Sequence Care Limited

Totteridge House

Inspection report

310 Totteridge Road
High Wycombe
Buckinghamshire
HP13 7LW

Tel: 01494744360

Date of inspection visit:
25 April 2017
26 April 2017

Date of publication:
15 June 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 25 and 26 April 2017. It was an announced visit to the service. This meant the service was given 24 hour notice of our inspection. This was to ensure we were able to gain access.

Totteridge House is a care home which provides accommodation and personal care for up to seven people with a learning disability and other associated conditions. At the time of our inspection there were six people living in the home.

The service is required to have a 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. A manager was in post since December 2016. They had applied to the Commission to be registered and their application was being processed.

This was the first inspection of Totteridge House since the service had been registered with us. This inspection was a comprehensive inspection to enable us to rate the service.

Some relatives were happy with the care provided whilst other relatives were dissatisfied with the care provided, lack of communication and involvement. Health professionals were also dissatisfied with aspects of the service, management and the lack of partnership working. Recommendations have been made to improve those areas of practice.

Staff were suitably recruited however staff were not inducted and trained to ensure they had the specialist skills and training to meet people's needs.

Records were not accurate, suitably maintained and up to date. Aspects of the service were audited but auditing was not effective in identifying the shortfalls in the service that we found. The home was not being effectively managed and systems were not established to seek and act on feedback on the service.

Systems were in place to safeguard people but the service was not working to local authority safeguarding procedures. The lack of effective communication between the home, other professionals, relatives, the environment and lack of suitably trained staff meant people were not adequately safeguarded.

The required staffing levels were maintained but staff were not deployed properly to ensure people got the required level of supervision they required at all times. A recommendation has been made to address this.

Risks to people were identified but risks to staff already identified were not managed. Improvements were required to medicine practices and staffs understanding of the medicine they administered to safeguard people. Recommendations have been made to address these shortfalls.

Staff were trained in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However the feedback on their practice would suggest they were not working to the principles of the act. A recommendation has made to address this.

Some staff were kind and caring whilst other staff were less engaging with people. People privacy and dignity was promoted but not consistently maintained by all staff members. A recommendation has been made for the provider to monitor staff practice.

Systems were in place to manage complaints but all concerns were not recorded and managed in line with the organisations policy on complaints. Examples were given to the provider to enable them to follow up with staff.

The home was clean, however there was a delay in making repairs safe. The home had access to contractors to carry out remedial work and there was a 10 year warranty on the building to address any structural issues.

The home was registered for seven people but due to the nature of the challenges people presented with the home did not have sufficient communal space to enable people to have adequate space.

People were offered choices and communication care plans were in place to promote and develop people's communication.

People had care plans in place and systems were in place to review people's needs. People had access to activities and these were being further developed.

The provider was in breach of three Regulations .of the Health and Social Care Act 2008. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

People were not consistently provided with the level of staff supervision they required.

People's medication was not managed in line with the organisations own policy and pharmaceutical guidance.

People had risk assessments in place to manage identified risks but some staff practice put staff at risk of injury.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported by staff who were not suitably inducted, skilled and trained to meet their needs.

People were supported to make decisions about their day to day care. The principles of the Mental Capacity Act 2005 and the deprivation of liberty safeguards were not always upheld.

People's health and nutritional needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not consistently supported by staff who were kind, caring and engaging.

People privacy and dignity was not always promoted.

Is the service responsive?

Good

The service was responsive.

People were assessed prior to admission and a transition plan was agreed.

People had care plans put in place to support staff to meet their needs and reviews of the placement took place.

Systems were in place to manage complaints but concerns raised were not always handled in line with the organisations policy.

Is the service well-led?

Requires Improvement

The service was not always well led.

People were not supported by a service that was effectively managed and monitored.

Communication systems within the home were not effective to benefit people.

Records were not suitably maintained, accurate and fit for purpose.

Totteridge House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 25 and 26 April 2017. It was an announced inspection. The provider was given 24 hours' notice because the location is a small care home for younger adults who may be out during the day. This was to ensure someone was available to facilitate the inspection.

