Enham Trust

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

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 10th, 11th and 12th April 2018 and was unannounced.

The last inspection of this service took place on 4th, 5th and 6th July 2016 and at that time the service was rated as requires improvement.

Enham Trust – Care Home Services (Elizabeth / Michael and William Houses) 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.

Elizabeth, Michael and William Houses are purpose built care homes which can accommodate up to 60 people. When we inspected there were 56 people living in the three homes. People live in self-contained 'flats' all of which have a kitchen area, living room, bedroom and en-suite shower and toilet. There were communal lounges, bathrooms and shower rooms and a large dining area in each of the houses.

The manager of the Care Home Services was in the process of applying to become the registered manager. 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 service was unable to ensure that call bells would be answered in a reasonable amount of time or that the care required by people could be provided when needed.

Changes to staffing had left some people reluctant to use their call bells, others waiting for extended periods for support and at times continence care was missed.

Low levels of legionella bacteria had been detected in the water system of Elizabeth House in late 2017. A risk assessment in January 2017 had identified this risk and a further risk assessment in February 2018 showed that actions had not been taken from the first assessment.

Fire safety procedures did not reflect Enham Trust's fire safety policy. There were fewer fire drills held than the policy stated there should be.

Fire doors did not provide adequate fire protection, a fire safety report identified that doors should be replaced and current practices around evacuation should be changed immediately. A recent Fire Safety report commissioned by Enham Trust stated that doors should be replaced as soon as possible.

There was no system for people to sign in and out of the buildings this meant that in the event of a fire there

was no accurate register of who was in each of the homes.

Medicines were managed safely and people, when possible, were supported to be independent with medicines.

Problems with catering had been dealt with through retaining a new catering provider.

Care plans were clear and covered relevant areas.

There was good use of assistive technologies and communication devices.

Staff were skilled in different communication techniques.

Staff received regular and effective supervisions.

We received a great deal of positive feedback about the quality of the care staff.

The service had, when necessary, supported people with planning for end of life care and will develop this in future as needed.

People accessed on-site day services if built into their care package, there were minimal additional activities provided in the 3 homes for people who did not access day services.

People knew how and to whom to see to make a complaint. Enham Trust dealt appropriately with a complaint during our inspection.

Changes to staffing numbers and structure were not communicated to people or their relatives by the homes management team. Frontline staff had to deliver the message that activities and outings could not go ahead due to having not enough staff.

Though concerns were raised a number of times about the reduction in staff, people had faith in the skills and commitment of the registered manager and head of care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not sufficient staff deployed to meet the complex needs of people living in the homes.

Fire safety procedures were not followed and the building fire protection systems needed updating.

Informal procedures of telling staff if someone was going out were not sufficient to ensure the safety of people in the event of a fire.

Peoples medicines were safely managed and people were encouraged to self medicate whenever possible.

Is the service effective?

Requires Improvement

The service was not always effective.

Peoples care plans had not been reviewed for over a year in some cases.

There had been problems with food quality, a new provider had been sourced who had, to some extent, alleviated issues.

Some flats were not clean, people were no longer supported to clean their own flats and the cleaners had not thoroughly cleaned people's rooms.

Staff had regular supervisions and training.

Is the service caring?

Requires Improvement

Peoples preferences of male or female carers and when they would like to have their care were not always met.

People had to wait longer than they felt they should for call bels to be answered and at times care was not completed due to staffing levels.

People and their relatives had confidence in the staff team and

believed they were caring and supportive.

Is the service responsive?

Requires Improvement

The service was not always responsive

There were few activities arranged for people to participate in within the homes.

People were at risk of becoming distressed due to changes in routine following reduction in staffing.

People were unable to access the community as frequently due to insufficient staff and drivers

Complaints were handled in a timely and competent way.

Is the service well-led?

Requires Improvement

The service was not well-led.

Management were not effectively monitoring maintenance requests and ensuring completion of works.

Risks to the service from legionella were not effectively monitored or addressed.

Important messages about changes to services were not communicated to people and their relatives by the provider.

The head of care and manager were trusted by people and staff felt supported by them.

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

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.

