Paradise Lodge Care Home Limited

Chignal House

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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected all three Paradise Lodge Care Home Limited services, known as Chignal House, Paradise Lodge and Willow Tree Lodge, over a period of three days, 07, 08 and 12 March 2018 as these services are all in close proximity.

The inspection of Chignal House took place on 08 March 2018 and was unannounced.

When we completed our previous inspection on 26 January 2017, we found there was a lack of good governance systems in place to monitor the quality of the care provided at the service. This was a breach of regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found care plans were not always person centred or regularly reviewed to ensure they reflected people's current needs. Medications were not always stored safely and their recruitment process needed reviewing to ensure people were safe. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe, responsive and well led to at least good. The provider did not send this action plan within the set timescales. The inspector contacted the provider to request a copy of this via email; however, at this inspection the provider told us they had not received these emails.

At this inspection, we found that, there continued to be a breach of regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to information not being analysed to identify an overall picture of how well the organisation was meeting people's needs and performing. Although the provider spent a lot time working across all three services, we found a lack consistency in outcomes for people. The provider and manager had not always understood their responsibilities concerning management of risk and regulatory requirements in relation to health and safety, mental capacity and deprivation of liberty.

We recommend the provider review their building risks assessment to ensure risks to people are assessed in line with recognised guidance on managing health and safety in care homes.

The manager and staff had not understood the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of adults who use the service by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals

who consider whether the restriction is appropriate and needed. The lack of governance and poor understanding of the appropriate decision making process and establishing people's capacity to make decisions had placed people at risk of harm and / or abuse.

Improvements had been made to the storage of medicines, however the medicines audit had not identified inconsistencies in the amount of a person's medicines held, resulting in medicine being unavailable when they needed it to help manage a period of distress and anxiety.

Following this inspection, the provider sent us a plan to address the issues we raised during our inspections of all three of Paradise Lodge Care Homes Limited services. This showed they had taken seriously the issues we raised and had taken steps to address these, including but not limited to carrying out an investigation into missing medicines, health and safety concerns and identifying a different training provider to deliver a robust MCA and DOLS training programme for all staff.

Chignal House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Chignal House accommodates three people in one adapted building.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen." Registering the Right Support CQC policy

There was a manager in post. Following an interview with CQC they have been approved as the registered manager as of 16 March 2018. 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.

A contingency plan was in place with contact details for staff to respond to emergencies and staff knew who to contact should an emergency occur. The service had infection prevention and control systems in place, which ensured people's health was protected. Staff were trained and understood their roles and responsibilities for maintaining cleanliness and hygiene.

Safeguarding matters and people's finances were well managed. Staff managed the complex needs of the people well and understood the support they needed to keep them safe. Where people had moved from a previous service, relatives were complimentary about how staff had supported their family members to make this transition.

There was sufficient staff on duty to keep people safe. A thorough recruitment and selection process was in place, which ensured staff recruited had the right skills and experience, and were suitable to work with people who used the service.

Staff understood what people could do for themselves, where they needed help and encouragement and how they communicated. Staff talked passionately about the people they supported and knew their care needs well. People's care plans were regularly reviewed to ensure they reflected people's current needs and covered all areas of the person's health, welfare and safety. These provided detailed guidance for staff to know how to support and provide care and treatment. Different communication methods had been used to

support people to understand information about their care and decide how they spent their day. People were supported to carry on with their usual routines, shopping and accessing places of interest in the community.

People were provided with sufficient to eat and drink to stay healthy and maintain a balanced diet. People had access to health care professionals, when they needed them.

The provider's mission statement contained a clear vision and strategy to deliver high-quality care and promote a positive culture achieving good outcomes for people. Staff were clear about the vision and values of the service in relation to providing compassionate care, with dignity and respect. Equality and diversity, was understood and promoted across all three services owned by the provider. The provider had taken steps to meet people's cultural needs.

People's relatives and staff spoke positively about the provider and the manager. Staff felt supported and said there was good communication between the management and themselves Staff felt supported. They described both the provider and manager as approachable, very hands on, supportive and demonstrated good leadership, leading by example.

At the time of our inspection, no one using the service was nearing the end of their life, and therefore we were unable to assess how this aspect of the service was managed. However, we noted that peoples' care plans did not contain information about people's preferences regarding future care at the end of their life, where they wished to die or their spiritual and cultural needs.