The inspection was undertaken by one inspector and an 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. The expert by experience speciality was learning disabilities.

We did not request a Provider Information Record (PIR) on the service prior to the inspection. The PIR is a form that the provider submits to the Commission which gives us key information about the service, what it does well and what improvements they plan to make. We reviewed other information we held about the service such as notifications and safeguarding alerts. We contacted the local authority, commissioners and health care professionals involved with the service to obtain their views about the care provided. We have included their written feedback within the report.

Some people who used the service were unable to communicate verbally with us. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we walked around the home to review the environment people lived in. We spoke with three people who used the service, the operations manager, four care staff and three health professionals employed by the organisation. We spoke with six relatives by telephone after the inspection. We looked at a number of records relating to individuals care and the running of the home. These included three care plans, medicine records for three people, shift planners, six staff recruitment files and staff supervision records. We asked the provider to send further documents after the inspection. The provider sent documents to us which

we used as additional evidence.

Requires Improvement

Is the service safe?

Our findings

One of the six people living at the home told us they did not always feel safe. This was because other people living at the home had been aggressive towards them. We saw these incidences were logged, safeguarding alerts made and the provider confirmed appropriate measures were put in place to minimise the risk of reoccurrence. People's care plans indicated people were vulnerable and required safeguarding from themselves, other people living at the home and when in the community.

Some relatives felt confident their family members were safe and gave examples where key codes were used on doors to promote this. Other relatives did not feel completely reassured that their family member was safe and gave examples where safeguarding alerts had been made. They also felt the turnover of staff meant their family member was not safe as they were being supported by staff they did not know. The provider told us as it was a relatively new service therefore new staff had been recruited as the service expanded. The staffing list showed eleven staff were recruited during 2016 and seven staff were recruited during 2017 which provided a mix of experienced staff and new staff.

The local authority and a health professional involved with the home raised concerns about the number of safeguarding alerts being made and questioned whether staff understood what needed reporting. A professional raised concerns that the provider allowed staff to continue to work in the service whilst a safeguarding alert against them was still under investigation without a plan in place as to how to manage that.

During discussion with us staff demonstrated they were aware of their responsibilities for reporting accidents, incidents, poor practice or concerns. The majority of staff were trained in safeguarding. Updates in this training was due for three out of 19 staff. The provider confirmed they were looking into advanced safeguarding training for senior staff. Policies and guidance on safeguarding were prominent on the notice board in the office. This supported staff's training and reinforced the steps to take in the event of a safeguarding incident.

After the inspection we were informed of a potential safeguarding incident. We made the home aware of it and asked them to make the required alert to the Local Authority safeguarding team. The provider confirmed they had commenced an internal investigation. This was prior to the Local Authority safeguarding team asking them to. This practice is not in line with Local Authority safeguarding procedures and could potentially jeopardise an investigation.

This is breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.This was because systems and processes were not established and operated effectively to safeguard people.

Relatives felt the staffing levels were generally sufficient. Some relatives expressed concern that one to one care was not consistently provided for their family member and that there was a high turnover of staff which impacted on their family members care. A relative commented "The lack of consistency in the staff team creates anxiety for [family member], which leads to an increase in behaviours. Another relative commented

"[Family member] is on one to one care, but most of the time when I visit I see [family member] by themselves". The provider told us that whilst people were on 1:1 staffing ratio they did not require to be observed at all times. However people's care plans were not specific as to the level of observation required to ensure staff knew who had to be observed at all times and who required staff to be close by.

A professional involved with the home commented "Due to the complex needs of the residents it has taken some time for new staff to develop the therapeutic relationship with the residents. However the turnover in staff led to some residents to display increase in their anxiety levels". The provider disputed this was the case. They provided us with data which showed an increase in some behaviours for people over the period January to March 2017.

Staff felt the staffing levels were sufficient and that the staffing levels had improved in recent months. One staff member felt at times they were under pressure and commented "This leads to low staff morale".