Enham Trust – Care Home Services (Elizabeth, Michael and William Houses) are 'care homes'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

This unannounced inspection took place on 10th, 11th, 12th April 2018 and was completed by two inspectors and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we had received about the service such as notifications. A notification is information about a specific event in the service that the provider has to send us by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 16 people who use the service and three relatives and received feedback and concerns from the Families and Friends of Enham Group. We spoke to 12 staff with caring responsibilities, the Head of Care and the manager who had applied to become registered manager and the Director of Care. We observed

care practices and interactions between staff and people using the service throughout the inspection and at key times such as meal times.

We looked at the care records of ten people who use the service to review their care plans and notes and risk assessments. We also checked records concerning the premises including fire, water safety and maintenance and assessed the environment for safety and suitability for purpose.

We reviewed five staff files to check that recruitment practices were safe. We also checked staff training records to ensure that staff were suitably qualified to work as carers. We checked staff duty rotas for several weeks to ensure there were sufficient staff on duty.

Inadequate

Is the service safe?

Our findings

At our last inspection in July 2016 the provider did not have a working call bell system in place which placed people at risk. Following our inspection, an action plan was sent to us by the provider and essential maintenance work was carried out to fix the call bell system. At this inspection we found the call bells were working properly.

At this inspection the director of care told us there had been a change to the staffing hours allocated to each of the three homes on site. The hours were reduced ten days before our inspection. A new staffing structure had been implemented which added a five-hour laundry assistant post and two senior personal assistants to the team in each of the houses, however there would be one less house manager and reduced care hours. The changes so far had reduced care staff by approximately one person per shift, and the reduction to house managers was about to take place. Laundry assistants had yet to be appointed.

The allocated hours in each house cover people's needs for personal care, support at mealtimes, taking people to activity sessions, laundry, providing personal assistant support as per people's care packages and writing up care files. All these duties were carried out by personal assistants with some support from house managers.

People told us they still had to wait significant amounts of time for a response to their call bells, one person had to wait 45 minutes before being able to go to bed and other people told us they had waited ten minutes to be supported for personal care. The delays were due to staff availability to answer calls rather than a call bell system that did not work.

People told us they were concerned about the changes and how they impacted on their lives, "There are not enough staff here, there isn't a fast response when I pull the buzzer and sometimes, when there are two male and two female staff working, I have to wait a long time to use the toilet". Other people told us they were left waiting in the toilet for some time before staff arrived to support them and there were not enough staff to take them to the day activities provided on site. Another person told us they had to wait 30 minutes after others had their meal for a staff member to be available to support them with their meal, at a different occasion, the person supporting with their meal had to answer a call bell while giving their meal. People felt frustrated about this, they praised the care staff for their skill and care but people we spoke with were of the opinion there were not enough staff.

People were supported with their health needs including being accompanied to appointments if necessary. However, the change to care hours meant this was not always achieved. For example, staff tried to arrange support for a person to attend a GP appointment for a planned blood test at a specific time. Every effort was made for the blood test appointment to be attended, however there were not sufficient staff members to do this without taking other care staff away from providing care, leaving the shift short of staff, or just one person supporting the appointment which was a risk to the person and staff member.

People living in the three houses have varied needs including physical and / or learning disabilities and

autistic spectrum disorder. In addition to such disabilities, some people had significant medical conditions such as epilepsy or sensory loss. Other people had a high risk of choking. At times people may use the call bell for urgent assistance as they are aware they may be about to experience a seizure. Staff members must respond to these calls as emergencies due to the nature of people's health conditions, something they told us they were concerned about as they felt it was likely they would not be able to provide the care people needed and answer emergency call bells. One staff member told us they were 'frightened a tragedy may happen'. People told us they worried about using the call bell in case someone else needed support at the same time that was more urgent than their own need.

The lack of sufficient staff to meet people's needs at all times was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

During late 2017 we had received information from the provider informing us they had identified low levels of legionella bacteria in the homes water systems. A risk assessment completed in February 2017 for Elizabeth House had identified some issues with the management controls and monitoring systems. These had not been addressed in a timely way. The provider completed a new risk assessment in February 2018 and sent us a copy which indicated the risks remained. During our inspection we discussed our concerns about the delay in action being taken with senior managers. They confirmed that they had not had the right people, with the right qualifications and skills, in post to oversee this area of responsibility. They had reviewed the senior management structure and had appointed a consultant to oversee the management of legionella and develop an action plan. We spoke with the consultant who explained the work they had completed so far and told us, "We have made huge strides forward. It's a work in progress."