We recommend that the service seek guidance from a reputable source, about supporting people with learning disabilities to express their views and involve them in decisions about their end of life care arrangements.

This is the second time the service has been rated Requires Improvement. We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

The risk management process did not always ensure people were protected from the risk of harm or abuse.

Medicines were not consistently managed in accordance with current legislation and guidance.

There were sufficient staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not have a good understanding of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards. We were concerned about the quality of the training provided due to staff's poor knowledge and understanding of the MCA and DOLS.

People's needs were assessed before they moved into the service. People were provided with the support they needed during the transition to their new home.

People were provided with enough to eat and drink to maintain a balanced diet. People had access to appropriate services, which ensured they received on-going healthcare support.

Is the service caring?

Good

The service was caring.

People were supported to express their views and make decisions about their day-to-day care and support.

Staff had developed positive relationships with people who used the service.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs.

People had opportunities to take part in activities that they enjoyed and to be involved in the local community.

Appropriate procedures were in place to respond to and manage complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The providers systems to assess and monitor the quality of the service was not used consistently across the organisation to ensure people were protected from the risk of harm.

The provider and manager had not always understood their responsibilities concerning regulatory requirements in relation health and safety, the mental capacity and deprivation of liberty and working in partnership with stakeholders, such as the local authority and CQC to share information.

Staff were clear about the vision and values of the service in relation to providing compassionate care, with dignity and respect.

Chignal House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check 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.

We inspected three of Paradise Lodge Care Home Limited services, known as Chignal House, Paradise Lodge and Willow Tree Lodge, as these services are all in close proximity. The first inspection of Paradise Lodge took place on 07 March 2018 and was unannounced. The following inspections of Chignal House and Willow Tree Lodge took place on 08 and 12 March 2018. Both inspections were announced. The inspection team consisted of two inspectors.

Before the inspection, we reviewed information available to us about this service. We reviewed previous inspection reports and the details of safeguarding events and statutory notifications sent by the provider. A notification is information about important events, which the provider is required to tell us by law, like a death or a serious injury. We also looked at information sent to us from others, for example the local authority. We used this information to plan what areas we were going to focus on during our inspection. The provider did not meet the minimum requirement of completing the Provider Information Return at least once annually. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We considered this when we made the judgements in this report.

During our inspection, not everyone chose to or was able to communicate effectively with us. Therefore, to establish if people received safe care and treatment, we looked at two people's care records, spoke with two staff and observed how staff interacted with the people using the service. We also spoke with the manager and the provider. We looked at three staff files and reviewed records relating to the management of medicines. We also looked at how the registered person monitored the quality of the service and records in relation to staff training, maintenance of the premises and equipment and complaints.

After the inspection, we spoke with two relatives to obtain their views about the quality of the service.

Requires Improvement

Our findings

Our previous inspection on 26 January 2017 identified that medicines were not always stored safely. This was because the medicine fridge where insulin was kept was broken and did not lock. At this inspection, we found people's medicines were stored correctly and in accordance with the provider's policy and procedure. Checks were being made daily of the temperature in the medicines room and fridge, which ensured medicines were being stored at the correct temperature and remained effective. Where medicines required using within a set time of opening, for example creams, staff had written opening dates on the boxes so that staff would know when they needed to be discarded.

However, when we checked the quantity of medicines held in stock to ensure there was the correct amount when compared to people's Medicines Administration Record (MAR), we found there was a discrepancy in one person's diazepam. They were prescribed Diazepam 2mg daily and 5mg PRN (as required) to help reduce anxiety. When calculating the number of 2mg diazepam administered against their MAR there was an excess of 12 tablets remaining. When we checked the 5mg diazepam, there should have been one tablet left in stock, however the packet was empty. This person's protocol for administering PRN medicines reflected when distressed and anxious staff should administer 5mg tablet. During the day, this person became very distressed and the manager confirmed they would normally have administered 5mg of Diazepam, but because there was none available, they had self-harmed, resulting in the emergency services being called.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems were in place to identify and reduce the risks associated with people's health and welfare; however, these were not consistently applied. Although, staff understood the importance of promoting people's independence and freedom, a lack understanding of the mental capacity act combined with balancing risk had left one person vulnerable when accessing the community alone. Their records showed they needed support from staff to access the community at all times to keep them and the public safe. This was due to behaviours that members of the public might interpret wrongly putting them at risk when in the community alone. The person's social worker, manager and GP had previously assessed them as having capacity to make some decisions. The manager and staff therefore believed it was appropriate for the person to access the community alone, despite the risks they posed to members of the public. The manager agreed to undertake an immediate review of the risks regarding this person accessing the community alone.