Each person was on one to one care and observation. A minimum of six staff were provided on each day time shift with extra staff provided to enable two to one care for individuals in the community. The manager worked nine to five and assisted on shift regularly and when required. Two waking night staff were provided on the night shift .Staff worked long days and were allocated to provide one to one observations to one person throughout the 12 hour shift. We saw this was not consistently maintained. Staff were seen to walk away and leave the person they were observing with another staff member who was observing someone else. People were also left in their bedrooms unsupervised whilst staff attended to their laundry and two people were in the kitchen with one staff member. On day two of the inspection at one point in the day three staff were outside with one person whilst the other five people were left in the home with the remaining three staff. The person required two staff for community access.

The provider confirmed after the inspection that all of the people living at Totteridge House are on a 1:1 staffing ratio. This means that there is a staff member allocated specifically to a person and a staff member needs to be in close range at all times. However they advised people do not require observations at all times and can be left unsupervised whilst chores are undertaken. This was not outlined in people's care plans or risk assessments.

Staff breaks were allocated on the allocation sheet. However no staff cover was allocated to cover the breaks to ensure the staff member got their break and that the people continued to get the one to one care they required. Some staff told us they got breaks and they just all covered each other to make it happen. Other staff told us their breaks were not on time and they had to wait ages. The provider advised that all staff are given a break though the times can vary depending on the needs of the service users at the time.

It is recommended the provider reviews the arrangements for one to one care. This is to ensure one staff member is not providing one to one care to the same person for the duration of the 12 hour shift, breaks are adequately covered and to ensure that staff retain responsibility for the person they are observing and continuously provide this.

The home had an on call system. Managers and senior members of the organisation provided on call support on a rota basis. Staff were aware of how to access on call support and told us the on call managers were always responsive and available. The home had five full time staff vacancies. They had recruited five new staff and were waiting the required pre recruitment checks to be completed to enable them to commence. They used bank and agency staff to cover the vacancies to ensure the required staffing levels were maintained.

The service followed safe recruitment practices. Staff files contained an application form, medical questionnaire and evidence of an interview and written assessment. Records showed checks had been made with the Disclosure and Barring Service (criminal records check) and appropriate references were obtained to make sure staff were suitable to work with the people they supported. The staff files in the home did not contain a recent photograph and whilst staff were provided with photo identification not all staff was wearing it. This was addressed immediately and photographs of staff were emailed from head office and placed on staff files.

None of the people who used the service were self-medicating. The manager and senior staff took responsibility for ordering and receipt of medicines. Medicines were stored appropriately. The medicine administration records showed no gaps in administration. Protocols were in place for when "as required" medicine should be given and why. Staff were trained and assessed as competent to administer medicines. We were told staff completed three observed medicine administration rounds. However the medicine competency record did not outline what aspects of medicine administration was assessed and did not show three assessed medicine rounds either as described. The operations manager agreed to review and change the medicine competency assessment form to reflect their practice.

The provider had a medicine administration policy and procedure in place. Staff told us when people went on weekend leave they ordered a supply of medicine from the supplying pharmacy. However for day leave they removed the medicine from the blister pack and put it in a dosette box. This is considered secondary dispensing and not in line with pharmaceutical guidance or the organisations own policy. The operations manager agreed to address this practice immediately and made arrangements with the supplying pharmacy for medicine for one person who was due to go on day leave that week. The relative told us they were given the medicine in a dosette box, which meant secondary dispensing of medicine continued after it was pointed out at the inspection.

A professional involved with the home told us they had raised concerns about staff's lack of knowledge around a particular medicine and the need for equipment such as a thermometer to be provided to ensure peoples well-being. The provider confirmed after the inspection a thermometer was available in the home should it be required.

A relative felt staff did not have a good understanding of medicine and its uses. They commented "Staff giving medication do not have a clue as to what they are giving as when asked what it is they are unable to explain". The provider confirmed staff are trained to administer medicines and have access to resources to refer relatives to if specific information on a medicine is required.

It is recommended the provider assess whether staff are suitably assessed and deemed competent to administer medicine, as well as ensuring they have a good understanding of the medicines they are administering and work to the organisations policy and any associated guidance.