We spoke with a member of maintenance staff who showed us records of the checks they carried out, such as the monitoring of water temperatures. House managers and care staff carried out additional water monitoring which was recorded. However, we noted there were some gaps in recording in one of the houses. The house manager explained that some staff had not felt they had received sufficient training and were reluctant to carry out the checks. Whilst training records showed senior managers and maintenance staff had received training in legionella, we received inconsistent feedback from staff about their training. This had now been addressed.

Fire safety did not follow the provider's own policy and fire risk assessment, for example, the provider stated they would have a fire evacuation 'at least every six months'. The fire book did not reflect this frequency, only one evacuation had been held since October 2016 in July 2017.

There was information recorded about problems with fire doors in several flats. These doors did not function correctly during fire alarm tests dating back to January 2018. This had taken some time to address. The maintenance manager explained the problems had been difficult to fix due to different contractors for different aspects of the problem. A site visit with the maintenance manager and the contractors involved was arranged to agree responsibilities and how to progress the repairs.

A report of a fire safety review carried out by an external contractor at Enham in April 2018 stated that 'the current plan of leaving the residents in their rooms for a phased evacuation is to be discontinued.' This was due to refuge areas needing to provide 60 minutes protection and there needed to be staff with every person left in the building. The report also stated the following, 'My investigations prove it is impossible for two staff to evacuate all residents from Michael and William'. Since our inspection Hampshire Fire and Rescue Service have inspected the service and believe that if staff from the three homes supported the evacuation it would be possible however this would leave two homes without staff.

A replacement programme of fire doors was due to start in each house on recommendation of the fire report. Letter boxes negated the fire protection of doors to flats. Doors to 'fire compartments' were to be replaced first, then flats in each home would have new doors thus improving fire protection to individuals. Hampshire Fire and Rescue found that it was unnecessary to replace all fire doors however some to fire compartments still need to be upgraded along with some that were damaged. These remain a priority and three months after the fire safety report commissioned by Enham was received by the provider, replacements have not been fitted.

These failures to assess, monitor and mitigate risk in a timely way are a breach of Regulation 17 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

People we spoke with told us they felt safe. Staff were trained in safeguarding and when asked could identify different types of abuse and told us what they would do if they suspected someone had experienced abuse. Staff also knew which outside agencies to speak to if concerns were not dealt with by the service management.

There were detailed risk assessments on people's files including fire safety, use of wheelchairs, personal care, shaving, road safety. There was a broad range of assessments and each identified ways to minimise risks in the situation described. Frequency of review varied across the three houses. Reviews were recorded monthly in one house yet in another, some assessments were not reviewed since September 2016. The house manager told us that if the review had not taken place it was due to the persons risks not changing in that time. Regularly looking at assessments and recording that they have been checked would offer reassurances that risks for each person were considered frequently.

Informal procedures in place when people left the buildings were not sufficient to ensure their safety in the event of a fire. When leaving the building, people would tell a staff member where they were going. This informed the service for purposes of fire safety and personal safety of individuals. This approach depended on people to remember to share when they were leaving the building and on staff to remember who was out.

People were not happy about this approach as at times, staff did not tell colleagues if a person was out and when they were due to return. One person told us they had been 'grilled about their whereabouts' in the dining room in front of others when information had not been shared about where they were going. They said they found this humiliating and it made them angry, particularly as not everyone shared information about where they were going. In a recent residents meeting people were encouraged to tell 2 or 3 staff members they were going out. This system was not adequate as in the event of a fire staff would not be able to inform the emergency services with certainty who was in the home and who was out.

This is a breach of Regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment.

People's medicines were managed safely. Medicines were stored in locked cabinets in people's flats, they key either held by the person or staff. Some people could manage their own medicines, this was risk assessed and staff audited medicines weekly to ensure they were being taken correctly. If people did not manage their medicines, or if they needed support, two staff members would check, administer and sign medicine administration record sheets (MAR). We saw medicines being delivered and signed in by two staff members and when checked, quantities of medicines and controlled drugs were as expected. Staff were trained in administering medicines and were signed off as competent once they had been observed several times and the service was satisfied they were safe to give medicines.

People were protected from the risk of staff not being suitable carers by a clear recruitment procedure and appropriate pre-employment checks. References were checked, full employment histories sought and a Disclosure and Barring (DBS) check completed before staff commenced in post.

