Mr Roy Bellhouse

The Cottage Residential Care Home

Inspection report

51 High Street
Brightlingsea
Colchester
Essex
CO7 0AQ

Tel: 01206303676

Date of inspection visit:
18 December 2017
19 December 2017
22 December 2017
11 January 2018

Date of publication:
22 March 2018

Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

The inspection process took place over four days, 19, 20, 22 December 2017 and 11 January 2018. This included a visit to the service and because of the findings it was extended to include information from external agencies who are involved with the service.

The Cottage accommodates up to 10 people who have a learning disability or autistic spectrum disorder. People who use the service may also have mental health needs, a physical disability or dementia. At the time of the inspection nine people were living in the service.

The Cottage 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.

There was a registered manager, who also owned the service. 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 has been managed by the same provider with the support of a stable group of staff who know people well. Despite this we found shortfalls in protecting/promoting people's best interests, risk management, health and safety, environment, infection control, medicines management, staff training, and effective care planning. The provider demonstrated a lack of awareness of national best practice guidelines and had not kept up to date to ensure the quality of care reflected this. This included the care Quality Commission's; Registering the Right Support to ensure people with learning disabilities and autism using the service can live as ordinary a life as any citizen, as well as other best practice guidance linked to people's needs.

Staff awareness of potential risks to people were not embedded in their day to day practice. Environmental risk assessments and checks in place were not comprehensive and were not based on nationally recognised health and safety requirements. The system in place to protect people from infection and promote good hygiene practice was not safe and effective. Improvements were needed to ensure people were consistently supported in a clean and hygienic environment. This extended to ensuring their own privacy and dignity was being respected at all times.

Improvements were needed in the management of people's medicines to ensure they were effectively administered and supported people's individual needs. Insufficient information and guidance for staff meant that opportunities to limit risk were not understood or recognised.

Risks were being mitigated by the support of other health and social care professionals. However we were concerned that the opportunity to take effective action and embed it in staff practice had not been taken

after our previous inspection in March 2016.

We identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following this inspection we took immediate enforcement action to restrict admissions and force improvement. The Commission is further considering its enforcement powers.

The overall rating for this service continues to be 'Inadequate' and the service is therefore in 'Special Measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The shortfalls we identified put people at potential risk of harm because staff were not following safe practice. Environmental risk assessments and checks in place were not always comprehensive enough.

The service did not have safe systems in place for the management of medication. We found shortfalls in the ordering, storage, administering and recording of people's prescribed medicines.

The system in place to protect people from infection and promote good hygiene practice was not safe or effective. The provider was not ensuring people were supported in a clean and hygienic environment. Safe recruitment practices were not always being followed.

We had concerns about staffing levels as there had been no assessment of people's needs to determine these and we also raised concerns about staff who were related working together, the potential conflict of interest and safeguarding implications. The provider and staff lacked an understanding of what safeguarding meant.

Improvements were needed in the management, storing and security of record keeping.

Is the service effective?

Requires Improvement

People were not always receiving quality care and support, which promoted their health, wellbeing and quality of life. We observed shortfalls in staff's practice.

Those responsible for training did not always have the knowledge and skills or were not up to date. This impacted on their ability to implement effective training. Systems were not in place to show that people were always supported appropriately with food and drink.

Records showed that applications had been made under DoLS to the relevant supervisory body, where people living in the service did not have capacity to make their own decisions

Is the service caring?

Requires Improvement

Feedback from social care professionals showed that staff were treating people with kindness and respect. People told us they liked the staff. Whilst staff were intuitively caring and knew people very well, opportunities to ensure all their needs were being met/provided for had been missed. This is because staff and the provider's practice was not always up to date on the latest support and guidance.

There was consistency in staffing, some of whom had also worked at the service for many years. The culture had not kept up with best practice and therefore some staff were working on assumptions that had not been challenged or explored.

Improvements were needed to support / demonstrate how individual people's privacy, dignity and independence were being respected and promoted.

Is the service responsive?

Requires Improvement

Further improvements were required to people's care records to demonstrate person centred, safe care, and how they are being supported to access full activities / occupation and community contact to meet their individual needs.

We found that the service benefited from having consistent staffing who knew people well but this was relied upon too much. As a result opportunities were being missed to support people to have a better quality of life. Poor records also meant that where positive actions had been taken the provider could not always demonstrate it. Whilst care plans were in place they were not developed enough.