People were supported to take risks to retain their independence whilst any known hazards were minimised to prevent harm. People's support plans included a range of individual risk assessments. These were in relation to risks associated with people's behaviours, personal care, finances, communication, activities, community access, life skills, physical and mental health and nutrition. Risk assessments were kept under review and updated as risks changed. Some staff had a good knowledge of the risks people presented with. Other staff were less knowledgeable and relied on other staff on duty to deal with challenging situations.

Accident and incidents were recorded. Care plans included positive behaviour support plans on managing behaviours that challenged. These were signed off and agreed by the organisations clinical psychologist and

challenging behaviour instructor to promote the persons safety. Debriefing meetings took place after incidents which included professionals involved in the persons care to promote learning and if necessary review and change management plans and guidance. During the inspection staff were continually responding to behaviours that challenged. They were reactive to the situation they were presented with rather than managing it to prevent occurrence.

Environmental risk assessments were in place. These were up to date and reviewed. They outlined risks to people, staff and visitors such as risks associated with driving the company vehicle, challenging behaviours, medication administration, cooking, cleaning and lone working. A fire risk assessment was in place and people's files included a Personal Emergency Evacuation Plan (PEEP) which provided guidance on how individuals were to be evacuated in the event of a fire.

A professional involved with the home raised concerns with us about staff wearing neck scarfs, hair not tied back and lanyards around their necks with keys attached in a service where people had a history of aggression. They told us it had been addressed following an incident where a staff member was placed at risk but it was not consistently followed. During the inspection we saw some staff wore lanyards around their neck and staff with long hair did not have it tied back so the risk remained. The provider told us they were unaware of such an incident. They advised these issues had been risk assessed by the home, however there was no risk assessment in place to support that.

It is recommended the provider promotes a safe working environment for staff.

Health and safety checks took place. These included checks of the water temperature, fire equipment, first aid box, fridge and freezer temperatures. Fire drills took place monthly. The fire equipment, gas safety, portable appliances and the fixed lighting were serviced and deemed safe. A contingency plan was in place which provided guidance for staff on what to do in the event of an emergency such as a fire, flood, gas leak or power cut. It provided details of places of safety for people to be taken to if the home was inhabitable such as a community centre and local hotels.

Staff were responsible for cleaning the home. Daily cleaning schedules were in place which outlined what needed cleaning and when. These were signed off when completed. Staff supported people to clean their bedrooms and involved them in the task. Systems were in place for reporting maintenance issues. Head office maintained a record of what was reported, urgency and when work was signed off as completed. We saw a person's bedroom door frame and the door leading into the laundry room were damaged. This had already been reported and a contractor had attended. However the contractor failed to make the person's bedroom door safe and staff at the home had not followed this up with them. The operations manager immediately contacted maintenance on day one of the inspection. A contractor attended and made the door frame safe until such time as it could be replaced. The provider confirmed they did not have a refurbishment plan in place. This was because the property was a new build and they had a 10 year warranty on the property to cover any structural issues. They confirmed contractors would attend to carry out any remedial work.

Requires Improvement

Is the service effective?

Our findings

Relatives told us some staff were more skilled than others. Other relatives told us they did not feel confident that all members of staff had the required skills and knowledge to work with their family members who presented with behaviours that challenged.

Staff told us they had received an induction which included 10 days training. Staff said they had an induction into the home and worked alongside other more experienced staff in supporting and getting to know people. We saw that the in house inductions were incomplete and were not signed off for a number of staff. The operations manager confirmed this had already been identified by them and as a result the team leader was nominated an induction champion. They were responsible for working through inductions with new staff and the inductions that they had been involved in were better completed. However a number of staff already in post had incomplete inductions into their role.

The provider told us staff that had a National Vocational Qualification level 2 or above were not expected to complete the Care Certificate training. The Care Certificate training is a recognised set of standards that health and social care workers adhere to in their daily work. This involves observations of staff performance and tests of their knowledge and skills. However there was no evidence on staff files that staff had completed it, including the staff member in the induction champion role despite being in post longer than six months. The operations manager confirmed by email after the inspection that three staff had equivalent qualifications, three staff were working through the Care Certificate training and four staff were due to commence it. There was no indication that the other nine staff employed at the service had the Care Certificate induction or equivalent.

