Care Quality Commission

Sequence Care Limited

Connington House

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

Connington House is a specialist residential service designed to support up to ten adults with learning disabilities who may also have autism, complex needs or behaviours that challenge services. The house is spread over three floors which are accessible by a lift. At the time of inspection there were six people using the service.

We carried out this unannounced inspection on 10, 11, 12, 13, 20 and 24 November 2015 and divided our inspection time between Connington House and the house next door, also run by the same provider. This was the first inspection of this service since its registration in October 2014.

There was no registered manager in post at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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 provider did not ensure that all reasonable steps were taken to ensure the risks to people were minimised when receiving care. We also found there were issues of concern around the management and safe administration of medicines. Staff were not given appropriate support through regular supervision and training opportunities. The provider was not providing care in line with people's consent and with mental capacity legislation. Not all staff put into practice their knowledge of promoting people's privacy and dignity. People's preferences and choice of activity were not consistently accounted for when planning care and not all staff understood the principles of providing a personalised care service. The service did not document all complaints made by people or their representatives. The manager did not have a system of carrying out quality checks on the service provided. The provider carried out quality audit visits of the service and found issues not addressed by the manager. People were not asked for feedback by the provider to help shape the service and were not given the opportunity to give their views through meetings.

Staff were knowledgeable about procedures around safeguarding and whistleblowing procedures. There were enough staff on duty. The provider had safe recruitment procedures for new staff. People were offered choices from a varied and nutritious menu and special diets were catered for. Records showed that people accessed health professionals as required. People were assisted to maintain their levels of independence. The provider had a clear complaints policy and an accessible pictorial complaints guide for people who used the service.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures 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. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe because the provider did not ensure risk assessments were detailed enough and covered all the possible risks which people faced. The provider did not ensure there were systems in place to ensure the safe administration of medicines.

Staff demonstrated they had an understanding about safeguarding and whistleblowing. There were adequate numbers of staff on duty. The provider carried out safe recruitment checks before new staff began employment.

Inadequate

Is the service effective?

The service was not effective because staff did not receive enough support through regular supervision and training opportunities. The service was not working within the principles of the Mental Capacity Act 2005 and in line with people's consent.

People were offered a varied and nutritious menu and there were plans to review the menus with people's involvement. We saw evidence that people had access to healthcare when required.

Inadequate

Is the service caring?

The service was not always caring because although staff were knowledgeable about promoting people's privacy and dignity, not all staff put this into practice.

Staff told us how they encouraged people to develop skills in becoming more independent and we saw evidence of this. Staff told us how they got to know people and their care needs.

Requires improvement

Is the service responsive?

The service was not responsive because people did not receive care which took into account their preferences and there was a lack of knowledge amongst staff about what personalised care was. People were not always able to engage in activities of their choice.

The service had a complaints policy but there was only one complaint documented since the service first opened. The operations manager told us there had been more complaints but these were not documented.

Inadequate

Is the service well-led?

The service was not well led because the home manager had not completed quality audits on the service provided or taken action when the provider identified issues.

Inadequate

Summary of findings

People were not given the opportunity to give feedback through meetings. The provider had not included this service in their annual feedback survey because the service was new.

Connington 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.

The inspection team consisted of one inspector on days one, four and five, who was joined on day two by 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. Two inspectors visited the service on day three and a specialist advisor in the Mental Capacity Act 2005 joined two inspectors on day six.

Before we visited the service we checked the information that we held about the service and the service provider. This included details of its registration and any notifications they had sent to the Care Quality Commission (CQC). We usually ask the provider to complete a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, due to receiving concerns about the service prior to this inspection, the provider was not asked to complete a PIR. We received concerns from two whistleblowers and the local authority relating to the care which people received.

During the inspection we spoke with four people who used the service, six care staff, two staff from the in-house multi-disciplinary team, two deputy managers and the operations manager. We also spoke with two visiting social workers and one community nurse. We observed interactions between staff and people living in the home and observed care and support in communal areas. We looked at care and management records including three people's care records, six staff files, training records, records relating to medicines and complaints, staff meeting minutes, quality assurance processes and policies and procedures.