Improvements were needed in end of life care plans and assessments. Although this was the case, we observed staff were caring and compassionate. No complaints were seen during this inspection so it was not possible to look at their management.

Is the service well-led?

Inadequate

The provider and leadership team had not effectively acted on the recommendations from our last inspection. They had not sought advice and guidance from a reputable source on up to date best practice regarding supporting people with autism and learning difficulties.

Systems were not in place to ensure where responsibility was

delegated to other staff; those staff were competent and up to date with their practice, promoted and modelled best practice.

The registered manager and registered provider had not kept themselves updated to ensure they met their regulatory commitments, which meant they were not meeting some of their legal requirements.

There was a lack of systems in place to support them in monitoring to ensure people are being supported in a safe, well maintained environment. Although other professionals and agencies were supporting the service, we were not assured that the provider had the oversight or systems in place to ensure a safe and effective service for people at all times. And some of the issues we had identified during this inspection was a continuation and/or deterioration from our previous inspection of the service, which meant that lessons were also not being learned and changes made to continually improve the service for people.

The Cottage Residential Care Home

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.

The inspection process took place over four days, 19, 20, 22 December 2017 and 11 January 2018. This included visiting the service and was extended to include information from external agencies who are involved with the service ongoing. The inspection team consisted of two Inspectors.

Prior to the inspection, the provider had been sent a provider Information Return (PIR) which they had not returned. 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 took this into account when we made the judgements in this report. Therefore the provider did not meet the minimum requirement of completing the Provider Information Return at least once annually.

During the inspection we spoke with the deputy manager, and four members of staff including team leader and care staff.

We spoke with three people living in the service, and the safeguarding and quality team at Essex County Council about their visits to the service. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

To help us assess how people's care needs were being met we reviewed five people's care records and other information, for example their risk assessments, diet and fluid intake charts and medicines records.

We looked at three staff members' recruitment paperwork and records relating to the management of the

service. This included training, fire risk assessment, infection control audits, and systems for assessing and monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection on 1 March 2016, we rated Safe as Good. However, at this inspection we found this rating had not been maintained. The shortfalls we identified put people at potential risk of harm because staff were not following safe practice.

Insufficient guidance for staff meant that opportunities to limit risk were not understood or recognised. As a result staff awareness of potential risks to people had not been embedded in their day to day practice and there were multiple areas which posed a risk. This included risks linked to people's day to day activities, management of health including epilepsy and anxiety, mobility, medication, environment and infection control. When this was discussed with the senior leadership team they lacked understanding of what they could do to improve this despite having had support from other professionals including the Clinical Commissioning Group and Essex County Council. This placed people using the service and staff in a vulnerable position.

We observed staff walk behind one person who was unsteady on their feet, standing behind and gripping their shoulders to prevent them falling. This could put the person at potential risk of bruising / shoulder injury and could have injured the staff member too if they had fallen onto them. One person was seen to be drinking constantly. Staff did not demonstrate awareness to explore the reason for this or the potential consequences of excessive fluid intake. For example this could have been an indicator of deterioration in their physical and/or mental health.

Three people had epilepsy but there were no risk assessments to inform staff what to do if a person had a seizure in the bath. There were no call bells in the bathroom for staff or the person to use if there was an emergency. Other actions could not be identified where professionals had identified risks around swallowing. There was no risk assessment around driving a person's mobility car. A social worker review identified others had been at risk because of a person's physical and verbal responses to them. There were no records in the incident book or any safeguarding notifications to the Commission or Essex County Council to show what action had been taken to intervene and reduce the risk to the person, others they lived with, staff and visitors.

Environmental risk assessments and checks in place were not always comprehensive enough, and were not based on nationally recognised health and safety requirements. The provider could not demonstrate that the staff members undertaking them were competent and experienced to do so. In November 2017 Essex County Council Quality Improvement Team (QIT) provided support to the leadership team including audit templates, checklists, policies and procedures because shortfalls had been identified in relation, understanding of correct fitment of window restrictors, legionella and fire safety risk assessments. However during our visit there was no comprehensive action plan or timescales set to test for legionella. The provider confirmed the identified windows had restrictors fitted, when we checked we found one where the restrictor was not effective and did not meet guidelines. Where one had a missing rope to support the sash windows opening and closing, there were no interim arrangements in place to ensure it was safe or information on what action had been taken to address it.

