they had provided references, participated in an interview and had a Disclosure and Barring Service check completed. The Disclosure and Barring Service carry out checks on individuals who intend to work with vulnerable children and adults, to help employers make safer recruitment decisions.

Using medicines safely
• We looked at the systems that were in place for the receipt, storage and administration of medicines. Since the last inspection the system to administer medicines had changed. Monitored dosage systems (MDS) were used for most medicines with others supplied in boxes or bottles. The medicines were stored safely and only administered by staff that had been trained and assessed as competent to do so.

• People had a medicines administration record (MAR) which contained information such as information about allergies they might have. The MARs contained no gaps or omissions and staff were aware of what they must do in the event of a medicines error being made.

• Prescribed topical medications were stored in people's flats and staff said records were checked regularly by seniors to ensure they had been applied as directed.

• There were regular checks regarding the management of medicines which had resulted in mistakes being avoided, for example one monitored dosage system supplied had contained the wrong number of medicines. This had been corrected by staff.

Preventing and controlling infection
• A cleaning team had commenced a deep clean of the building including each of the flats. The company had also been tasked with recommending a cleaning schedule to maintain the standards of hygiene after the deep clean.

• The premises were clean and there were no unpleasant odours at any time during the inspection. Tables and food service areas were cleaned immediately after lunch using appropriate detergents. We had to ask that the cleaning products were safely stored as they were left out in two of the three homes following lunch.

• Changes were being made to storage areas in Elizabeth House, cleaning items were being moved to a different store. The cupboard was not locked between use however staff secured this when we asked them to.

Learning lessons when things go wrong
• A recently introduced monitoring system for accidents and incidents was in place. Reports were submitted by each of the houses and these were analysed and ways to reduce possible repeat incidents were considered.

Good

Is the service effective?

Our findings

Effective – this means that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence
Good: People's outcomes were consistently good, and people's feedback confirmed this.

Ensuring consent to care and treatment in line with law and guidance
• We looked at how the service was acting in accordance with the Mental Capacity Act 2005 (MCA). The MCA 2005 provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

• Although staff had been trained in the principles of the MCA, the information contained within people's records was at times contradictory which indicated that staff had not always fully followed legislation and guidance.

• Staff told us that most people at Enham had capacity to consent to their care and support. People had permission forms in their records. These provided consent to share information with key professionals and for staff to carry out activities necessary for their care or safety. For example, permission for staff to carry out night checks.

• 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

• Staff told us a person had a Deprivation of Liberties Safeguarding authorisation in place. When we checked their records, there was an application for a DoLS but no evidence this had been granted. The reason for applying for the DoLS was that this person needed supervision when out. There was no mental capacity assessment regarding the person to support the DoLS application.

• We recommend that the provider review records concerning MCA and DoLS to ensure they are complete.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• A pre-admission assessment was completed before people moved into the care homes. Following that assessment, additional assessments took place over the persons first days and weeks living in the home to develop an in-depth and accurate care plan.

• People met with their lead personal assistant each month to ensure that their care plans were working to meet their needs.

Staff skills, knowledge and experience

• Staff completed mandatory training courses which were updated annually. These included, safeguarding adults, data protection, fire safety, health and safety, moving and assisting, administration of medicines and infection control. Non-mandatory training, or training that staff did not have to complete included epilepsy, control of substances hazardous to health (COSHH), food safety, working with challenging behaviour, Makaton and ski pad evacuation.

• Staff participated in monthly supervision sessions with their line managers and an annual appraisal. A staff member told us, "Supervision is useful, a good tool. I can get things off my chest and make progress in my job". Regular staff meetings were also held and staff had handover meetings when commencing on shift.

• A relative told us, "There are really good PA's (personal assistants) here, salt of the earth. The house managers are good, stellar". A visiting professional said there was a wide range of staff working at Enham, "Some are super amazing, others show less initiative. Some are able to anticipate people's needs because they know them so well".

Supporting people to eat and drink enough with choice in a balanced diet
• Food was prepared for people according to their needs. For example, meals were pureed, fork mashable or served as finger food according to people assessments by speech and language therapy, (SALT) or their personal preferences.