Inadequate

Is the service safe?

Our findings

The provider had a risk management policy which stated a single tool should be used to cover all risks relating to the individual. This tool used a complicated colour coded scoring system which we saw could be difficult for new or agency staff to understand. The deputy manager explained that red indicated a high risk, amber indicated a medium risk and green indicated a low risk. However the deputy manager explained that the tool also gave consideration to the likelihood of a risk occurring which could affect the colour coding. We saw this was the case for one person who was assessed as being a medium risk but was given a green coding because the likelihood was low. The policy did not state how often risk assessments should be reviewed.

We found the risk assessments were incomplete for two people. We saw the risk management plan sections for household safety or mobility were not completed for one service user. Additionally we saw risks around finances and drinking excessive fluids were mentioned in the support plan but the file copy was different to the electronic version and these risks were not covered in the risk management plan. The risk management plan did not contain the name of the assessor, signature, date of completion or date to be reviewed. We saw the risk management plan for the other person was not signed or dated and the section covering challenging behaviour did not mention the risk of this person removing their clothes in public but this was mentioned in the support plan. Both the support plan and the risk management plan mentioned that physical intervention may be necessary but neither plan specified which physical interventions could be safely used. We noted all staff had been trained in physical intervention techniques.

The provider had a medicines policy which was updated on 1 May 2015 and gave clear guidance to staff around the supply, storage and administration of medicines. During the inspection, we looked at the arrangements for storing and administering medicines. We saw medicines were stored in a lockable trolley and administered from a small busy office environment. We observed there were telephones ringing constantly and staff entering and leaving the office frequently to get files or speak with management. This meant staff could become easily distracted and potentially errors could occur during administration.

We found ten medicine issues which included not writing explanations for why medicines were not administered. For example, one person had tablets left in their blister packs for three medicines which had all been signed for on the medicine administration record sheet (MAR), as been administered but there was no explanatory note as to why they remained in the packs. This meant the provider could not be sure if people were receiving their medicines as prescribed. The MAR sheets were non-specific for the times medicines should be administered and indicated general times of morning, lunch, teatime and bedtime. This meant the service could not be sure there was an adequate time gap between doses. Where medicines were prescribed to be given 'only when needed' or where they were to be used only under specific circumstances, individual when required protocols were in place. However the administration guidance on these protocols were non-specific about the dosage to give each time and staff were not qualified to make the decision about how much of this medicine would be safe to administer. Additionally, the protocol guidance on dosages and timings between doses did not match up with what was stated on the MAR sheets for three people. This meant the guidance for staff about administering medicines was unclear and they did not have the information they required to administer medicines safely.

We noted that since the inspection the provider has taken steps to relocate the storage of medicines to reduce the risk of staff becoming distracted and errors occurring when staff are administering medicines. We are also aware the provider has now employed nursing staff to oversee the management of medicines.

The above is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not do all that is reasonably practicable to mitigate any risks to the health and safety of people receiving care and did not have systems in place to ensure the proper and safe management of medicines.

Some staff members we spoke with had a good understanding of issues related to safeguarding adults and whistleblowing. For example, one member of staff told us if they witnessed abuse they would inform the person in

Inadequate

Is the service safe?

charge and, “Its better you say, when they don’t take it up, you can go to the local safeguarding authority.” However one staff member was not able to tell us what abuse was and another staff member thought whistleblowing was about taking a complaint to the next stage. This meant knowledge about safeguarding and whistleblowing was not consistent among staff. The service had a safeguarding adults’ procedure in place. This made clear their responsibility for reporting any allegation of abuse to the relevant local authority and the Care Quality Commission however the policy did not have the local contact details for the local authority. This means it was not clear for staff who they should report allegations of abuse to. We noted there was a “Safeguarding Tree” on the office wall which listed the six main types of abuse and how to recognise them. The service had a whistleblowing procedure in place which made clear staff had the right to whistle blow to outside agencies if appropriate.

