Paradise Lodge Care Home Limited

Willow Tree Lodge

Inspection report

133 Chignal Road
Chelmsford
Essex
CM1 2JD

Tel: 01245355434
Website: www.caringfuture.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

The inspection of Willow Tree Lodge took place on 12 March 2018 and was announced.

Willow Tree Lodge 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. Willow Tree Lodge accommodates five people in one adapted building.

Although the provider spent a lot time working across all three services, we found a lack of consistency in outcomes for people. The provider and manager had not always understood their responsibilities concerning regulatory requirements in relation to health and safety, mental capacity and deprivation of liberty. The provider had worked well with health professionals in relation to peoples care needs, however they had not always worked well in partnership with stakeholders, such as the local authority and CQC to share information.

Although, the provider had identified risks to people's safety, and taken action to address them, they had not always assessed the ongoing risk of harm. 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.

The provider and 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.

Although care plans were in place to guide staff on how to support people's health; welfare and safety, we found one exception where there was no care plan in place in relation to a person's epilepsy, or how this should be managed in the event of a seizure.

We recommend that the service seek appropriate professional advice regarding the management of epilepsy.

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.

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.

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. 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. 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.

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.

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.

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.

Staff spoke positively about the provider and the manager. Staff felt supported and said there was good communication between the management and themselves. 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.

We found a breach 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?

Good

The service was safe.

Systems were in place to manage risk, including protecting people from harm. Staff understood how to recognise abuse or potential abuse and how to respond and report these concerns appropriately.

There were enough staff to meet people's needs.

Effective systems were in place to provide people with their medicines when they needed them and in a safe manner.

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 had access to appropriate healthcare services; however, specific health needs, such as epilepsy were not always managed in accordance with recognised guidance.

People were provided with enough to eat and drink to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

People were supported to express their views and make decisions about their 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 and support that was responsive to their needs.

People's wellbeing and social inclusion was assessed, planned and delivered to ensure that their social needs were met.

There was a complaints system in place to show that complaints were investigated, responded to and used to improve the quality of the service.

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.

Willow Tree Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 Paradise Lodge, Chignal House 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.

We also reviewed all the information we had available about the service including notifications sent to us by the manager. This is information about important events which the provider is required to send to us by law. 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 the inspection we observed how people interacted with staff and received their care and support. Not everyone chose to or were able to communicate effectively or articulately with us.

We spoke with one member of staff, the manager and the provider. We looked at two people's care records, three staff files and reviewed records relating to the management of medicines, complaints, staff training, records in relation to maintenance of the premises and equipment and how the registered persons monitored the quality of the service.

Good

Our findings

An easy read version 'Understanding and reporting abuse' provided by the local authority was available to people using the service. The providers 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. One member of 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.

Measures had been taken to assess and manage risks to people's safety yet, promoting their independence and freedom. For example, a protocol and emergency plan was in place to support a person with known inappropriate sexual behaviours within the home and in the community. This provided good instruction for staff to manage situations where the person or others may be exposed to the risk of harm or if they refused to cooperate with the plans in place to support them. This included a missing person profile and contact details of the police and relevant health professionals.

One member of staff spoken with had a good understanding of risk management and their responsibility to raise concerns where they identified risks to people's safety. They knew the people using the service well and the risks involved in providing the care and support they needed. This included the use of equipment to keep people safe, such as hoists and the correct type and size of slings. One person's, personal safety assessment, stated they were at risk of becoming agitated in certain situations, and may become angry towards others. The member of staff spoken with had a good understanding of what action to take to prevent such incidents occurring and the triggers, which had the potential to cause this person and others using the service distress. They were clear that the service had a 'no restraint' policy in place and was able to talk through 'distraction techniques' used to deescalate people's behaviours when anxious or distressed to minimise the risk of harm

Records showed that external companies were contracted to carry out regular checks on fire system, electrics and Portable Appliances Testing (PAT). Equipment such as hoists and slings had been serviced regularly in accordance with the Lifting Operations Lifting Equipment Regulations 1998 (LOLER). A contingency plan was also 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.

During our inspection, we saw there was sufficient staff to meet people's needs and support them to access external activities of their choice. This was confirmed in discussion with a member of staff, who told us, "We are never short staffed; we keep in touch with each other so that we can make sure there is always enough staff to support people with their activities." The manager told us they did not use a dependency assessment tool to calculate staffing levels, as they continuously adjusted staffing numbers to meet people's care needs and support their various activities. The member of staff confirmed this and told us they worked flexibly across the providers three services to support people's social inclusion.

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's DBS had disclosed that they had a conviction. 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.