The fire risk assessment had been updated but had not been carried out by a competent person. They had not identified concerns around missing signage to assist people in locating the fire exits or the inappropriate use of door wedges to keep the laundry, internal corridor and people's bedroom fire doors open. In the event of a fire these doors would not provide any effective barrier against smoke / fire because the wedge prevented the automatic closure if the alarm went off. Following the inspection we referred our concerns the Essex Fire Service who have visited the service to review their fire safety.

Other risks we observed included unstable furniture and fittings which could pose a risk to those who are frail or unstable balance, damp which could impact on people's health and the communal garden was not safe or hazard free due to broken/old furniture being in situ.

The deputy manager was unable to locate staffing rotas. They told us "Everyone knows what they are working". There was no information on how staff numbers were being calculated because no dependency assessment tool was being used. Staffing levels did not provide flexibility to take people out and because of the lack of assessment staff could not demonstrate how they facilitated people's requests when they wanted to go out or how one staff member managed safely at night. People living at the service benefited from a stable staff team who knew them well but the lack of information on how they were working meant that we had concerns about how people's needs were being assessed and met, how their independence was being promoted and how many staff were needed to ensure their safety. The lack of oversight and effective robust risk assessment added to this concern.

The service did not have safe systems in place for the management of medication. We found shortfalls in the ordering, storage, administering and recording of people's prescribed medicines. This included not following safe procedures when administering controlled drugs to ensure the correct paperwork is completed and staff witnessing to confirm the medication is given. Internal audits had not identified gaps in recording.

The local Clinical Commissioning Group (CCG) had provided support and there were plans to support staff with training. There had been no effective system to ensure staff were up to date and competent to administer medication. For example one person was prescribed medication for seizures which required specific and individual guidance to administer, however staff had not had an update since 2012. Checks were not completed to see if staff were competent and errors were not identified and addressed in records. Staff lacked understanding of pain assessment tools to support them in responding appropriately to those at the end of their lives or those who were unable to verbally communicate.

Other unclear systems for ensuring people received their medication safely included, poor recording of prescribed creams, use of out of date creams and checks of controlled drug processes showed inconsistencies and gaps in recording.

The system in place to protect people from infection and promote good hygiene practice was not safe or effective. Staff were not clear about their responsibilities and the service did not follow recognised national guidance. Staff lacked understanding of the principles of good infection control. This put people at potential risk of infections being passed from person to person. For example, the use of communal towels and bars of soap put people at risk of bacterial infections being passed from person to person. Staff did not follow good hand hygiene; not washing their hands prior taking over food preparation, carrying soiled laundry without protecting their clothes or hands with gloves/aprons.

The provider was not ensuring people were supported in a clean and hygienic environment. Staff and management either did not recognise, where unaware or did nothing to mitigate risks. On one day of

inspection we found an unflushed toilet full of faeces and a used continent pad on the floor at 10.15. We checked again at 1.00pm and was still the same. Where bedding had been stripped, pillows and quilts were stained.

All of the above is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider and staff lacked an understanding of what safeguarding meant. They were unable to demonstrate safe systems were in place to identify and act on potential risks to people's safety and wellbeing. For example conflicts of interest had not been identified when supporting people with their finances. The accounts systems and processes did not protect people from the potential risk of financial abuse. These matters were also a concern to Essex County Council and work is ongoing to ensure that people's finances have been managed appropriately. This involves demonstrating the financial arrangements for appropriate use of a mobility car, holiday arrangements, lack of independent advocates to help people make independent decisions and/or have control over their money. In addition, the provider had not considered the risks to people and staff where relatives worked together on the same shifts and the potential conflict of interest this may cause.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment practices were not always being followed. The provider could not show us that all staff had the required Disclosure and Barring Service (DBS) checks and references at the time of the inspection. They had to supply this information afterwards. All DBS' had been undertaken but we noted that one had not been undertaken until December 2017 despite the staff member working at the service for a number of years. In addition, there was no application form or references for the same staff member. Another staff member did not have references on file to show their suitability for the role.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst senior staff acknowledged that improvements were needed, these were slow to occur and shortfalls were not always being learned from. For example, despite known concerns about the lack of mileage records to support the use of the mobility car, records had not been introduced at our inspection when the social work professional revisited in January 2018. In November 2017 concerns had been raised about staffing levels and professional boundaries where relatives were working together. No learning had been taken from this to ensure that people using the service and staff were protected as far as possible from risks around staffing levels and/or allegations against each other. Although Essex County Council's safeguarding team had discussed having a dependency tool, the provider felt they knew the people best and did not need one.