Staff and people living in the homes were aware of infection control procedures when asked but told us that staff did not always wear gloves when supporting with personal care. One person told us that 'staff sometimes did not wear gloves and they never wore aprons except for today and yesterday for CQC's benefit'. A staff member also told us that they had colleagues who did not wear gloves during personal care. We spoke to the head of care and registered manager about this and they immediately addressed this with staff. A staff member told us that a recent change in gloves purchased was a significant improvement as those previously supplied were thin and split frequently when in use.

The service investigated accidents and incidents as they occurred. We saw in-depth investigation reports and accidents were monitored using audits and learning from them shared appropriately.

Requires Improvement

Is the service effective?

Our findings

People were supported with nutrition. A new catering contract had commenced on 8th January 2018 and people told us that the food had improved a great deal. On the days we inspected, food looked appetising and people ate with enthusiasm. It was noted in resident's meetings in March 2018 however that people were not entirely happy with the food provision as it was often still cold and the names of some meals were confusing. People suggested having a short description of the food with the menu as they were reluctant to order and try new things if they had no idea what they were. Snacks such as crisps and fruit were available between meals. It is recommended following best practice and ensuring people have an accessible picture based menu in addition to the written one to support their meal choices.

People had care plans and risk assessments supporting their nutrition and hydration needs. Several people living in the homes needed support due to being at a high risk of choking and others had swallowing difficulties. Staff were aware of people living in the home who needed support around, food, nutrition and weight management. They were careful to ensure that those at risk of choking had only suitable foods and advised others how to maintain their health through diet.

One person told us they were unhappy about the choices offered to them as they had to have a dairy free and low-fat diet. They had spoken to the catering manager who had offered to find some different foods for them to try. The person told us that they were happy with the outcome and said, 'I wished I had spoken to them sooner'.

Meals were prepared in a central kitchen on site and taken to each house in a hot trolley. Choices were made from a weekly menu and people found they did not always recall what they had ordered and were unsure what meals they were having on which day. We were also told that at times the menu would be given to them on Thursday to be ready for Friday which didn't give everyone time to consider their choices fully. People went to shops in the village and purchased food, often unhealthy items, to supplement meals in the home. Staff told us they would intervene if someone was purchasing unhealthy foods or behaving in a manner that was not good for their health but, if the person had capacity to make choices, they would only advise.

Care plans were detailed and included clear instructions as to how best to support people. A person-centred profile was in many people's files however some people had chosen not to have one. Those we looked at were completed with the person and had photos and pictures to show likes, dislikes and other things important to them. The frequency of care plan reviews varied between the three houses, from monthly to over a year since review. The house manager of the home with fewer reviews told us this was due to people's needs remaining the same. Records would benefit from being reviewed more frequently, in line with the other houses as there was no evidence the person's needs had been considered since the care plan was written.

People could choose to have a hospital pack in their files. This was represented by a record detailing what information needed to be sent with them should they ever be admitted to hospital.

Assistive technology was widely used in all three of the houses. Doors were automatic and there was a nurse call system. People had individual devices that controlled a variety of items such as doors, lights, TV and music. People used speech generating devices such as eye controlled tablets and monitoring equipment such as seizure monitors and pressure mats were available. Technology was important to people in the service, it offered a freedom to participate more fully and independently in life.

Staff told us they received regular supervisions with their line manager and their meetings were useful. They discussed people's well-being as well as their own progress in their roles and had an opportunity to offload and be supported by their line manager.

Staff training has been reviewed over the last year, some training has been sourced from outside of the organisation and the Head of Care has attended 'train the trainer' sessions so they can provide in house training. Staff received induction training and a number of courses that the service deemed as mandatory on commencing in their posts. The training included fire safety, moving and assisting, data protection and health and safety. Records of training were held centrally and most of the records we checked were up to date with training, those that had lapsed were mainly due to those staff being night staff and scheduling training was proving difficult. Staff we spoke to were knowledgeable about social care and told us they had also received specific training in areas such as administering rescue medications.