We reviewed a full range of risk assessments and records of weekly checks to protect people's safety,

including, but not limited to fire systems, legionella, equipment and utilities. Overall, these assessed the risks to people using the service, staff and visitors and reflected measures to minimise the risk of harm. However, throughout the premises we found radiators and pipe work feeding the radiators were not covered. This posed a potential risk to these people sustaining burns if they had prolonged contact with hot pipework or the exposed surface of the radiators. The risk assessment had not adequately assessed the risk of people sustaining burns. Additionally, the window restrictors on both windows in one person's room, which was on the top floor, were broken. The person was known to repeatedly break the restrictors; however, the restrictors in place were not sufficiently robust to prevent further breakage and did not conform to recognised guidance provided by the Health and Safety Executive (HSE).

We recommend the provider review their building risks assessment to ensure risks to people are assessed in line with recognised guidance on managing health and safety in care homes.

A contingency plan was in place with contact details for staff to respond to emergencies, such as power failure and staff knew who to contact should an emergency occur. The contingency plan contained a copy of each person's Personal Emergency Evacuation Plan (PEEP). These provided staff with details about the person's needs and the support they needed in the event of an emergency evacuation. Where a fire drill had been carried out, the service had recorded the reaction of each person to the drill to ensure it was appropriate.

The previous inspection found pre-employment checks had not complied with the requirements of regulations. This was because gaps in staff's employment history had not been explained, which placed people at risk of being supported by staff not suitable to work with them. At this inspection, we checked to see the provider's recruitment practices had improved. We looked at the recruitment records for three staff and found relevant background checks in place, including Disclosure and Barring Service (DBS) checks, references and employment history. [DBS checks help employers make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.] We found one employee had disclosed that they had convictions on their application form. The manager was aware of the conviction and had discussed this issue with the provider's solicitor and the employee to assess their suitability to work with vulnerable adults. Although, a decision was reached that the employee was not a risk to people using the service, the manager had not recorded their findings in a risk assessment.

An easy read version 'Understanding and reporting abuse' provided by the local authority was available to people using the service. The provider's policies in relation to safeguarding vulnerable adults reflected local procedures and the relevant contact information of external agencies. Additionally, posters were on display about reporting safeguarding concerns and how to whistle blow. These provided clear guidance to staff on how to report concerns. Staff told us they had received updated safeguarding training and were aware of different forms of abuse. They demonstrated a good knowledge of safeguarding procedures and knew whom to inform both within the organisation and to outside agencies if they witnessed or had an allegation of abuse reported to them. The manager was aware of their responsibility to liaise with the local authority were safeguarding concerns had been raised and such incidents had been managed well. For example, where a person refused care, resulting in deterioration in their health the manager had raised a safeguarding concern. They and a senior member of staff had attended a safeguarding meeting where they were involved in discussions about what had gone wrong and the measures needed moving forward to ensure the person received appropriate care, support and treatment.

Staff had developed positive relationships with people and were observed managing situations well where people behaved in a way that challenged others. This was confirmed in discussion with one relative, who

told us, "I am happy with the care provided to [Person], I feel they are safe." Staff had a good understanding of what action to take to prevent such incidents occurring and the triggers, which had the potential to cause people distress. Staff were clear that the service had a 'no restraint' policy in place and were able to talk through 'distraction techniques' used to deescalate people's behaviours when anxious or distressed to minimise the risk of harm. One member of staff told us, "We have had good training on using 'Breakaway techniques', we do not use restraint, if you actually restrain someone this can make the situation worse."

Staff told us there were sufficient staff to meet people's assessed needs and to keep people safe. Conversation with staff and relatives confirmed this. One relative told us, "There are enough staff, I am getting to know them all and they are lovely". Another relative told us, "I definitely feel my [Person] is safe and well cared for. It was agreed at the beginning that they would have one to one care. When I visit my [Person] always has a carer with him." The manager told us they assessed staffing levels daily, and according to people's needs. Additional staff were provided to support people's activities, attendance at college and holidays. One member of staff told us, "Staffing numbers are normally two staff across the daytime hours, with one waking night staff; however staff work flexibly across Chignal, Paradise and Willow Tree Lodge to support people's activities."