The provider's policy on training made no reference to the Care Certificate induction. The providers policy on supervision stated that "Supervision underpins the Induction programme (for newly appointed workers) and is the foundation on which appraisal is built". The in house inductions and Care Certificate induction were not referred to within one to one meeting records viewed. Therefore the provider had not assessed that staff had the skills and competencies to do their job. During the inspection we saw some staff were confident in their roles, whilst other staff who had not had their induction signed off seemed to lack confidence and the skills to manage situations and engage with people.

All staff had access to training the provider considered mandatory at induction and on an ongoing basis. This included face to face training and eLearning on topics such as fire safety, food hygiene, first aid, health and safety, safeguarding of vulnerable adults, infection control and medicines management. Alongside this staff had access to specialist training in mental health, learning disabilities, autism, Positive Range of Options to Avoid Crisis and use Therapy, Strategies for Crisis Intervention and Prevention (PROACT-SCIPr) to enable them to safely manage behaviours that challenged. A training matrix was in place which showed the training that had taken place and highlighted when updates in training were due. From this we saw nine out of the 19 staff had training in mental health and learning disabilities, two out of 19 staff had training in autism and four out of 19 staff had training in Makaton. The operations manager confirmed updates in training was booked to take place in May. However it is a concern that staff were supporting people in a

specialist area including people with a mental health diagnosis, learning disabilities and autism without the required skills and training.

A professional involved with the home commented "That given the complex needs of residents at the home staff would benefit from Autism Specific Intensive interaction training and Makaton as they had observed some gaps in staff knowledge". They told us they heard a staff member say "He does not have autism because he can speak" which they felt demonstrated their lack of understanding of autism.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because staff were not suitably inducted and did not have the required skills and specialist training to meet people's needs.

Staff told us they felt supported and received regular one to one supervisions with the manager. The provider's policy on supervision outlined that formal supervision must be carried out as a minimum six weekly. We looked at a sample of supervision records. We saw staff were not having supervision in line with the organisations policy. This had been picked up by the operations manager and formal supervisions of staff had commenced but was not yet fully established for all staff. The operations manager told us there was no formal system in place to record probationary reviews and any issues regarding performance would be discussed in supervisions. The provider carried out annual appraisals. There was one staff member who had been employed over a year since January 2017. There no evidence an annual appraisal had been completed for them. Written confirmation was received that an appraisal had been carried out for that staff member after the inspection. The operations manager also confirmed that a matrix had been put in place to alert the manager when appraisals were due in order to plan in advance.

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 so that they can 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. DoLS applications had been made to the Local Authority for people who required it. A record was maintained of applications that had been made and approved.

We were informed of an incident where a person was secluded in their bedroom for four hours. This exceeded the restrictions stated in the persons DoLs. Staff did not know who to contact or how to manage the situation which lead to staff keeping the person in their bedroom even though the person's behaviour had deescalated. A safeguarding alert was made in relation to this incident but it raised concerns about staff's lack of ability and skills to manage the situation.

A relative told us of a situation where staff wanted to lock their family member in their bedroom to keep them safe from other people at the home. The relative did not agree with this practice and felt it was an unnecessary restriction being imposed on them. This was fed back to the provider to investigate.

Another relative told us they found the service used medication to manage behaviours. They informed us their family member was given "as required" medication without consultation with them. They were only

informed after the event. The provider provided evidence that medicine was not administered until after the relative was informed. However the decision was already made to prescribe "As required" medicines and there was no evidence this decision was made within a best interest meeting as is required for people who lack capacity to consent on their care and treatment.

People's care plans made no reference to whether people had a power of attorney for their finances and care and treatment. The operations manager was unaware if this had been established.

Staff had been trained in DoLS. and the MCA. During discussion with us they indicated they understood how it related to the people they supported. They were aware that having the door locked and one to one supervision restricted people. However the above feedback would suggest they did not fully understand DoLs and MCA and that their actions are not in line with the requirements of the act.

It is recommended the provider ensures staff work to the principles of the Mental Capacity Act 2005.

