Essex Care Consortium Limited

Essex Care Consortium - Colchester

Inspection report

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Ratings

Overall rating for this service	Inadequate ●
Is the service safe?	**Inadequate** ●
Is the service well-led?	**Inadequate** ●

Summary of findings

Overall summary

About the service
Essex care Consortium – Colchester is a residential care home providing the regulated activity accommodation for people who require personal and nursing care to up to a maximum of 20 people. The service provides support to people with a learning disability and autistic people. At the time of our inspection there were 17 people using the service.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

The service was not consistently meeting the underpinning principles of Right support, right care, right culture. The service was not well led. The service had a range of managers responsible for the management and oversight of the service. However, systems and processes to assess, monitor and improve the quality and safety of the service were not identifying where improvements were needed. There was a lack of understanding of the risks and issues facing the service. Legal requirements were not always fully understood or met. The provider was not following their own policies and procedures, including safeguarding people and duty of candour.

Governance arrangements needed to improve to ensure effective oversight of the quality and safety of the service and used to identify and drive improvement. Failure to have oversight of all incidents occurring in the service placed people at a risk of harm, or a significant risk of harm occurring. Systems to log incidents, accidents, and safeguarding concerns were not effectively used to identify themes or trends. Where incidents had occurred, these had sometimes lacked the full rigour needed to thoroughly investigate the root cause or actions for improved practice to prevent any reoccurrence.

Right Support:
Essex Care Consortium – Colchester is made up of a series of houses in a campus style setting on the outskirts of the town of Colchester, which enables people to access the local community and its amenities. People had exclusive possession of their own rooms, in shared accommodation and access to shared gardens and woodlands. Internally the premises were well designed for the people living there.

The service had enough staff on duty to meet people's needs, including additional staff 1-1 hours to support people to manage anxieties and have a good day, including accessing day care facilities and the community. People were provided with opportunities to gain new skills and become more independent. Staff were kind, and caring and as a result we saw people were at ease, happy, engaged and stimulated. Staff worked well with other professionals to ensure people received the right level of support to manage their health and

manage signs of distress and or frustration.

Right Care:
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. However, further work was needed to ensure where people lacked capacity, the use of video monitors to detect seizure activity at night were granted under the Deprivation of Liberty Safeguards (DoLS). We have made a recommendation about making DoLS applications regarding people's right to privacy.

Safeguarding concerns were not routinely being identified and reported to the appropriate authorities. Safeguarding incidents were not given sufficient priority to ensure concerns about people's safety were investigated and lessons learned when things had gone wrong. Risks to people's safety, were not managed well. Personal Emergency Evacuation Plan's (PEEP's) did not contain sufficient information for staff to safely evacuate people in the event of a fire or similar emergency.

Managers and staff were failing to properly assess and manage risks to people at risk of choking and mealtime behaviours, such as eating too quickly which placed them at risk of harm or exposed them to a significant risk of harm occurring. Information in peoples care records and in kitchens was inconsistent and did not provide clear guidance for staff on how to deliver safe care, including the safe consumption of food and drink. Staff had not received training to provide them with the knowledge and skills to safely prepare, cook and support people to eat and drink, in line with speech and language therapist (SaLT) recommendations. Staff had made decisions on people' s behalf about food choices where they did not have the capacity to make decisions or consent to all aspects of their care, which had placed them at risk of harm.

People's medicines were being managed in line with the principles of Stopping over-medication of people with a learning disability, autism, or both (STOMP). However, improvements were needed to ensure people's records contained accurate information about their medicines to ensure these were administered correctly and accounted for. We have made a recommendation about medicines management.

Effective recruitment systems were in place to ensure staff were suitable to work with people using the service.

Right Culture:
Improvements were needed to ensure the service was transparent, and open with all relevant external stakeholders and agencies, including the local authority safeguarding team, CQC and the police. Review of documentation identified allegations of physical abuse, a previous choking incident and where a person sustained a fractured ankle had not been reported to the appropriate authorities.

The registered manager and the assistant manager were passionate about the service, people, and the staff, but lacked support and direction by the nominated individual (NI) (responsible for supervising the management of the service on behalf of the provider) and general manager to ensure they were adhering to best practice, and legislation.

People, their representatives and staff provided positive feedback about the service. Staff told us they felt supported by the managers.