• We asked people what they thought of the food, one person told us, "It's slightly less tasty than average but definitely acceptable. We get two main courses". Another person told us, "It goes up and down. Some days it's okay, some days it's not. We can have a good dinner and rubbish tea or a good tea and rubbish dinner, it's a bit unbalanced". Another person who was a vegetarian said, "It's got better. It was veggie burgers and chips all the time now it's quiche's and salad. We had stuffed peppers yesterday, they were delicious. There's only one thing I can have and we have to choose from the menu a week in advance".

• We saw lunch served and the food looked appetising and people seemed to enjoy it. People who did not want the main meals had omelettes or sandwiches. People were unsure if they could change their meal choice on the day, people had mixed experiences, sometimes they could change but other people didn't ask as they thought they couldn't. The provider assured us that people could change their choice if there were sufficient quantities.

Staff providing consistent, effective, timely care
• Care staff supported people to attend medical appointments if there were available drivers. People and their relatives told us that there were frequently not drivers available to take people out for leisure activities and many relatives took people to appointments to ensure they were kept.

• The new call bell system had enabled the provider to interrogate stored data and each day the log would be checked and all calls talking over five minutes to respond to would be investigated.

• People's care records held information from professionals such as psychologists, physiotherapists and medical practitioners. In one person's care record there was advice from clinical psychology as to how to manage their behaviours. Psychology suggested to use visual prompts such as a red piece of tape they know not to cross and enter other people's rooms and an 'I feel anxious' flashcard. Staff told us that the measures had been tried but were no longer effective. Staff were working with the person using different techniques to try to manage their behaviours. The provider had not referred to psychology for a review.

Adapting service, design, decoration to meet people's needs

• Some areas of the homes needed redecoration. Redecoration would be considered after all necessary maintenance was completed. The provider had prioritised upgrading fire doors and call bells. People could decorate their flats as they liked and the communal areas of the homes displayed lots of pieces of art work completed by people living in the homes.

• The recent replacement fire doors had not been popular with a number of people who were wheelchair users. Doors were previously fitted as a large door covering two thirds of the corridor with a small door for the other third. The new doors were equal in size and when approached both would open whereas wheelchairs would have fitted through one door. We saw fire doors that had been well fitted and were fit for purpose, one was awaiting a new opening mechanism however the doors did not reduce access for people and met safety standards.

• The provider was in process of moving the day service provision from its current location to the Resource Centre, currently the administration hub onsite and the location of the café. This will be partially completed and in use by the end of March 2019. People and their relatives were happy about this development as they believed the service would be much improved in the new venue.

Good

Is the service caring?

Our findings

Caring – this means that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

• At our last inspection the provider was in breach of Regulation 9 Health and Social Care Act Regulated Activities Regulations 2014, Person Centred Care. People had not been supported by their preferred gender of carer or received continence support when requested. People told us they had to occasionally wait a short time for care provision however the new call bell system evidenced that most calls were responded to in the target time of five minutes. The provider is no longer in breach of this regulation.

Ensuring people are well treated and supported
• We saw lots of positive interactions between staff and people living in the care homes. In Elizabeth House people tended to congregate by the main entrance to meet people visiting the home and see what was going on. As staff passed this area they chatted with people, clearly knowing them well and all enjoyed 'banter'.

• One staff member told us, "Our priority is the residents. Last year it was snowing and there were no staff! We walked here from Andover because there was no one here to help the residents!"

• Another staff member said, "It's all about looking after these guys, I always look at it like would I put my kid in here and I would".

• One staff member supported someone in their own time, "I go to Basingstoke football matches and, because one of the residents likes it, I take them and I take my kids too. Their funding stopped for that activity so I take them Saturday afternoons. The cutting of one to one funding has had an impact on them. They didn't realise they had to pay for it and then got a massive bill so it was cut. We get on really well, they enjoy it. I'd go on my own anyway, we have a good giggle".

• People told us that staff were usually kind and caring and treated them with respect. At times staff could be sharp or behave as though rushed, people felt able to report this to house managers or say something to staff. One person felt this was because staff worked hard and could become tired.