People living in the homes could choose the décor in their flats. One person had just had new wallpaper and was thrilled with the results. The maintenance manager told us there was a programme of flooring replacement underway, old carpets were being replaced with more practical and washable cushion flooring. People were enthusiastic about having the new flooring however there had been some problems as installation of the flooring meant people had to move out of their flats briefly and they were reluctant to do this. When we inspected we noted that some of the flats had not been thoroughly cleaned. People could choose to clean their flats rather than have the housekeeping team do it for them. Personal assistants had supported people to clean their own flats enabling them to retain independence and develop or maintain daily living skills. This was no longer happening partly due to having cleaners and partly due to staff not having time to support people. The impact on people was that they may not be able to develop daily living skills to move into independent living accommodation in the future as per the plans of the registered manager and the head of care who were keen to utilise some of the care homes as transitional placements for people moving on to independence.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked to see if the service worked within the principles of the MCA. Staff members had a good understanding of the principles and there was evidence of capacity assessments in people's files. People told us that before providing care, staff asked for consent and that if they didn't ask it was due to forgetting and just 'getting on with things'. The person that told us about this was happy even if not asked as the staff knew them so well. Staff also understood the importance of making decisions in people's best interest if they lacked capacity and we observed them asking people to make simple, day to day choices.

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

The service applied for DoLS authorisations as needed. There were clear records of applications and outcomes and at the time we inspected there was no-one subject to a DoLS authorisation. The service recognised that people's capacity fluctuated and would reapply for authorisations if someone became at risk and took advice from DoLS assessors as needed.

Requires Improvement

Is the service caring?

Our findings

People told us they were concerned that staff would not answer their call bells at certain times due to them being busy elsewhere and had tried not to call for assistance. One person was very upset when they called for assistance with personal care to be told that staff members were busy and they should have called earlier. The person had to point out they did not need support earlier but did now. This had the effect of the person feeling they were an inconvenience to staff.

Another person who was concerned about the length of time they had to wait for a call to be answered. They routinely had to wait ten minutes or more for support, but thought less than one minute would be the correct waiting time. They did tell us that when they were supported, though they generally had positive relationships with staff, 'they [staff] get angry because they are short [of staff]'. When asked how this made them feel they told us it frustrated them. We asked if their care was as good if there were fewer staff available and they told us that they needed to have a change to continence products at lunch and dinner times and when short of staff this may not be done at lunch time. Not changing incontinence pads puts people at risk of infection, skin sores and breakdown and, impacts on their dignity.

People's preferences and choices were not always supported. Some people had stated a preference for male or female care staff and other people liked to choose who supported them. One care plan stated 'I require support with showering and choose the member of staff I would like to support me and on which night I would like my shower. This is clearly marked on the shift pattern along with the time I want my shower.' While we were inspecting we were told that baths were now not going to be supported in one of the homes as there were not enough care staff available in the evenings or weekends, staffing levels also impact how and with whom showers can be provided.

This is a breach of Regulation 9 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person Centred Care.

People and their families told us that staff were caring, treated people respectfully and provided care in a dignified manner. Due to the changes in staffing we received several representations from people's families, all of whom praised staff members, the registered manager and the head of care for their hard work and the quality of the care they provided.

One person told us that 'staff have a dedication to the job and to being able to provide good care'. They told us this because they perceived that at times there were not enough staff, and they believed that those staff worked very hard to ensure people were safe and cared for even though they were very busy and under pressure.

Family members contacted us during and after our inspection and gave overwhelmingly positive feedback about the personal assistants and house managers, they witnessed good care being delivered and told us that staff had positive relationships with their relatives. There were concerns about the recent staffing changes and the possibility of fewer staff but one relative told us, "My wife and I owe a debt of gratitude to

the front-end staff. [Relative] has been kept safe and they are very happy living in [name] House. There is a great rapport between them and the staff and they are much loved".

We saw people being supported at lunchtime in all the houses and observed interactions that were fun and appropriate to people. There was a lot of laughter and lunch was a good social occasion.

When possible, staff made time for people if they wanted to chat or needed support. While we were looking at care notes with the house manager, a person came to speak several times. Even though busy with what they were doing, the staff member made time to speak and reassure the person, telling us that the person responded well and could cope better with the day if they took a little time with them.

People communicated in many ways and staff could support them well. People had speech devices that staff supported them to use. People used Makaton signing or their own signs, that staff interpreted and responded to according to people's needs. There were regular training sessions in Makaton; some staff were very skilled using it. Makaton uses signs and symbols to help people communicate. Makaton is based on the signs used in BSL (British Sign Language). Unlike BSL, Makaton signs are used in conjunction with speech always and in English grammatical word order.