Systems were in place to manage and dispense people's medicines safely. Staff had received appropriate training to support people with their medicines. People's records contained up to date information about their medical history and the medicines prescribed to them. Protocols were in place providing guidance for staff where people had been prescribed medicines to be taken on an 'as required' (PRN) basis. Random sampling of people's medicines, against their Medicines Administration Records (MAR) confirmed they were receiving their medicines, as prescribed by their GP.

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

We found a disparity in staffs 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.

One member of staff spoken with had understood the process and had completed a MCA around a person's capacity to make decisions about managing their own medicines. They had followed the correct process and the person was deemed not to have capacity to manage this safely. Therefore, in their best interests, an agreement was reached that staff would administer their medicines. However, not all of the assessments we looked at contained evidence that people's capacity had been correctly assessed. For example, one person had, had their capacity assessed as to whether they were able to consent to personal care and having their medicines managed by the service. One of the forms said they were able to communicate decisions, the other said they were not. This was confusing as to what support the person needed and whether or not they had capacity to make their own decisions to consent to receiving care and / or treatment.

The SALT team had assessed one person as requiring their food blended due to a high risk of choking. However, the person did not want their food blended and continued to eat whole foods, which placed their health at risk. Where there were concerns about the person's capacity to understand the risks the manager had initiated a significant decision MCA assessment, however this was incorrectly completed. This assessment form did not demonstrate the best interest decision-making process, who had been involved or the final decision.

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 that applications had been submitted for the five people using the service to deprive them of their liberty for their safety. We looked at one application and found that it did not contain the full information about why the person needed a DoLS authorised. Another person's application had been submitted with regards to their behaviour and accessing the community. The request stated they became frustrated if not understood, and was a potential risk to the public, however the

application form did not specify that they needed continuous one to one staff support in the community, which was the reason why the request to deprive the person of their liberty needed to be made.

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

Overall people were supported to live healthier lives, have access to healthcare services and receive ongoing healthcare support. People's records confirmed they had input from a range of healthcare services including the GP, specialist nurses, psychologist, physiotherapist and dietician. However, one person's care plan recorded that they lived with epilepsy. There was no care plan in place in relation to this condition to guide staff on how this should be managed, other than their epilepsy was being controlled by medication. National Institute of Excellence (NICE) guidelines say that everyone living with epilepsy should have a regular structured review at least yearly with their GP or a specialist. Records did not demonstrate that this had taken place. However, another person's care plan reflected their Asperger's diagnosis and contained detailed information on how this was managed.

We recommend that the service seek appropriate professional advice regarding the management of epilepsy.

We saw staff worked well together to ensure they delivered effective care and support to people using the service. One member of staff told us and certificates in their recruitment file confirmed they had received a range of training designed to give them the knowledge and skills to carry out their roles and responsibilities. They told us they had completed their level 5 Management in Health and Social Care qualification. This is a recognised National Vocational Qualification (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 MCA, assessments carried out under the MCA did not always demonstrate a thorough understanding.

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, three staff files reviewed showed they had completed an induction, when they started working at the service. One member of staff confirmed this, they told us, "When I joined about eight years ago I had a very full induction and all the proper checks before I started working in the service."

Staff told us and we saw for ourselves that people were encouraged to take part in preparing their meals. We saw people were provided with a balanced diet and had sufficient quantities to eat and drink to stay healthy. People's records showed their 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. One person's records demonstrated how they had been supported to lose weight, which they were particularly proud of. Where required, people had been referred to the Speech and Language Therapy (SALT) services. Their input and advice was clearly recorded and was being followed by staff.

The service had recently been refurbished with level access to the garden and outside decking area. We saw people moved freely around the premises, including those who used wheelchairs. People, had their own

bedrooms and could choose to spend time in communal areas or alone in their rooms. During our inspection, we saw one person who chose to spend time in their bedroom listening to music. Equipment, such as profiling beds and hoists had been provided to where people required this for their mobility and safety.

Good

Our findings

During our inspection, we saw staff treated people with kindness, respect and compassion. The interactions between staff and people using the service were caring and friendly. One member of staff told us they had worked across all three of the provider's services for a number of years and we could see from their interaction with people that they had clearly built positive relationships with them.

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. For example, we saw a member of staff supported one person to make their lunch. Another member of staff supported a person to make a cup of tea. Both staff stood back to enable these people to do as much as they could do for themselves, and only intervened when they needed help.

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. Staff were patient allowing people the time they needed to talk about topics of interest and communicate their views.