The service had infection prevention and control systems in place, which ensured people's health was protected. Staff were trained and understood their roles and responsibilities for maintaining cleanliness and hygiene. These included regularly cleaning of premises and equipment, hand hygiene, safe handling of soiled linen and waste and when required staff wore Personal Protective Equipment (PPE). People were encouraged to take part in daily living tasks keeping their home clean and tidy. Staff had completed food hygiene training and the service had procedures for the safe preparation and storage of food. The Food Standards Agency (FSA) had given the service a food hygiene rating of five at their last inspection. The Food Standards Agency is an independent Government department, which rates services reflecting the standards of food hygiene, five being the highest.

Requires Improvement

Our findings

Our previous inspection on 26 January 2017 found assessments of people's capacity were out of date, poorly recorded and did not clearly identify what measures would be taken to support the person in their best interests. At this inspection, we found there continued to be a lack of understanding of the Mental Capacity Act (MCA) 2005 and the application of this legislation. The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. We found MCA assessment forms around the decision-making process contained contradictory information. Although, there was an understanding that people must be assumed to have capacity to make decisions unless proven otherwise, none of the people's assessments we looked at contained evidence that their capacity had been correctly assessed. For example, one form stated the person had capacity to make decisions around their personal care, however the form contained a description of the actions staff needed to take to meet the person's needs in their 'best interest'. This was confusing as to what support the person needed and whether or not they had capacity to make their own decision. Neither had the MCA assessments been reviewed regularly, one person's MCA had not been reviewed since 2015. Failure to regularly review these assessments could mean that if a person's capacity changed this was not recognised.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The authorisation procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). Providers are required to submit applications to deprive a person of their liberty to a supervisory body (Local Authority) for authorisation. The manager told us the previous registered manager had submitted DoLS applications to lawfully deprive three people living at Chignal House of their liberty for their own safety. The local authority to date had not granted these. We found the manager and staff lacked understanding of when people should be deprived of their liberty, for example, where a person had been assessed as having capacity to leave the premises and access the community alone during the day, staff were locking the front door at night when they tried to leave. They told us that this was for the person's own safety. The manager said they were unaware of this practice. There was no separate DoLS request or authorisation in place to support this practice.

This was a breach of regulation 11 Need for Consent of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

One relative told us their [Person] had recently moved to the service and felt the transition between their previous placement to Chignal House had gone well. They told us, "The provider and manager had several meetings with me and the intensive support team to discuss [Person's] needs. Following this, they arranged for [Person] to visit Chignal House on several occasions, before moving in. [Person] took their pottery with them, took them straight to their room and laid on the bed, and said "Stay here". I knew they would be alright and there would be no upset."

A review of people's care records showed that prior to admission to the service; a detailed assessment of their needs was completed. These initial assessments formed the basis of the persons care plan and clearly set out how their care and where required treatment was to be provided. This included liaison with health professionals, to ensure people's specific health needs were met. For example, one person diagnosed with epilepsy, with unpredictable seizures required constant monitoring to ensure their safety and well-being. Their care records showed they had regular input from neurologist, GP and epilepsy nurse. Where this person was at risk of sudden and prolonged seizures, an emergency care plan was in place. This plan was in accordance with the Joint Epilepsy Council (JEC) guidelines for administration of rectal diazepam for non-medical staff in emergencies. Staff told us they had received training to administer rectal diazepam in the event of prolonged seizures requiring emergency treatment.

We saw that people were supported to live healthier lives, have access to healthcare services and receive ongoing healthcare support. One relative told us, "My [Person] is well cared for and continues to get better after a long period in hospital. The care they receive at Chignal House is much better, compared to where they were before." People's records confirmed they had input from a range of healthcare services including the GP, specialist nurses, psychologist, physiotherapist and dietician. For example, one person's care records reflected that they administered their own insulin, but needed staff to monitor this, as they would throw tablets away or hide them. Staff had received training about diabetes and understood the importance of ensuring people had their insulin, where prescribed. Staff told us they also supported this person to attend regular diabetic checks, including diabetic eye screening. Their care records showed staff were monitoring their blood sugar levels and liaised with the GP if there were any significant changes.