People told us they thought there were enough staff. However one person said, “It’s a bit difficult sometimes because they have to look after someone on the first floor who needs 24 hours care.” Staff told us “We have enough staff”, and, “I think the majority of the time the staff level is good.” However staff also told us “Sometimes on a Wednesday when they send five staff to college, sometimes it interferes with staffing levels”, and, “If you draw attention to a lack of staff, they will get agency.” We reviewed the staff rota and handover sheets and saw there was enough staff on duty and people needing one or two staff working with them during the day were catered for. The provider had a bank of staff who they called on regularly to cover staff absences and we saw evidence of this from the rotas. We observed on the second inspection day that there were times when there seemed to be a surplus of staff and three or four members of staff were sitting in the communal lounge watching television or sitting around a table writing notes in folders. We discussed this with one of the deputy managers who explained that on the second inspection day these were agency staff who were being inducted to the service. The operations manager told us there were a few vacancies which they had filled with agency staff with a view to offering them permanent contracts. The operations manager also told us the rota was in the process of being reviewed to make it clearer to staff which house and person they would be working with each day.

Safe recruitment checks were made. We found all pre-employment checks had been carried out as required. Staff had produced evidence of identification, had completed application forms with any gaps in employment explained, had been provided with employment references, had a criminal records check and where appropriate there was confirmation that the person was legally entitled to work in the UK.

Inadequate

Is the service effective?

Our findings

The service had a policy on staff supervision. The policy stated that supervisions should be at regular intervals throughout the year and at a minimum frequency of six times per year. All staff files we looked at had a signed supervision agreement agreeing to supervision monthly. We found that supervisions were not being completed monthly as stated on the supervision agreements. We also found not all staff were getting supervisions. For example, one staff member had no supervision records in their file. We asked the operations manager if this staff member had completed any supervision. The operations manager told us, "[Staff member] hasn't had supervision because system around supervision hasn't been working. Gaps everywhere else as you've seen." This meant staff were not receiving appropriate support through supervision in line with the provider's procedure.

Some staff told us the provider was, "Good for training at Sequence, they have empathy with the service users", but other staff told us they had not had much training since they began employment. We reviewed the staff training matrix which consisted of 34 staff including bank staff and found training for staff was not up to date. For example, we saw six staff were overdue doing refresher safeguarding training and 14 staff were recorded as not receiving safeguarding training with the provider since they began employment. This explained the inconsistent knowledge among staff about safeguarding. We saw from care records that three people who used the service had epilepsy but only 14 staff had received epilepsy training. Similarly, one person who used the service had diabetes but only one staff member had received diabetes training. Training records showed only two staff had received up to date training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards and only two staff had received training in mental capacity awareness.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff had not received support from supervision in line with the policy or agreements and regular supervision would have helped to identify performance issues and training needs.

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.

During the inspection we observed that the kitchen and laundry rooms were locked. One person told us they currently had to ask staff every time they wanted to use the kitchen as it needed to be unlocked. This person told us they would like to have a microwave or kettle in the kitchenette area of their room to help them to work towards independence. Staff we spoke with told us the locked doors was a policy decision rather than based on risk assessment. This is not consistent with the MCA or DoLs as it is a restriction on people's liberty and must be assessed on an individual basis.

One service user had a DoLS authorisation on file but there was no evidence of the DoLS assessment, a capacity assessment, or a best interest's assessment to document why this decision was taken. The decision to apply for DoLS was on the basis that this person lacked the capacity to consent to living at Connington House for the purpose of receiving care and treatment. However, the evidence we saw on file indicated that this person was assumed to have capacity and consented to receiving care and treatment. For example the speech and language therapist reports noted this person had a high level of understanding. The epilepsy support plan noted the plan had been read to this person and they did not wish to add anything or make changes. There was a "Discussion of Treatment and Mental Capacity Record", which indicated that this person's capacity to understand and debate their medicines was intact. We also observed that this person had insight when we witnessed them identifying to staff a number of objects which they may use if they wanted to self-harm and they asked staff to remove these objects. The inspection team

Inadequate

Is the service effective?

heard this person say consistently they did not like Connington House and they wanted to move. As this person was assumed to have capacity, this meant he was not consenting to live at Connington House

Care records for another person diagnosed with a severe learning disability, epilepsy and autism contained no capacity assessments but there was a wide variety of decisions being made on their behalf on a daily basis. This person had a deputy for health and welfare appointed. A deputy for health and welfare is a person (usually a family member) who is authorised legally to make decisions on behalf of somebody who lacks mental capacity. There were no records of how this person's deputy was involved by the service in decision making. The only recorded contact by the service with this person's deputy was when the deputy phoned to check on this person's welfare. However, records of these telephone contacts did not reflect any discussions about day to day decisions about the person's care.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider was not providing care in accordance with people's consent and in accordance with the Mental Capacity Act (2005).