Some people were unable to easily access written information due to their healthcare needs. In people's files in Elizabeth House there was a form identifying the best way to present information to people. For example, 12, 14 or 16-point font with bold or capital letters, Widget symbols, pictures or 'I'll let you know'. When this form wasn't used in the other houses, we asked how information would be presented and were told that staff would know how best to support people as they were familiar with their needs. The simple form in use in one of the homes would be useful in all homes as, though current staff know people's needs, agency cover or new staff won't know or have records of this. We recommend all three homes consider how they will enable accessible information to be provided for all residents and to support the service meeting the requirements of the Accessible Information Standard (AIS).

End of life care did not play a part in life at the home due to many of the residents being young and it not being relevant to them at this stage of their lives however some residents had been supported to consider end of life care, had pre-paid for funerals and had some of their wishes recorded with funeral directors. The staff team and Head of Care had provided support to a person and enabled them to return home from hospital to receive care with support from local health professionals. The Head of Care told us the experience had, they believed, been a positive one, a privilege to be part of and one that had offered comfort to the person and their relatives. When people passed away staff told us they supported people through the difficult time that followed. Memorial services had been held for those who had not wished to, or been able to attend the funeral, and a memory tree had been created and was displayed in one of the houses with people's memories of the person on the leaves. This offered people an outlet for their feelings about bereavement and grief. They intend to provide similar care in future should it be needed.

People's personal files were stored in each of the houses in the House Managers office. They were stored in lockable cupboards and accessed by staff as and when needed. There was a daily notes file that staff updated throughout the day which was on a desk and easily accessible but the door to the office was locked when unoccupied keeping people's personal information confidential and within current requirements of legislation. People had also agreed to share information with relevant others such as CQC in their files.

Care files held information about people that was person centred. There was a life history and information about the person that they were happy to share, if they did not want details about their history available then it was not retained and shared.

We saw people treated with dignity and staff told us, when asked, how they ensured that care they provided retained peoples dignity. They told us they kept people covered, gave privacy, closed doors and spoke to people about what they were doing keeping them informed of what was happening.

Requires Improvement

Is the service responsive?

Our findings

People attended the on-site day services, Choices, or other services in the community. If people did not attend day services there were limited opportunities to participate in activities in the homes. One person told us they sat in their room and watched television as they had nothing else to do. We saw people briefly socialising at lunchtime then returning to their flats, some people preferring to sit in the main entrance area where they occasionally chatted with staff as they passed by. We were told by a person living in one of the homes that 'We now have a charity shop and a café and there is a lot going on in the village but not as much in the houses'. When asked specifically if there were activities in the home, they told us 'sometimes, it's boring here'. Since our inspection, the provider supplied us with a list of available activities at the day services and a list of seven additional activities run on an ad-hoc basis in the homes, most less than weekly.

A relative told us that their person has a need, due to having a type of autism, to have a rigid routine with few changes. Any adjustments would have to be carefully explained and may still cause the individual much upset and confusion. Due to the reduction in staffing, changes to planned activities would cause upset if not managed well. Other relatives expressed concerns as people were very close to staff and any changes to staffing or routine were upsetting.

Other people told us they were worried they would not be able to access the community to go shopping or go to the Choices day service as there were not enough staff to take them there. Previously staff had stayed at the day service to support with additional needs or had been able to attend physiotherapy when a seizure happened. There were significant worries from people and their relatives that these aspects of the service would not continue. One person told us they had their planned shopping trip to buy Easter gifts cancelled due to staff not being available to support them, they were upset particularly as their family had visited and they had been unable to give them gifts because they had not been to the shops.

Some communal events were arranged at the Resource Centre where there was also a café. Entertainers were booked for everyone to attend if they wished and there were discos arranged. These events enabled people to meet up and forge or maintain friendships. People were also encouraged to visit their friends in the village or who lived within the complex. Peoples access to the café was limited because its opening times clashed with their activities and lunchtimes.

Residents meeting minutes reflected that in-house activities were being discussed but these would be led by people living in the home or volunteers and would not be something run by the staff team.

People told us if they had concerns or worries or wanted to make a complaint they would speak to any of the personal assistants or the house managers. They understood the process and two of the people we spoke to told us they would speak up as if they didn't, things would stay the same, they were also concerned about their peers who were unable to speak up for themselves. They told us they used to be involved in a residents committee and would like to have the chance again so they could speak up for people.