Staff maintained good records of health care appointments, including any action taken following consultation. One member of staff told us, "[Person] was supported to have a blood test yesterday. If there are any changes in their health I update their care plan and inform their relative." Peoples care records showed they had had an annual health check, regular reviews from the dentist, optician and their doctor. Advice from health professionals was documented, for example, we saw where a person was experiencing swallowing difficulties and at risk of choking, the SALT team had been involved and staff were following their advice.

Relatives were confident their family member's health was being monitored and that they were kept informed if they were unwell. One relative commented, "Staff are pretty good and on the ball about letting me know if something has happened or [Person] is unwell. One time they called to tell me, my [Person] had hit their head and that the paramedics had been called."

Staff were complimentary about the face to face training received. They told us, and certificates in their recruitment files confirmed they had received a range of training designed to give them the knowledge and skills to carry out their roles and responsibilities. Staff had completed recognised qualifications in health and social care, including various levels of National Vocational Qualifications (NVQ). Certificates showed staff had completed training to meet the specific needs of the people using the service, including but not limited to autism, learning disability epilepsy and diabetes. They had also completed mandatory training in health and safety, food safety, medication management, first aid, mental capacity, deprivation of liberty,

infection control, safeguarding and moving and handling. Although staff had received training in relation to the Mental Capacity Act, they had very little understanding about this legislation and how this should be applied. We were concerned about the quality of the training provided due to staff's poor knowledge and understanding of the MCA and DOLS.

The provider had developed workbooks that encompassed the Care Certificate. The Care Certificate was developed jointly by the Skills for Care, Health Education England and Skills for Health. It applies across health and social care and sets a minimum standard that should be covered as part of induction training of new care workers. Although, these books had not yet been implemented the manager told us all newly recruited care staff had attended an induction. This had included an orientation of the home, health and safety, residents' likes and dislikes and policies procedures. Three staff files reviewed showed they had completed an induction, when they started working at the service. Staff told us, as part of their induction they had spent time shadowing more experienced staff so that they could learn about people's needs and how best to support them. We saw staff worked well together to ensure they delivered effective care and support to people using the service.

We saw people were provided with a balanced diet and had sufficient quantities to eat and drink to stay healthy. One relative told us, "My [Person] has a good diet, they are 'alive and growing', they look well, fuller in the face and since they moved into the service they have gained weight." One member of staff told us, "People can eat what they want. We try our best to get them to eat healthy." People's nutritional requirements had been assessed and their individual needs, documented. Staff had good knowledge of people's dietary needs, including specialist diets, and their likes and dislikes around food and drink. Where required, people had been referred to the Speech and Language Therapy (SALT) services. Their input and advice was clearly recorded and being followed by staff. Staff told us and we saw for ourselves that people were encouraged to take part in preparing their meals. One person had cooked their own Chinese meal, which they had taken to their room to eat.

We saw people moved freely around the premises and gardens, including those who used wheelchairs. Where required, equipment had been provided to help staff support a person whose mobility needs had changed. A physiotherapist was visiting during the inspection to assess what further equipment the person needed to help their mobility. People, had their own bedrooms and could choose to spend time in communal areas or alone in their rooms. We saw one person had hung a sign on their door saying 'Do not disturb' and staff respected this.

Good

Our findings

One relative told us, "The staff are really caring, although my [Person] has not been at the service long, they are already getting to know them. [Person] is getting used to the staff and they are getting used to him." During our inspection, we saw staff treated people with kindness, respect and compassion, and gave people emotional support when they needed it. For example, we saw one person became anxious and distressed when returning from a swimming trip. Staff knew how to support this person to reduce their anxiety and how to keep them and others safe. The persons relative commented, "Staff treat [Person] well, they are very patient with them."

The interactions between staff and people using the service were caring and friendly. Staff told us they had worked at the service for a number of years and we could see from their interaction with people that they had clearly built positive relationships with them. One member of staff told us, "I am a naturally caring person. "If people can't understand me, I try to put myself in their shoes, to try to understand how they are feeling and what they want." We saw staff referred to people by their preferred names and spoke discreetly about their personal care needs. People looked comfortable in the staff's presence and appeared happy for staff to support them.