We saw the service had a four week rolling menu which was varied and nutritious and contained two choices for the main meal each day. People were offered choices of cereal, toast or cooked breakfast and we saw one person chose to have a selection of fruit for breakfast. Staff told us there were plans to discuss the menu with people to see if they would like any part of it changed. We saw evidence that special diets were catered for. For example, one person who was diabetic had diabetic jam and ice cream stored in the kitchen. We also saw that people were able to have a take-away meal of their choice once a week and this was documented on the menu. However, we noted there was a bowl of fresh fruit in the kitchen but people were not able to help themselves as the kitchen door was kept locked.

Care records showed that people had access to healthcare as and when required. The provider had their own in-house multi-disciplinary team consisting of a responsible clinician, specialist learning disability nurse, psychology assistant, speech and language therapy assistant and an occupational therapy assistant. This team worked across the whole organisation and individual members of this team were seen at the home throughout the inspection working with individuals. We also observed one person being supported to go to the GP when they were not feeling well.

Requires improvement

Is the service caring?

Our findings

We saw two incidents on 11 November 2015 where one person's dignity was not respected. The first incident was when a member of the inspection team asked to talk to a person, a member of staff knocked on this person's door and opened the door. The person was in bed under the covers so the inspection team member said they would leave talking to them. A staff member called the inspection team member back to the bedroom door and told them they could speak to the person. The person was naked to her waist so the inspection team member said they would come back when the person was dressed. Three members of staff were seen standing looking at this person. One of these staff members sang to the person and tried to encourage her to put her top clothing on. The other two staff watched. There was no indication that staff understood it was inappropriate for us to speak with this person in a state of undress.

The second observation was later in the afternoon when a member of the inspection team was leaving a room to go downstairs in order to speak with the deputy manager. As the inspection team member was leaving, they saw a person lying on the floor in the room next door in a state of undress. The inspection team member noticed there were two members of staff sitting on the sofa on the other side of this room watching the person. We raised this with the deputy manager who deduced it was the same person observed in the first incident and confirmed this was not the accepted way to work with this person's behaviour. The deputy team manager explained the accepted way was to cover this person with a blanket and keep talking to them in order to find distractions until they were ready to get up and move to their room or to an activity. Care records showed this was the case. We reviewed this person's file on 18 November 2015 and saw the night notes were not age appropriate and said "Staff changed [person's] nappy and observed [person]."

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because this person's dignity was not respected by staff working with them and dignity was not promoted in care records.

At other times during the inspection we observed staff knocked on people's doors and waited to be invited in. We spoke with staff about how they respected people's privacy and dignity. One staff member said, "Only two people need personal care assistance, cover them up and ask for their permission to help." Another staff member told us they, "Knock if you need to go into their bedroom and ask their consent. Having a level of confidentiality unless they are at risk. Respect they need to have time on their own."

People told us they thought staff were caring but one person thought they were restricted by staff in what they could do. For example, this person told us, "When I want to go out they won't let me." We discussed this with the deputy manager who explained this person had moved into the service a few days before from a hospital environment and was on a community treatment order. They explained they were waiting to receive the treatment plan to know what staffing was required to enable this person to go out into the community. The deputy manager immediately made a telephone call and the treatment plan was sent through advising this person was able to go out with one staff member. We observed the deputy manager apologised to this person for the delay and offered to arrange for staff to go out them that day. Staff were able to demonstrate they were knowledgeable about encouraging people to develop their levels of independence. For example, one staff member told us they, "Try to have them do as much as they can on their own." Another staff member told us promoting independence was, "By assisting and not doing for them." During the inspection we observed people helping to unpack grocery shopping and put the food items away. We also saw people being assisted to do laundry and fold their clothes. The deputy manager told us, "I want to empower them for when they're in their own flat."