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

Rating at last inspection
The last rating for this service was good (published 09 January 2020)

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of choking. This inspection examined those risks.

We undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

Immediately following the inspection, the registered manager confirmed PEEPs had been updated. The management team had worked well with CQC, the local authority's learning disability and speech and language therapy (SaLT) teams to make the required improvements to reduce the risk of further choking incidents. As of 1 December 2023, all staff had completed dysphagia training. The SaLT team had arranged to provide additional person specific training. Staff competency to prepare food and drink in line with SaLT guidance had been assessed to ensure they had the knowledge and skills to support people with dysphagia and associated choking risks. These measures ensured there were always suitably qualified and competent staff on duty to support people to eat and drink safely. The records for people at risk of choking had been reviewed to ensure these contained the correct information to guide staff in relation to safe consumption of food and drink.

Enforcement and Recommendations
We have identified breaches in relation to safeguarding people from abuse, safe care and treatment and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. You can see what action we have asked the provider to take at the end of this full report. You can also read the report from our last comprehensive inspection, by selecting the 'all reports' link for Essex Care Consortium - Colchester on our website at www.cqc.org.uk.

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements. If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or

overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service well-led? The service was not well led	**Inadequate**

Care Quality Commission

Essex Care Consortium - Colchester

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 Health and Social Care Act 2008.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 2 inspectors.

Service and service type
Essex Care Consortium - Colchester is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Essex Care Consortium - Colchester does not provide nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced. Inspection activity started on 21 November 2023 and ended on 22 November 2023. We visited the service on both days.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We talked with people who used the service whilst observing their experience of the care they received. We spoke with the nominated individual (NI) responsible for supervising the management of the service on behalf of the provider, registered manager, assistant manager, business support manager, administrator, and the general manager. We also spoke with 5 members of care staff. We reviewed a range of records, including 5 people's care records, 3 staff files in relation to recruitment, staff supervision and a variety of records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse;
● Staff had received training on how to recognise and report abuse. However, safeguarding matters and incidents were not given sufficient priority to ensure concerns about people's safety were investigated and lessons learned when things had gone wrong.
● For example, staff meeting minutes from August 2023 identified concerns had been raised about staff using unsafe restrictive practices when supporting 2 people using the service. Staff were described using non-recognised restraint techniques which placed these people at the risk of harm (physical injury).
● A group supervision record in July 2023 reflected concerns were raised about 2 members of staff not following proper moving and handling techniques.
● The registered manager had identified all these incidents as completely unacceptable. However, no safeguarding referrals had been made to the local authority, and CQC had not been notified as required in accordance with Care Quality Commission (Registration) Regulations 2009. Following the inspection we raised a safeguard alert to the local authority about these concerns.

Whilst these people had not come to harm, managers were not following the providers safeguarding policy to deal with allegations of abuse promptly, including raising a Safeguarding alert to the local authority. This was breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● The service had 4 people assessed by the SaLT as having swallowing difficulties, and mealtime behaviours which placed them at risk of choking.
● SaLT guidance, in line with the International Dysphagia Diet Standardisation Initiative (IDDSI) to help manage the risk of choking were not consistently being followed. IDDSI is the global standard to describe texture modified foods and thickened liquids used for individuals with dysphagia of all ages, in all care settings, and for all cultures.
● Information in people's care plans, key work folders and located in kitchens was inconsistent and did not provide clear guidance for staff on how to deliver safe care, including the safe consumption of food and drink.
● Although staff had completed a range of training, only 3 of the staff team had received training to provide them with the knowledge and skills to safely prepare, cook and support people to eat and drink, in line with SaLT recommendations.
● An incident where a person choked had occurred in June 2023. This incident happened 5 months ago. Although a referral had been made to the SaLT, there had been no review or learning from this near miss event to understand what went wrong, or what could be done differently to avoid the risk of further choking episodes.

- Personal Emergency Evacuation Plan's (PEEP's) did not contain sufficient information for staff to safely evacuate people in the event of a fire or similar emergency. For example, where a person had fractured their foot, their PEEP had not been updated to reflect deterioration in their mobility and they were now using a walking frame.
- PEEPs did not include information relating to the effects on people from prescribed medicines which may cause drowsiness, or prescribed emollients for skin conditions, such as eczema. Emollients can soak into clothing, or bedding leaving a flammable residue, creating a fire if exposure to a naked flame or a heat source.