Staff understood what people could do for themselves, where they needed help and encouragement and how they communicated. We found staff responded to people's individual communication needs and adhered to the Accessible Information Standard (a requirement to ensure anyone with a communication need is assessed so they receive all the information they need). People's communication needs were clearly documented in their care plans, for example one person's records identified that they communicated by repeating words, to make simple choices. Where a person's first language was not English, staff had made flip cards with simple words and instructions in English and Cantonese. For example, take your plate to the sink and take your laundry to staff. We observed staff using these varying methods to communicate with people throughout the inspection. Staff were patient allowing people the time they needed to communicate their views and to make day to day decisions.

We observed staff asking people for their views and saw that staff supported them to make appropriate day-to-day choices. However, where significant decisions were required in relation to health and/ or finance we saw people's relatives, or other relevant bodies had been involved in the decision making process. For example, one person's relative held Power of Attorney (POA) to manage their finances. A POA can be assigned to act in a person's best interests by a court of law, should they not have mental capacity to make decisions. Where there was no next of kin to facilitate this Essex Guardians managed people's finances.

Where possible, people had been involved in the implementation of their care plans. Where they had been unable to provide input into their care plans, family members had signed to say they agreed with the contents of the plan. One relative told us, "I a lot of meetings with the manager and provider before my [Person] moved to the service and I was involved in developing their care plan. I got to know the manager and provider really well and it was easy to discuss things about my [Persons] care needs."

Staff used photographs to help people discuss activities they had taken part in and plan future activities. Additionally, the manager showed us questionnaires asking people a series of questions about the quality of the service they received at Chignal House, including if they were happy with the staff and the service in general. Although these questionnaires had been developed using easy read type, pictures and symbols to aid people with limited communication to complete, the person's key worker or another member of staff had assisted the person to complete the questionnaire. We shared our concerns that given as it was staff asking the question if people would feel comfortable about providing a true response and whether or not it would be better if an independent person, such as an advocate was involved. Advocacy services help vulnerable people to access information and services, be involved in decisions about their lives, explore choices and options, defend and promote their rights and responsibilities and speak out about issues that matter to them.

During the inspection, we saw staff were aware of the importance of ensuring people's dignity was respected at all times. Staff were observed gaining people's consent to enter their rooms and provide personal care. Staff knocked on people's doors whether or not they were open or closed, rather than just walking in. Staff understood equality and diversity, and told us this was promoted across the services owned by the provider. One member of staff gave an example where people using the service, their relatives and staff had enjoyed a cultural day, where people's relatives and staff had cooked meals from their nationality and brought them together to celebrate the different cultures and lifestyles.

The provider had taken steps to meet people's cultural needs by ensuring there were staff were available that were able to speak their first language and by supporting people to access local amenities that supported particular ethnic and cultural groups. For example, one member of staff accompanied a person to a local Chinese and carers befriending group. The manager was also in the process of making a request for an Independent Mental Health Advocate (IMCA) who could speak Cantonese to advocate on the person's behalf.

Although staff tended to work in the same service, occasionally they worked across the other services owned by the same provider. Staff had a good understanding of the diverse needs of the people using these services, in relation to their disability, dietary requirements, personal care, gender, ethnicity, faith and sexual orientation. People were supported to express their sexuality, maintain good hygiene and were given choice about personal grooming. Information in people's care records reflected staff supported them to express their sexuality, based on staff understanding of who was important to the person, their life history, their cultural background and their sexual orientation.

Good

Our findings

Our previous inspection on 26 January 2017 identified the documentation in people's care plans was not always clear and at times was contradictory. At this inspection, we found people's care plans clearly reflected their needs. Where possible, people, their relatives and other professionals had, had the opportunity to talk about how people's care and support was to be delivered. One relative spoken with confirmed they had been involved in the initial planning of their family members care, and consulted when changes occurred. Care plans covered all areas of the person's health, welfare and safety and provided detailed guidance for staff to know how to support and provide care and treatment. This included guidance for staff to manage specific health conditions, such as epilepsy and diabetes. Care plans were being reviewed monthly, or sooner according to people's needs. Where changes in people's needs were identified these were responded to promptly. For example, one relative told us staff had acted quickly contacting the community nurse when they had identified a red area on their [Person's] sacrum, and early intervention had prevented this developing into a wound.