People's care plans outlined the support they required with their health needs. Each person had a hospital passport in place. This outlined people's medical needs, medications, allergies, communication needs and key people involved with individuals. People had access to a GP, dentists and opticians. The organisation employed a team of health professionals such as a clinical psychologist, assistant psychologist, occupational therapist and speech and language therapist. They worked with people in developing behaviour plans, communication passports and in providing support to staff in how best to manage situations and behaviours. All the people living at the home had care manager involvement and some people had input from the community clinical nurse specialist for learning disabilities.

Relatives felt people's health needs were met. Some relatives were unaware of the input and support their family member received from the professionals employed by the organisation. Other relatives felt the specialist input should be provided by external health professionals and not the provider to ensure impartiality.

A professional involved with the home told us there was lack of clarity as to what was provided to individuals by the organisations health professionals. They commented that "The lack of communication and insight caused a great deal of concern to me". The provider confirmed there was an agreed protocol for the home and Local Authority to work together and told us they were not aware of what the specific concerns were to enable them to be addressed.

The home had a four week rolling menu. People's care plans outlined their likes and dislikes in relation to food choices and the support people required with their meals. Risk assessments were in place for people who were considered at risk of choking and malnutrition. People were weighed monthly and referrals made to the dietician for people who required it.

Records were maintained of the meals offered and eaten. Some people did not eat at meal times and were offered snacks and meals during the day to ensure their nutritional needs were met. We observed lunch being prepared and served. Staff took responsibility for cooking but involved some people in the task.

The home is registered for seven people but has limited communal space for seven people with behaviours that challenge. The corridors are narrow, the stairs are steep and the sitting room is small. An empty bedroom was being used as a dining room with the room meant as a dining room being used as office space due to the designated office being small. The local authority contract monitoring team had already picked this up as an issue but the organisation had not agreed to reduce their numbers to six. The organisation had

a large wooden workshop installed in the garden which was meant to be used for activities and provide extra space. This was not in use at the time of the inspection.

Requires Improvement

Is the service caring?

Our findings

People told us staff were nice and they helped them when they needed help.

We observed and received mixed feedback on staff providing care. Staff were welcoming, friendly and approachable. They were kind, caring, patient and gave people time to respond to questions and make choices and decisions. They called people by their first names and promoted their dignity and respect. They ensured people who refused to come back into the home was suitably clothed for the weather conditions. As it started to rain they brought the person's jacket to them and offered them food and drinks. They offered people who were distressed support and distractions.

However some staff failed to engage with people whilst supporting them with their meals and backed away from situations where people presented as challenging. We heard another staff member tell a person we were engaging with to "Sit back down" without any explanation as to why.

A professional involved with the home commented "I thought that staff appeared to be caring". Relatives said they found staff to be caring but some staff were less engaging. A relative commented "I have been ignored during visits and saw residents including my family member ignored too".

People told us their privacy was respected. They told us staff knocked on their bedroom doors prior to going into their bedrooms. During the inspection we saw some staff consistently knocked on people's doors, whilst other staff did not routinely do that. People's bedrooms were personalised and decorated to their taste.

It is recommended the provider monitors staff practice to promote a caring and inclusive environment for people which promotes people's dignity, respect and privacy.

People were encouraged and enabled to be involved in their care and their independence was promoted. The provider confirmed all the people living at the home were supported to take an active role in life skills such as cooking, shopping, laundry and making drinks to promote their independence, within a risk management framework. During the inspection we saw some people making drinks and being involved in the meal preparation.

People's care plans outlined their communication needs and what behaviours, gestures and symbols indicated the person was happy or not. One person used an app on their iPad to communicate. This was used consistently by staff when engaging with the person. Other people used picture boards, objects of reference, gestures and signing to communicate their needs. Some staff on duty promoted communication with people whilst other staff backed away from engaging with people. We saw in one person's care plan viewed that they used Makaton to communicate. Makaton is a language programme using signs and symbols to help people to communicate. We did not see Makaton being used with that person during the inspection. The provider confirmed the Speech and Language team were working with the person towards achieving this goal.