Supporting people to express their views and be involved in making decisions about their care
• People, if able, were involved in planning their care. One person told us, "We recently updated it, I'm happy with the way it's been written. They stopped the employment centre, there was a time when you could get a job. Choices, [on-site day service] is a bit babyish, we sit around and do colouring. Since this morning (named staff) has updated my care plan and now I'm happy with it."

• Another person talked to us about their care plan, "I've seen it, I was involved and I signed it as well". We

asked if they had an advocate to support them, they told us, "My parent have always done that but I feel quite capable doing it myself".

• We received mixed feedback from social care professionals about how much involvement people had in their care. One professional reported they were concerned that there was not an enabling culture, "The support provided was often disabling, disempowering, doing things for people rather than with them, the culture was quite paternalistic." A second professional told us, "The staff team I have met and worked with a very person centred and caring in their approach and skill base".

Respecting and promoting people's privacy, dignity and independence
• People were keen to maintain and develop their independence. The provider was supporting one person to learn how to cook and learn housekeeping skills as they planned to move from the care home to one of the providers supported living services. They regularly visited the supported living venue and were becoming familiar with it to aid their transition.

• There had been a reduction in physiotherapy and occupational therapy hours in the months before we completed our inspection. The Chief Executive Officer assured us that all people who had been admitted to Enham Care Homes with an assessed need for physiotherapy or occupational therapy, and who were funded for it were still receiving it.

• The people who had their therapy sessions cancelled were not funded for or assessed on admission to need this support. Cancelling sessions had impacted on people's ability to remain independent, people felt their mobility was at risk of deteriorating whether due to being less practiced in moving or through an increase in pain causing a reluctance to move.

• Though not everyone had an assessed need for therapies on admission to Enham, many people had lived there for a number of years and if assessed today may meet the criteria.

• When people received personal care, staff ensured that doors were closed and curtains pulled. Support provided to people with meals was discreet and devices such as plate guards, lidded beakers and moulded spoons were used to enable people's independence.

Good

Is the service responsive?

Our findings

Responsive – this means that services met people's needs
Good: People's needs were met through good organisation and delivery.
How people's needs are met
• Enham Trust had, for a number of years, provided unfunded one to one support of 16 hours per week for people which was paid for through fundraising or using the charities monies. This was significantly reduced approximately one year ago and was an unpopular decision for many people as it changed their experience of Enham Care Homes. People who are funded to have one to one support continue to have this as planned. People living in the homes continued to compare current provision levels to past provision levels. Past provision levels were not sustainable without funding from commissioners, some of whom had also reduced the price they were willing to pay for placements.
• Activities at Enham were provided by Choices, a day service on site. People could pay to attend activities at Choices. Some people enjoyed the activities, drama and putting on shows were popular while other people chose not to attend.

• People told us how they chose to spend their days at Enham. One person told us, "I find getting out my room hard and going to activities. I go breakfast club, dinner and tea. We usually have breakfast in our flats but came out today because it was breakfast club". Breakfast Club was arranged by a visiting occupational therapist who was working with people to develop their independence in preparing breakfast, and offering the meal as a more social gathering.

• Another person told us, "I'm just on my laptop, watching TV or reading books. The activities on offer are not for me, I prefer to be on my laptop doing something. We used to work, that's what I miss about here, being able to be productive".

• Not everyone had the same experience of choosing to do day time activities, one person told us, "On a Monday evening {I do} choir, Tuesday Physiotherapy, Wednesday Revision, Thursday evening College, Friday, voluntary work in a shop". They had a busy schedule which was in contrast to most people's responses to our questions.

• Another person's day involved, 'Get up. I know they have Choices [onsite day service] over the road. The Choices area is not what it used to be, it isn't for everybody. It's not for me". This person had chosen not to attend the Choices activities, they had been living at Enham long enough to remember occupational based activities that had stopped a few years ago and having activities in a different building to the current Choices building.