We observed staff supporting people 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, Essex Guardians managed people's finances, where there was no next of kin to facilitate this. People's care records showed, where possible they had been involved in making decisions about their care. Photographs helped people to discuss activities they had taken part in and plan future activities. Where people had been unable to provide input into their care plans, family members had signed to say they agreed with the contents of the plan.

Monthly group service user meetings took place. The minutes of these meetings showed people were asked their opinions of the service. All stated they were happy living in the service. One person had commented, "I want to live here for the rest of my life." People stated the manager and staff did their best to support everyone. All agreed they were happy with the menu panning that took place on a Sunday and were happy with the quality of the food. All stated that they went out regularly in line with their choice of activities. One person had stated that they wanted to attend a friend's funeral. An additional note had been added to reflect this had happened.

Additionally, the manager showed us questionnaires asking people a series of questions about the quality of the service they received at Willow Tree Lodge, including if they were happy with the staff and the service in general. Comments included, "Yes I am involved in updating my care plan" and "Yes they read it (care plan) to me and I am happy with it." 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. One member of staff told us, "I always ensure doors are closed when I am supporting people with their personal care, to maintain their dignity." 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.

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, who chose to were supported to attend the local Church of every Sunday. Information in people's care records showed they were supported 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

A review of people's care records showed that prior to admission to the service; a detailed assessment of their needs was completed. The provider told us this initial assessment was key to getting the right people to ensure compatibility with the existing people using the service. We saw this initial assessment formed the basis of the people's care plans and clearly set out how their care and where required treatment was to be provided. Where possible, the person, their relatives and other professionals had, had the opportunity to talk about how they would like their care and support delivered. One care plan recorded that the person could not read or write but they had been able to express their choices. Care plans covered the person's health, welfare and safety and provided detailed guidance for staff to know how to support and provide care and treatment. 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.

One member of staff spoke passionately about the people they supported and had a good understanding of their individual personalities and what could cause their behaviours to change. They understood the support people needed when they experienced distress and during incidents of behaviour which was challenging to others. People's 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.

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. One member of staff told us part of their role was to support people to maintain contact with their family, community and arrange holidays. They told us they had spent time with their key client talking about places they wanted to visit. They had wanted to go to London, and this had happened on three separate occasions, by train. They told us the person loved travelling by train and had been to Cardiff, Scotland, Yorkshire, Hertfordshire and Norfolk.

We observed how people spent their day. We saw people returning from a shopping trip. They spent the rest of the day spending time as they chose in their rooms, watching television in the lounge. We saw people also had access to a range of activities in the community, based on their individual needs and hobbies. For example, bowling, accessing a local day centre and the local pubs. Two people regularly attended college, where they took part in computer and arts and crafts sessions.

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. 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 advice and guidance from a reputable source, about supporting people to express their views and involving them in decisions about their end of life care arrangements.

Requires Improvement

Our findings

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. We did not get a sense of how well the provider and manager worked together to ensure necessary improvements were made and best practice shared with staff when things went wrong. For example, we identified medicines issues at both Paradise Lodge and Chignal House, but not at Willow Tree Lodge.

The provider had identified risks to people's safety, and taken action to address them, they had not always assessed the ongoing risk of harm. For example, the last two months routine checks of the premises had identified high water temperatures from the hot tap in the kitchen. The provider had contacted engineers to check the source of the problem. However, they had not assessed the ongoing risk of people scolding their hands from the hot water, until the necessary repairs have been made. Additionally, 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.

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 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 provider told us they were aware of the importance of forward planning to ensure the development of their services. However, we found a lack consistency across the three services. The provider acknowledged there had been a disparity, in particular Paradise Road. This had been largely due to the prolonged sale of the service, and as a result they had had left existing processes in place, which had fallen behind. They advised they have reviewed the financial viability of each service, and having a manager at each location. They told us their vision had been to have three, three bedded homes providing a specialist service for people with learning disabilities. However, due to rising costs of running a care service and changes in

funding they were looking to increase numbers at Willow Tree Lodge to accommodate six people. They acknowledged this needed careful consideration to ensure the increase in numbers complied with the Registering the Right Support guidance.

Although the provider 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. They had not responded to emails for information from us, or the local authority. 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.

The provider and 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. The member of staff spoken with was aware of the providers vision and values of the service and was committed to making a positive difference to people's lives. They told us management and staff worked together as a team. They described the manager as approachable and were particularly positive about the provider, commenting, "They are very hands on, I don't think any other provider is like [Name]. They are always ready to have a laugh and a joke with people using the service and us."

Records showed 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. The member of staff spoken with told us they felt well-supported and received 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.

The member of staff spoken with 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)