Some information was provided in a format that was accessible and understood by people such as menu plans, activity programmes and the complaints procedure. A staff picture board was on displayed in the corridor but was photos of all staff employed rather than specifically what staff were on duty on each shift. The provider confirmed the board was not intended only for people to know who is working on shift on a particular day but to enable people to know all staff that may come into the building. They advised an individual bespoke picture board has been created for one of the people using the service who had difficulty with working with staff that he did not know.

The operations manager confirmed they were able to access advocates for people when it was required.

Good

Is the service responsive?

Our findings

People were assessed prior to admission. A transition plan was agreed which included staff from the home working with the person in their own environment, as well as the person coming to the home for visits and meals prior to them being admitted to the home.

Some relatives felt the transition to the home went well and confirmed their family member had a series of visits from staff and to the service. A relative confirmed their family member was assessed and the admission was agreed. They commented "Staff struggled with their family member's transition to the home and it appeared to them staff were overwhelmed and had difficulty managing their family member's needs". Other relatives described the transition to the home as "Disorganised and chaotic". They commented "It was all last minute". A third relative told us that they did not feel the home had considered if people were compatible with each other and as a result this was having a negative impact on their family member. The provider confirmed people living at the home were provided with easy read social stores on people coming to live at the home to give them information on the person they are sharing their home with.

Care plans viewed outlined the support people required to meet their needs. They were informative as to the care required. They included detailed guidelines from the organisations health professionals to support staff to provide consistent care to people. Care plans were kept up to date and reviewed in response to changes in people's needs. People had regular reviews to which family and professionals were invited to. This was an opportunity to review the placement and agree actions moving forward. There was some duplication of information between care plans and risk assessments. The operations manager confirmed that the organisation was in the process of trialling an electronic care plan system with the plan being to introduce electronic care plans across the schemes.

Relatives confirmed they were invited to reviews and involved in their family members care plans at the point of admission. Some relatives did not feel confident that issues agreed in reviews were followed through. This was because they were not provided with updates or seen that actions agreed had been completed.

People had a keyworker. A key worker is a named member of staff who supported the person to coordinate their care. The keyworker completed weekly and monthly reports on the person and their progress. Staff were aware who they acted as key worker too and what the role entailed. Some families were aware who their family member's keyworker was, whilst others were not aware or did not feel confident that their family member's keyworkers had the skills to support their family member appropriately.

Each person had a weekly plan of activities which included college and leisure activities. People were supported to be involved in community based activities such as trampolining, swimming, meals out, going for walks, going to the park and shopping despite the challenging behaviours they presented with. The occupational therapist worked alongside staff in developing their skills and strategies to support people safely on activities in the community. They assisted and acted as positive role models to staff in developing staff skills and confidences in supporting people in the community.

Relatives felt there was a range of activities provided whilst other relatives told us there was no structured in house activities available which meant very little activities happened at weekends or in the evenings. The provider provided copies of activity schedules for people which showed that there was a programme of regular activities taking place including weekends.

The home had a complaints procedure in place. A user friendly version of the complaints procedure was available to people. Systems were in place to log complaints. Records were maintained of the investigation and outcome. The home had two complaints logged for 2017. During the inspection a concern was raised by a member of the public. Staff listened and provided the complainant with reassurance. However the staff member failed to recognise, log and record the issue raised as a complaint. This was handed over to the operations manager who addressed it with the staff member concerned and sent a written formal response to the complainant.

Relatives could not recall being given a copy of the complaints procedure however they told us they would raise any concerns they had with the manager. Some relatives told us they had raised concerns with the manager in relation to their family members care but did not always get feedback. None of those concerns raised by family members since January 2017 had been recorded. The issues raised were fed back to the provider to address.

Requires Improvement

Is the service well-led?

Our findings

Records required for regulation were not accurate. The staff duty rota and daily allocation sheet did not accurately reflect the staff on duty. This meant staff who were not on duty were allocated for one to one care which they were not available to carry out. People's daily records were completed by staff not rostered on the rota. Staff names on the rota did not correspond with the name on the allocation sheet and people's daily records in that different variations of names were used for the same staff members. People's daily records did not include their full name and one person's daily record had the wrong person's name on it. Some daily records were only partially completed and in some cases daily records were not completed for a morning or afternoon shift.