• A person we spoke with told us, "We used to get one to one. The only time I get one to one is for personal care or when I go shopping once a month. We used to sit and watch a DVD together but not anymore. I go out on my own to the village shop and the charity shop, it helps break the monotony of being on my own".

• People and their relatives told us they paid for additional staff support to enable people to participate

more fully in community activities.

• One person told us they had missed the spiritual support that had been offered by a visiting Vicar who had recently retired. We asked the provider how they were ensuring people's spiritual needs were being met and they told us there was a monthly church service that everyone could attend and there were services in the village chapel that some people attended that the person could go to.

Personalised care
• People had care plans that were person centred and reflected how they wanted to receive their care. Staff told us that not everyone had a contract detailing what care they were funded to receive and the provider was working to address this. The contracts we saw were not presented in an accessible format for people, there were no easy to read versions, these were being developed by the provider and were supplied to us in draft form following the inspection.

• Care plans had information about people's backgrounds, life history and where they were from, and preferred routines and an essential lifestyle plan. We also saw good assessments about people's health needs.

• People were supported by male and female care staff and we did not speak to anyone who had expressed a preference as to which gender they wanted to be supported by. One person had asked not to have agency care staff as they told us they were 'fed up' of having to tell them how they should provide their care.

Improving care quality in response to complaints or concerns
• We asked people what they would do if they were unhappy with their care or how they were treated, one person told us, "I would talk to [staff name], I trust her the most. There is a language barrier as English is not her first language but she is a really good carer".

• Another person told us, "I know how to complain. If I didn't like something I would tell them. I did make a complaint". They also told us their complaint had been resolved.

• We looked at the complaints logs for each of the three homes. We saw that complaints were mainly dealt with within one or two days of receipt and most concerns were addressed through meeting with the complainant, meeting staff or updating care plans.

• During and after our inspection we received a number of representations from relatives about people's care and life experiences living in Enham Care Homes. We agreed to pass on any concerns so that the provider can address the matters raised through their complaints procedure.

End of life care and support
• There was a wide age range of people living in the care homes and end of life care had not been focussed on. The Provider Information Return (PIR) stated, "Due to the age range of residents there are few end of life care plans in place as it is respected that this is not something that residents wish to discuss or plan; however, if any of the service users do wish to discuss this, the team are able to have an appropriate discussion in a confident and compassionate manner ensuring dignity is maintained".

• There are plans to develop an in-depth training programme for staff around dignity and end of life care. Though there are younger people living in the homes, there are people who have health conditions that may be life limiting and as such may find having an end of life care plan in place a comfort. The provider told us that everyone had been asked about an end of life plan.

Requires Improvement

Is the service well-led?

Our findings

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

Requires Improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Leadership and management
• At our last inspection we found the provider to be in breach of Regulation 17 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance due to lack of oversight of maintenance issues such as legionella safety management. We found the provider had greatly improved their monitoring systems, legionella management was completed well however there is a continuing breach of this regulation. Please see details below.

Continuous learning and improving care
The provider completed regular health and safety checks, including maintenance of the home. Health and Safety checks had identified the need for repairs in respect of the emergency lighting system used to aid safe evacuation of the building in the event of a fire or other emergency situation.

• For example, 24 emergency lights in William House were reported as being faulty in February 2018. All those lights checked again in November 2018 remained faulty and an additional eight lights were found to be faulty. When we inspected in January 2019 there had been no action taken to remedy the situation.

• Emergency lighting is required to operate fully automatically and give illumination of a sufficiently high level to enable all occupants to evacuate the premises safely.

• The provider told us they had been replacing fire doors and had intended to address the emergency lighting after the work on doors had been completed. Although the provider has assured us that quotes are being obtained for the necessary works to remedy the emergency lighting people living at the service continued to be at risk.

• 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.

• The provider had systems in place to review incidents and accidents, look for trends and put in measure to prevent reoccurrences.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements
• There was no registered manager in place. The contracted care consultant (manager) was in process of

becoming the registered manager and a second manager who would be the long term registered manager had just commenced the process of becoming registered. A registered manager is a person who has registered with the Care Quality Commission 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.