During the inspection, we saw that staff clearly knew the people in their care well and what they needed to do to ensure they responded to their needs. For example, where a person refused medical treatment resulting in deterioration in their health, staff had requested intervention from the GP. Following their visit the GP arranged for the person's admission to hospital. Prior to the person returning to the service, the provider requested a crisis meeting with health professionals involved in the persons care to ensure appropriate levels of support would be provided to help their recovery. Following this meeting, a plan was put in place with support from the intensive support team, district nurses, physiotherapist and GP. Since returning to the service, the manager told us, with support from the staff and physiotherapist, the person's physical and mental health has improved and they can now walk short distances.

Staff talked passionately about the people they supported and had a good understanding of their individual personalities and what could cause their behaviours to change. Care plans for managing behaviours, which could challenge others, guided staff on how to support people in a consistent and positive way. The plans promoted people's dignity and rights, and protected them and others from potential risks of harm. Staff understood the support people needed when they experienced distress and during incidents of behaviour which was challenging to others. During the inspection, we observed an occasion where a person's behaviour placed them and others at risk of harm. Staff dealt with this situation well. They spoke in a calm, patient, kind and caring manner and the person responded well to this approach.

Each person using the service had a nominated a key worker to enable a higher level of consistency in the

care and support they received. [A key worker is a named member of staff who works with the person and acts as a link with their family]. This role ensured staff working with the people understood their needs, their life history and were aware of things that may define them such as their cultural background, gender and personal preferences. They also had a key role in supporting people to keep in contact with their family, ensure they had adequate toiletries and ensure they maintained their personal hygiene.

We observed how people spent their day. We saw people were able to spend their time as they chose in their rooms, watching television in the lounge or outside in the garden. People also had good links with the community, such as visiting places of interest and access to college. People's care records showed they access a range of activities in the community based on their individual needs and hobbies, including accessing the local pubs. For example, one person does sport to build their confidence, and they told us they were going swimming. Their relative told us, "[Person] loves being outdoors, likes animals and regularly attends a farm so they could spend time with the farm animals." Staff encouraged and supported people to maintain relationships. One relative told us, "Staff drive [Person] to my house, or we arrange to meet in town so that they can spend time with their family."

We looked to see what arrangements were in place for responding to any concerns or complaints about the service. A 'making a complaint' procedure was displayed on the notice board in a format people could understand. Although a complaints process was in place, no relative or person had had cause to use this in the past 12 months. One relative was aware of the complaints procedure and told us, "If I had any concerns I would raise them with the provider or manager, or contact CQC." The manager told us they had regular contact with people's relatives by telephone or when they visited and any issues or concerns were discussed and resolved at the time. The manager told us outcomes of investigations were shared at meetings to learn from things that had not worked as well as expected. Staff told us they were aware of the complaints procedure and knew how to respond to complaints.

At the time of our inspection, no one using the service was nearing the end of their life, and therefore we were unable to assess how this aspect of the service was managed. However, we noted that peoples' care plans did not contain information about people's preferences regarding future care at the end of their life, where they wished to die or their spiritual and cultural needs.

We recommend that the service seek guidance from a reputable source, about supporting people with learning disabilities to express their views and involve them in decisions about their end of life care arrangements.

Requires Improvement

Our findings

Our previous inspection on 26 January 2017 identified the service was not always well managed and systems for monitoring the quality of the service needed improving. At this inspection, we found that, although regular checks of people's care and the service were made, the information was not being analysed to identify an overall picture of how well the service was meeting people's needs and performing. The provider told us they spent a lot time working in all of their services and that this gave them oversight of what was happening on a day-to-day basis. However, we found a lack of consistency in the service people received across all three services. The provider and manager did not work together to ensure necessary improvements were made and best practice shared with staff across the three services. For example, we identified medicines issues at both Paradise Lodge and Chignal House, but not at Willow Tree Lodge."