The operations manager confirmed after the inspection they had revised the shift planner and handover sheet and had reminded staff of the importance of keeping accurate records. They provided us with copies of the documents to evidence this.

Systems were in place to audit aspects of the service. These included audits of medicines, health and safety, infection control, care plans, and staff files. Alongside this the operations manager carried out three monthly audits and an external auditor carried out an audit of the service in October 2016. As a result of the audits the operations manager had identified some of the issues we had found such as gaps in staff supervisions and inductions, which were being addressed. However the audits failed to address the gaps in staff skills, training and poor record keeping.

Individual action plans were put in place to address issues from audits. This made it difficult to review actions completed and actions outstanding. The operations manager told us they follow up on actions from their previous audit at the next audit and in one to one's. However they agreed to put one action plan in place for all audits to ensure actions from audits were monitored and signed off.

Systems were not established to enable the provider to gain feedback on the service. Staff and resident meetings took place monthly. It was not clear from the minutes of the resident meetings how people with limited verbal communication contributed to the meetings and whether any of their communication aids were used to enable them to be involved.

We were told annual surveys were sent out to people who used the service, relatives, staff and other professionals to gain feedback on their experience of the service provided. We saw responses from people who used the service on file dated December 2016 and responses from staff dated July 2016. There was no indication that surveys had been sent or received back from stakeholders or relatives. The results of the surveys were not collated to indicate actions taken. Only one out of the six relatives spoken with recalled being sent a survey to complete. Relatives felt their only option to feedback on their family members care was at reviews.

These were all breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because records were not suitably maintained, the service was not effectively audited to safeguard

people and systems were not in place to seek and act on feedback from relevant people.

People were not supported by a service that was always well led. The manager had been in post since December 2016. They had applied to the Commission to be the registered manager. The manager was on leave during the inspection and therefore the inspection was facilitated by the operations manager. The manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe. We noted there was a high number of challenging behaviours incidences reported to us for the size of the service.

We received mixed feedback on the management of the service. Staff told us the home was well managed. They felt the manager was accessible, approachable and provided assistance on shifts. Some relatives felt the home was well managed and the manager made himself known to them. Other relatives did not feel reassured that the manager involved them in their family members care and they did not feel they had built a rapport with them. Some relatives felt communication with the home could be better. They told us they did not feel involved and others felt their request for information and updates went unanswered.

A professional involved with the home told us they were consistently having to chase staff and management to follow up on things. They felt communication with the home needed to improve. They confirmed the majority of the issues they had previously and consistently raised directly with the managers of Sequence Care but they had not been addressed. Another professional commented "I did feel that sometimes the care home could have been more proactive in communicating incidents with care management. It tended to be that unless I asked the home directly, they would only contact me if there was a crisis or a safeguarding, where if I knew there had been an incident (e.g. assault of staff member)".

The provider confirmed that Totteridge House operates an open door policy where relatives and professionals are able to contact the service at any time to request information and raise concerns. Professionals involved with the service user's and families are invited to Care Programme Approach (CPA) and do attend. Information is shared about the progress of the service user's. Internal professionals send a report and families have copies. Health professionals work at Totteridge House on a weekly basis.

Systems were in place to promote communication within the team. A communication book was in use to inform staff of important issues. Daily handovers, team meetings and multi-disciplinary meetings took place to keep staff informed of key issues. Staff were required to sign to say they had read and understood people's care plans, risk assessments, policies, procedures, team meeting minutes and the communication book. However not all staff had signed to say they had read and understood these documents. This practice did not promote effective communication and involvement.

It is recommended the provider ensures all staff read and understand key information on people as well as liaising with family and professionals involved in people's care to improve communication.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established and operated effectively to safeguard people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not suitably maintained, the service was not effectively audited to safeguard people and systems were not in place to seek and act on feedback from relevant people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not suitably inducted and did not have the required skills and specialist training to meet people's needs.