• Since our last inspection two senior personal assistants have been recruited to each of the care home teams to support the house managers. House managers were currently managed by both managers who were applying for registration. Staff senior to the registered manager were a head of care and a director of care.

• We spoke with the chair of the board of trustees who told us that trustees were spending time in all the houses and leading focus groups with people to discuss their views about the service. They told us about the broad range of skills and experience that the trustees had and about the on-going work that was being done in the services.

• The chair of the board of trustees also spoke with us about the improving relationship with the Enham Family and Friends Group. Two board members met with the group regularly to discuss concerns and to update them about developments.

• We spoke with the Head of Quality and Governance. The provider had improved the system to report accidents and incidents which was now an electronic record. All incidents are immediately reviewed as to what happened and what actions had been taken to prevent a reoccurrence. On a monthly basis these records were reviewed to look for possible trends. The system had only been in place for two months however had already identified a medicines issue which had been addressed. The analysis of incidents was shared with the board of trustees.

• There was a comprehensive programme of audits across the service covering environmental aspects such as monthly checks of maintenance requirements, decoration, lighting and flooring, the quality team completed internal checks. These included checking occupancy levels, staffing levels, reporting and finance. There was a quarterly walk around by members of the senior management team and actions set by the quality team were reviewed on a quarterly basis. Some audits completed by house managers were validated by the overall manager and the quality team and senior management team ensured that other checks were completed as they should be.

• The manager completed audits to ensure that each home was using resources such as daily check sheets, these covered the general day to day health and safety needs of the services. The checks were completed and actions set which were completed and signed off by house managers within an agreed timescale.

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong
• The provider planned person centred, high quality care however this was to be delivered within a 'financial envelope' which was limiting what could be provided. Changes had been made to the care provision in terms of personal assistant support hours and physiotherapy and occupational therapy provision. The provider was considering ways to mitigate the impact of the reduction in provision.

• People, their relatives and staff told us they had confidence in the two managers who were seeking registration.

Engaging and involving people using the service, the public and staff; Working in partnership with others
• The provider had arranged for a consultation session with people using the service, staff and relatives about future activities provision. The meeting was held in the café and people were invited to contribute to a discussion about how to fund activities and the move from the current Choices building, activities people would like to participate in, how communication about events and developments could be improved and ideas how to improve the environment for activities.
• At our last inspection, people and their relatives were concerned that allocated personal assistant hours had been significantly reduced but the provider had not informed them in advance. The provider had not learned from this. At this inspection there had been a reduction in physiotherapy services which people had not been informed of until the services were stopped. Effectively communicating these changes would have enabled people to seek alternative provision and involved people in decisions about their care.

• People spoke with their lead personal assistants each month to ensure that care plans were current and to give an opportunity to raise any concerns. Each house held a monthly residents meeting, we saw minutes of one meeting from December. Issues discussed included water temperatures, food not being hot enough, deep cleaning of the flats and people feeling hungry during the evenings. All concerns were explained and solutions provided when possible, for example, people were told to ask staff for snacks and drinks as they were always available. Minutes from the meetings were presented in both written and easy rea formats.

• Staff were kept informed through supervisions and staff meetings. These were usually held in each house however following the last inspection a full-service meeting was held to discuss the report's findings. We received mixed feedback about the meeting from staff, some had found the experience beneficial as they felt involved and could give their opinions. Other staff found the experience less positive as comments made by the staff team were printed and displayed on the walls. Staff had been encouraged to speak freely at the inspection and their comments, if negative, had been highlighted and addressed by senior management.

• One parent had been on an interview panel for the senior personal assistant post. They told us this had been a positive experience and had been able to use their previous professional skills and knowledge to support the recruitment process.

• A weekly email had been introduced for all relatives and people who wanted to receive it. The email informed people about what had been happening in each of the homes and the day services and detailed plans for the weekend and following week.

• We found that relatives were keen to become involved in working alongside Enham staff and management to enhance the service provision. One relative told us, "We could give so much to make this place so much more sociable more interactive".

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 17 HSCA RA Regulations 2014 Good governance There was ongoing insufficient oversight of maintenance in the homes.