The provider and manager had not always understood their responsibilities concerning management of risk and regulatory requirements in relation to health and safety, mental capacity and deprivation of liberty. The lack of governance and poor understanding of the appropriate decision making process and establishing people's capacity to make decisions had placed people at risk of harm and / or abuse. Additionally, there was a lack of formal and effective auditing by the manager and provider. The manager told us they had carried out regular audits of medicines, but we found concerns with medicines in two of the three services. We also found staff had routinely recorded one person's seizures; but there had been no monitoring of these to identify patterns or trends linked to their seizures. We identified that prior to six seizures the person had refused their medicines. The audits had not identified these issues. Maintenance audits carried out by the provider had not identified issues we found during the inspection. For example, the last three health and safety checks carried out January to March 2018 had not identified the broken window restrictors in Chignal House. The manager told us they were aware these were broken, but no action had been taken to replace them with fittings that were more appropriate.

This was a continued breach of regulation 17 good governance of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The provider told us they were aware of the importance of forward planning to ensure the development of the service. Although, they had worked well with health professionals in relation to peoples care needs, they had not always worked well in partnership with stakeholders, such as the local authority and CQC to share information about how they planned to develop the service and meet previously unmet regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the previous inspection, they had not sent us an action plan as required under these regulations to tell us how they were making the

required improvements. They had not responded to our emails for this information. At this inspection, the provider told us they had not received these emails and provided their email address. When we checked the email address, this was the correct address we held on our system and used by the inspector and the local authority.

Following this inspection, the provider sent us a plan to address the issues we raised during our feedback of the inspection of all three services. This showed they had taken seriously the issues we raised and had taken steps to address these, including but not limited to carrying out an investigation into missing medicines, health and safety concerns and identifying a different training provider to deliver a robust MCA and DOLS training programme for all staff. They had also taken steps to enrol one member of staff from each service to become a safeguarding champion. Champions are staff that have shown a specific interest in particular areas. They are essential in bringing best practice in to the service, by sharing their learning; acting as a role model for other staff and supporting them to ensure people receive good care.

The manager told us they kept up to date with current guidelines and best practice in care services through a variety of networks, including CQC web site, Essex Association of Independent Care Providers who do forums, conferences and workshops. However, none of these forums related to most recent guidance and ways of supporting the specific client group using the service.

The provider's mission statement contained a clear vision and strategy to deliver high-quality care and promote a positive culture achieving good outcomes for people. The provider told us their focus was to provide a family orientated service and integration of people into the community as much as possible. Staff spoken with were aware of the vision and values of the service and were committed to make a positive difference to people's lives. Staff told us they worked together as a team, including the provider and manager, who helped out where needed. The manager told us they had an open door policy and spent time working on the floor so that they could monitor day-to-day culture in the service. This was confirmed in conversations with staff. Staff were particularly positive about the provider. One member of staff told us, "The provider is easy to talk to and down to earth. They visit the service at least three to four times a week and at weekends. Both the provider and manager are hands on. I have never met a provider like [Name] before, they are not like an owner, and they help out, including carrying out personal care." Another member of staff told us, "The provider is approachable, hands on and always around. We are a good team. We try to do our best. The provider is constantly telling us to take people out, they like the 'guys' to have fun." Staff told us the provider took staff out once a month 'for a bit of fun' and to show their appreciation.

Staff told us regular staff meetings were taking place. The minutes of the last three meetings, showed detailed discussions about people's needs, any changes and any action to be taken and by whom, had taken place. The minutes also showed constructive discussions had taken place about policies and procedures, good practice and where further improvements were needed. Staff told us they felt well-supported and received regular supervision. Supervision is a formal meeting where staff can discuss their performance, training needs and any concerns they may have with a more senior member of staff. Information in staff files confirmed staff had a formal supervision session, a minimum of twice yearly. The sessions included medicines competence assessments, direct observations, and questions and answers about a range of topics to test staff understanding, including the member of staff describing a scenario that could happen in community, how they would assess the risk and manage the situation. Supervision record also showed staff were given the opportunity to discuss plans, ideas and their future personal development.

Staff felt there was good communication between the management and themselves. The provider told us they had implemented an electronic instant messaging service so that management and staff were able to communicate quickly and effectively. This enabled staff to work flexibly picking up shifts, where needed to

support people to access activities and the wider community.

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 The rights of people using the service were not protected against the risks associated with restrictions on their freedom and liberty. This was because staff lacked understanding of the MCA 2005 and DoLS and the application of this legislation, to determine whether the restrictions were appropriate and needed. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with the proper and safe management of medicines. Regulation 12 (2) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who use services and others were not protected against the risks associated with the

ongoing failure to have good governance systems in place to monitor the quality of the care provided.

Regulation 17