During our inspection, relatives made a complaint about aspects of the service their person was receiving

and how this had made the person feel very upset. The complaint was processed through the organisations complaints procedure and allocated to the manager to investigate and to speak to the person to address their concerns. The complaint was handled in a timely and appropriate manner and the drafted response addressed all points of concern raised in a satisfactory way.

Enham Trust sends a survey out at regular intervals to obtain feedback from people as to their performance. The survey monitors equality in addition to quality, looking at age, disability, gender, religion and ethnicity as well as asking questions about service provision. Comments received in the October 2017 questionnaire were mostly positive, for example 81% of people who replied agreed that Enham Trust responded to them as quickly as possible and 89% of people agreed that Enham Trust had a positive impact on their lives. Food choice and quality scored poorly and since this survey a contractor has been bought in to provide meals.

Requires Improvement

Is the service well-led?

Our findings

When we inspected in July 2016, we identified a breach of Regulation 17 (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance. The provider did not have robust quality assurance systems in place which resulted in lack of maintenance work being carried out. We were provided with an action plan detailing how this was to be addressed following the last inspection.

At this inspection we looked at the maintenance tracker system developed after the last inspection and noted that there was a system in place to ensure the manager monitored when jobs were referred to maintenance, whether urgent or routine and when they should be and were completed. We noted there were still on-going issues with regard to delays in maintenance being completed in the document we were supplied with. We were in fact supplied with an incorrect monitoring spreadsheet that was no longer in use and a new system was in place which showed that maintenance concerns were being dealt with in a timely way. There was a quality assurance system in place however, at the time of our inspection, it was not known to the senior staff in the care homes.

The provider had not maintained oversight of the risks within the service from legionella. When we discussed our concerns with senior managers during the inspection, we were told that there was a leadership team meeting every month which looked at all areas of performance, including any health and safety related concerns. However, the risk assessment and actions identified in the February 2017 risk assessment had not been monitored at these meetings. When asked, a senior manager confirmed they would have relied on the manager with responsibility for legionella management to raise issues, which they had not done, so this had 'slipped through the net.' They assured us they had reviewed what had gone wrong and now had a plan in place to restructure the senior management team and the allocation of responsibilities which would ensure appropriate oversight and accountability.

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

The service had clear visions and values which staff strived to reflect in their practice. These were visible on the services website and on display in the homes. There was a wide range of policies and procedures covering the premises and care provision. The policies were available to staff and reflected current good practice.

The Head of Care and Manager were looking to further develop the services offered and had plans to develop the homes into a transitional service for some people to learn daily living skills and move into independent living settings.

We received feedback from people, staff and relatives on the Head of Care and Manager, people had faith in their commitment and were reassured by their presence. We were told they were regularly in the homes and would support teams and people with hands on care if needed. People told us they felt supported by them and would go to them if they had problems.

Changes to staffing had impacted on people. The changes had taken place ten days before our inspection. Staff told us they were unhappy with how the information was shared with people using the service. They told us "We feel like we (personal assistants) are seen as 'bad guys', the person delivering the message gets the fall but people may have understood if they had been spoken to". Personal assistants had to tell people using the service that outings were not happening and they would not be accompanied to activities due to staffing shortages. We raised this with the provider and were told that House Managers could have shared the information with people as a group which may have prevented staff delivering the information.

We were contacted by several relatives during and after our inspection who were concerned at the staffing changes and that the proposals were not shared before implementing. They told us that there had been a plan to recruit to existing vacancies in the homes two months before the inspection which caused them additional concerns due to the staffing having now been reduced. The Director of Care told us 'we are aware that we need to talk to residents and staff to understand what is a reasonable expectation in terms of additional support above meeting care needs'.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Not able to meet requests such as male / female preferences of carer, extended waiting for care to be provided and continence products not being provided at the agreed time.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The ad hoc method of telling staff when people left the building did not provide an adequate record of who was in the home for a fire register.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Own fire procedures not followed, insufficient fire evacuations held and faults with fire doors had not been fixed though they were recorded as faulty in January 2018. Maintenance tracker had not improved timescales and accountability for maintenance jobs and there was insufficient oversight over risks associated with legionella.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Significant problems with response times to

call bells and people were reluctant to use the call bell I case someone needed more urgent support as they were aware there were insufficient staff to answer call bells.