Improvements were needed in the management, storing and security of record keeping. Staff left people's records in the shared kitchen / dining area, and in unlocked drawers, these could be potentially read by other people and visitors. Records of care were not being completed in a timely way. When they were done they did not fully reflect the care we had observed taking place. Lack of accurate and/or up to date records does not help to pro-actively identify changes to a person's wellbeing or allow for prompting a review if a person's health or wellbeing deteriorates.

Requires Improvement

Is the service effective?

Our findings

People were not always receiving quality care and support, which promoted their health, wellbeing and quality of life. We observed shortfalls in staff's practice; moving people safely, infection control, monitoring nutrition, medicines, care planning, record keeping and health and safety. This reflected feedback from social care professionals. There were also raised concerns around leadership and staff's ability to support people with their communication, medical, emotional and mental health needs

Those responsible for training did not always have the knowledge and skills or were not up to date. This impacted on their ability to implement effective training. Whilst their intentions were always caring, people were at risk of receiving care that could be unsafe or inappropriate. Our observations demonstrated this to be the case.

The cause of this was lack of an effective training plan reflecting the current needs of the people using the service and the stated aims of the service. Improvements were needed to ensure people are supported by staff that have up to date knowledge and skills to support their range of needs, linked to current best practice. This included epilepsy, dementia, autism, mental and physical health. Improvements were needed in training, understanding and implementation of MCA.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems were not in place to show that people were always supported appropriately with food and drink. Staff were not completing food and diet charts accurately. We saw no drinks made available in a person's bedroom. Records were not clear about how they were supported to drink. When we checked the records again the next day staff had retrospectively completed them and some of the information did not reflect what we had observed. Accurate records are needed to demonstrate that the right care is being provided and effectively support early identification of any related risks, for example weight loss or infection/illness. We also found staff had no clear guidance when a person is assisted in bed and reliant on staff to support them to eat and drink enough. These shortfalls could impact on people's nutritional health and their wellbeing.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed where people were being supported to access different healthcare services as part of receiving ongoing healthcare. However, they did not evidence how people were being supported to take up health pursuits if they wish, or customise individual health eating plans. Minutes of meetings with people showed they were happy with the food provided but there was no information about how staff supported people to make choices, be aware of healthy eating campaigns and/or weight management.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The 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 made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed that applications had been made under DoLS to the relevant supervisory body, where people living in the service did not have capacity to make their own decisions

The culture at the service was based on staff knowing people well but in making decisions, they had not always actively involving advocates to support or explore independent decision making for people in the service.

Decoration, signage, and the garden area did not support promotion of independence especially where people are developing memory problems and living with dementia.

Requires Improvement

Is the service caring?

Our findings

Feedback from social care professionals showed that staff were treating people with kindness and respect. People told us they liked the staff. Whilst staff were intuitively caring and knew people very well, opportunities to ensure all their needs were being met/provided for had been missed. This is because staff and the provider's practice was not always up to date on the latest support and guidance. For example changes in the way smaller care homes are run (Registering The Right Support).

Some people had lived in the service for many years. There was consistency in staffing, some of whom had also worked at the service for many years. The culture had not kept up with best practice and therefore some staff were working on assumptions that had not been challenged or explored. For example, one staff member told us, "We make the choices as they have learning disabilities. They can't tell you." In another example we observed a person say they wanted "Ham and salad cream" for their lunch. Staff told them there was no ham and offered them cheese. Everyone was then made a cheese sandwich for lunch. The service is close to local shops and there was no consideration of the person and/or staff going out to get ham, which would have promoted their independence and choice.

Improvements were needed to support / demonstrate how individual people's privacy, dignity and independence were being respected and promoted. In the shared bathroom there was an unnamed hairbrush which two different colours of hair; brown and grey, indicating it was used by more than one person. Staff could not tell us who it belonged to. In the bathroom was a plastic tub with six used tooth brushes. When we asked staff they did not know why they were there and said everyone had an electric toothbrush. Another staff member could only recall one person with an electric toothbrush and said all but two people brushed their teeth in the bathroom, as it is easier to do this when they have a bath. So it was possible that the toothbrushes we found were being used in a communal way, which is not only undignified but unhygienic.