Failure to assess and manage risks to people placed them at risk of harm and exposed them to a significant risk of harm occurring. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Immediately following the inspection, the registered manager confirmed all staff had completed dysphagia training, and had their competency to support people to safely eat and drink assessed. The care plans and risk assessments of each of the people at risk of choking had been reviewed with the speech and language therapist to ensure these contained the correct information to guide staff in relation to safe consumption of food and drink. People's PEEPs had been updated, with the correct information.

- People diagnosed with epilepsy, had detailed management plans in place for staff to identify and manage the risk of seizures. These contained good detail about the use of buccal midazolam, a drug used on an as needed (PRN) basis to treat prolonged seizures.
- The service had developed a good 'E-safety' policy to guide staff on supporting people to safely access the internet to remain both safe and legal when using the internet and related technologies, including the risk of Cyberbullying.

Using medicines safely
- People had their own secure lockable cabinets for medicines in their rooms and were being supported to take their medicines in private.
- Improvements were needed to ensure records contained accurate information about people's medicines to ensure these were administered correctly and accounted for. For example, controlled drugs (CD) are subject to strict legal controls to prevent misuse, being obtained illegally or causing harm. A CD register was in place for each individual prescribed these medicines. Review of a person's CD register found their name, and name of the control drug was missing from the last 6 pages, which failed to provide a complete audit trail.
- Guidelines for a person's transdermal patch to manage pain, stated a new patch needed to be applied every 7 days. The instruction leaflet stated, the patch should not be applied to the same part of the body for 3-4 weeks. However, staff told us they were alternating the patch to opposite sides of the person's upper body weekly. Using the same site every time can cause skin irritation, and in some cases thinning of the skin. There was no chart being completed to ensure the patch was applied to a different part of the body as instructed on a clear 4-week cycle.
- Where a person had been prescribed, morphine oral solution for managing pain, guidelines for staff referred to following the PRN protocol and risk assessment. A risk assessment was in place assessing the risks, safe storage, possible side effects, and allergic reactions. However, there was no PRN protocol on file to inform staff when to administer, or signs to look for to assess if the person was in pain.
- Systems were not in place to ensure staff routinely completed temperature checks of the overflow medicine cabinet. Failure to store medicines within accepted safe range of temperatures may result in medicines not being safe to use.

We recommend the provider considers current guidance on the recording, storage, and administration of medicines, based on current best practice, and take action to update their practice accordingly.

● The registered manager demonstrated a good awareness of the principles of Stopping over-medication of people with a learning disability, autism, or both (STOMP).
● Information in people's records reflects GPs were actively involved in reviewing people's medicines to monitor the effects on their health and wellbeing and reducing these as and when appropriate.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)
● Staff knew about people's capacity to make decisions, including those assessed as lacking mental capacity for certain decisions and this was well documented.
● Staff were observed empowering people to make their own decisions about their care and support. However, staff had made best interests' decisions on food choices for people who did not have the capacity to make decisions or consent to all aspects of their care, which had placed them at risk of harm.
● We found the service was not always working within the principles of the MCA and appropriate legal authorisations to deprive a person of their liberty. The use of video monitors to detect seizure activity at night for 7 people had been considered as part of their MCA assessments and agreed in their best interests. However, these people's DoLS assessments had not included, or granted the use of video monitors in people's private rooms to deprive them of their human right to liberty and privacy.

We recommend the provider seeks guidance from a reputable source on the application of DoLs and the use of video monitors in people's private rooms, where they lack capacity to consent to their use.

Preventing and controlling infection
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection. The premises including en-suites, shared toilets, showers, and bathrooms were clean and hygienic. People's accommodation was personalised to them, clean, modern, and homely.
● We were assured that the provider was preventing people, staff and visitors from catching and spreading infections. Hand gel, and PPE was readily available throughout the service. Staff were aware of how to and when to use PPE effectively and safely.