A kitchen cupboard used by people had a 'bed change chart' which gave names of the people and which day they had their bed changed. With a side note which named four people living in the service, saying 'bed linen to be changed when wet or soiled.' This did not protect their dignity or privacy. Two shared toilets off a main walkway had no privacy locks fitted.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

Further improvements were required to people's care records to demonstrate person centred, safe care, and how they are being supported to access full activities / occupation and community contact to meet their individual needs.

We found that the service benefited from having consistent staffing who knew people well but this was relied upon too much. As a result opportunities were being missed to support people to have a better quality of life. Poor records also meant that where positive actions had been taken the provider could not always demonstrate it. Whilst care plans were in place they were not developed enough. This was linked to staff's limited knowledge of current best practice and their ability to apply it to benefit people they supported. This also meant that aims and goals to support people's development could not be tracked to inform if any changes to their care were needed or could be explored further.

Improvements were needed in end of life care plans and assessments. This included preferred priorities of care, hospital passport (used if they needed to move to a hospital / hospice), pain management tools and guidance for staff on supporting the person to have a comfortable, dignified and pain free death.

All of the above is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although there was a lack of plan and guidance for end of life care, we observed staff were caring and compassionate. There was the involvement of the hospice team, and staff were monitoring to ensure the person was not in pain. The person looked content and comfortable, asleep in the living room, where they preferred to be.

No complaints were seen during this inspection so it was not possible to look at their management. However, we were made aware Essex County Council have given support on how to set up complaints template. Feedback from social care professionals included that people were happy and there had been no complaints during reviews.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 1 March 2016, we found the service was not being consistently well-led. They were not keeping themselves up to date with current guidance and good practice relevant to the people they supported. We made a recommendation to drive improvement in this area. We also found the quality assurance systems in place were not robust enough to ensure people received a consistent, safe and good quality service.

At this inspection we found the provider and leadership team had not effectively acted on the recommendations from our last inspection. They had not sought advice and guidance from a reputable source on up to date best practice regarding supporting people with autism and learning difficulties. This was demonstrated through observations, care records and discussions with staff. Oversight and governance systems were therefore not demonstrating that care was of good quality and safe. They did not have a clear understanding of the risks and issues facing the service which placed people and staff at risk.

Systems were not in place to ensure where responsibility was delegated to other staff; those staff were competent and up to date with their practice, promoted and modelled best practice. Competency of those checking staff practice, embedding staff training into practice, environmental risk assessments and care planning. Systems in place for identifying, capturing and managing organisational risks were ineffective. They had not identified the risk to people's health, welfare and safety which we had identified.

The registered manager and registered provider had not kept themselves updated to ensure they met their regulatory commitments, which meant they were not meeting some of their legal requirements. This included not displaying their rating or sending notifications when required to keep us updated of issues which has had an impact on people's safety or welfare. For example, we had not been notified about a traffic accident, or where a person had required hospital treatment for an injury. This information supports the Commission in monitoring effective action taken by the provider to mitigate any risk to the person, or others. We will write separately to the provider about this.

Other opportunities to tell us about the service and its progress/development had been missed. We requested a provider information return (PIR) but it was not returned by the required date. The Commission monitors information and assesses how provider's respond to risk as part of the regulations. Without this information being accurate, timely and transparent we are concerned about how the service operates in the best interests of people who live there.

There was a lack of systems in place to support them in monitoring to ensure people are being supported in a safe, well maintained environment. We asked about on-going refurbishment linked to the old carpets, wear and tear, broken furniture. A book showed items they had brought each month, for example a new washing machine, but there was no ongoing plan for the whole service. It was not clear if ongoing maintenance/replacement was being financially planned for.

People using the service were given I opportunities to feedback in meetings or through surveys. However, no system had been established to support independent views because staff were either present or helped them to complete these. Feedback from Essex County Council had advised the use of different communication tools which might help. This was being implemented at the time of the inspection. In addition, the deputy manager is being assisted by the Registered Manager from another service to set up systems.

To reduce the potential risk of harm to people, in the absence of effective oversight, the leadership were being supported by external stakeholders including Essex County Council and a Community Pharmacy Technician. Although this was being provided, we were not assured that the provider had the oversight or systems in place to ensure a safe and effective service for people at all times. And some of the issues we had identified during this inspection was a continuation and/or deterioration from our previous inspection of the service, which meant that lessons were also not being learned and changes made to continually improve the service for people.

All of the above is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.