Staffing and recruitment
● The service had enough staff on duty to meet people's needs, including additional 1-1 hours to support people to manage anxieties and have a good day, including accessing the community.
● The service had effective recruitment systems in place which ensured the right staff were recruited. The interview process explored the candidates' skills, experience, and suitability for the post they were applying for.
● The required documents had been obtained to ensure staff were fit to work with people using the service, including the right to work and DBS checks. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The

information helps employers make safer recruitment decisions.

Visiting in care homes
- People were able to receive visitors without restrictions in line with best practice guidance.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care;
● The provider did not have robust and effective systems in place to assess, monitor and drive improvement in the quality and safety of the service.
●The General Manager was based at the service. They told us, although they carried out regular reviews there was no formal record to demonstrate how they are monitoring the quality and safety of the service. They confirmed there was no overarching service improvement plan in place to review the longer-term oversight of safety and quality of the service to ensure improvements were identified, carried out and sustained.
● The registered manager had completed monthly audits; however, these did not assess or evaluate the overall quality of the service being provided, including risks to the health safety and welfare of people using the service. Audits had not identified safeguarding concerns, issues in relation to the risks to people eating and drinking, poor record keeping in relation to medicines to ensure these were administered as prescribed / directed by the manufacturers, and incomplete PEEPs.
● Failure to have oversight of all incidents occurring in the service placed people at a significant risk of harm. Systems to log, incidents, accidents, and safeguarding concerns had recently been introduced, but were not effectively used to identify themes or trends.
● Where incidents had occurred, these had sometimes lacked the full rigour needed to thoroughly investigate the root cause or actions for improved practice to prevent any reoccurrence.
● The registered manager had received several compliments from other health professionals, about their knowledge of people and dedication to the service. They and the assistant manager demonstrated a passion about the service, people and staff, but lacked support and direction by the NI and general manager to ensure they were adhering to best practice, and legislation.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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; Working in partnership with others
● Following a recent safety incident, the provider had not fully complied with their own duty of candour policy, including making an apology, as soon as was reasonably practicable.
● Improvements were needed to ensure the service was transparent, and open with all relevant external

stakeholders and agencies, including the local authority safeguarding team, CQC and the police. Although there was evidence to reflect referrals were made to health professionals, and staff worked well with them, this was not consistent.
● Reporting of incidents, risks, and safeguarding concerns was unreliable or inconsistent. For example, review of documentation, identified allegations of physical abuse, a previous choking incident and where a person sustained a fractured ankle had not been reported to the appropriate authorities.
● In addition to the NI, the service had a range of managers who did not fully understand the risks and issues facing the service. Legal requirements were not always fully understood or met.
● The provider did not have robust policies and procedures in place to comply with legislation for safe and appropriate use of CCTV, including video monitors and recording equipment. The provider's data protection policy had not fully explored the use of recording equipment and privacy risks.

All of the above demonstrated failure to effectively assess, monitor and mitigate risks to relating to the health, safety and welfare of people using the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they felt supported by managers. One member of staff commented, "We can rely on managers, they are always at the end of the phone."
● Staff told us morale had been low due to a big staff turnover, working with minimum staff, high use of agency and the aftermath of the impact of COVID-19, however morale had stated to improve.
● Managers had completed training to become mental health counsellors and a mental health first aider. Following a recent death in the service, arrangements had been made to provide the staff involved with a debrief session to give them the opportunity to talk about the incident.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider sought feedback from people and those important to them. People had individual meetings with their keyworker monthly to have their say about their home and the support, they received.
● Questionnaires had been sent to people's representatives to obtain their views on the quality of care. Feedback from these surveys was positive. They reflected relatives were generally happy with the care their [family member] received and had good relationship with staff.
● Easy read information had been developed for people using the service to help them understand aspects of their care. This included information about their medicines to help them understand why a medicine was prescribed, how to take it, and about telling staff if they are worried about their medication.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People who use services and others were not protected against abuse or improper treatment. Systems and processes for acting on and reporting allegations of abuse were not being made immediately upon becoming aware allegations in line with the providers policy and national safeguarding guidance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider does not have robust and effective systems in place to assess, monitor, mitigate risks to relating to the health, safety and welfare of people using and drive improvement in the quality and safety of the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have robust systems in place to assess and manage risks to people which placed them at risk of harm and exposed them to a significant risk of harm occurring.

The enforcement action we took:

Urgent Notice of decision to impose conditions on providers and registered managers registration