One staff member told us they got to know people who used the service through, "Reading their files and through other staff." Another staff member told us they, "Communicate on their level, build a rapport and communicate with staff who know [person] well." Staff demonstrated they knew people well by explaining their preferences. For example, a member of staff showed us the pictures they use to help people to indicate their choices of food. This staff member told us which cereal one person preferred and demonstrated to us how they showed this person all the breakfast cereals and "[person] always chooses this one or sometimes this one." Another staff

Requires improvement

Is the service caring?

member said, “They have a right to choose. We take [person] to the wardrobe to choose clothes. We take [person] to the fridge and [person] chooses semi-skimmed milk and yoghurt.”

Inadequate

Is the service responsive?

Our findings

Three staff we spoke with were not able to demonstrate they knew how to deliver personalised care. One staff member told us personalised care was, "Make sure room is clean, daily room temperatures, make sure they participate in activities." Another staff member told us personalised care is, "Not having a particular person you like. Being there for everyone, not just a particular person." The third staff member told us, "It's to be there for service users, to help them and to respect them." These are task focussed approaches and do not correspond with the definition of personalised care which is care and support designed around individual needs and preferences. A member of the in-house multi-disciplinary team told us, "Person centred [care] is there but could be better," and "Staff are caring, could be a bit more person centred."

We saw that support plans in care files had a section for the individual to give their views but this was not always completed in two of the care records. For example one person had a support plan for epilepsy management. The file copy dated 28 March 2015 contained this person's feedback and was signed to indicate their agreement. However, the updated version of this plan dated 9 September 2015 was not signed by the person and a note had been added "feedback will be discussed with [person] at first key work session." This had not been updated with the feedback at the time of inspection. Also for this person, the care plan for supporting them to understand their placement dated 8 October 2015, the section for person's views said, "At the time of completing, [person] is unavailable to give [their] opinion on this plan." This person remained within the home most of the time so it was unclear why they were not available to give their views. Another person's finance support plan on file, dated 14 June 2015, did not contain a section for person's views and was not signed by the person. The deputy manager gave us an electronic version which was updated on 14 August 2015 which did contain the person's views but had not been signed by the person by way of agreement. This meant the service was not including people in their care planning and supporting people to express and document their views or preferences.

Three people who used the service were smokers and they told us they had to sign up to a smoking regime when they first moved into the service. One person told us it was not because they were trying to give up smoking they were on this regime. This person said it was staff who had decided the times they were allowed a cigarette and felt they had no choice about having a smoking regime in place. We asked this person if they were happy with this arrangement and they said they would prefer to have the freedom to smoke when they wanted to. This meant care was not designed and delivered in line with this person's preferences.

One person asked one of the inspection team to accompany them to the office to witness their request to leave the home independently at 7 am the following day, for a home visit. We witnessed staff reassuring this person that this was agreed and writing this in the house diary so staff the following day would be aware. After this person returned from home leave, they told the inspection team they had enjoyed their trip but were not happy as they had been unable to leave until 8 am due to their medicines not being prepared on time. This meant this person's time on home leave was reduced and their needs were not being met. We discussed this with one of the deputy managers who found a solution for the next time this person went on home leave.

One person told us, "I go out and do nice things. I do a lot of activities here." However family members told us there were not a lot of activities offered to people. A professional worker from a local authority told us they had found little evidence in the care records that the person they represented was being engaged in activities and this was partly why they were looking for an alternative placement for this person. We noted from this person's care records that they spent a lot of time watching television even though activities including swimming, trampolining, horse-riding and going to church twice a month had been identified as activities they were interested in. There was no indication from the care records that any attempts had been made to take this person to church or to source a horse-riding facility. The records indicated that attempts had been made to take this person swimming but they had become upset when they passed by the trampolining venue. We also noted that the service accessed activities for this person out of the borough which meant there needed to be a driver on shift to enable their activities to happen. We raised this with staff and the managers who did not know what facilities were available locally. Care

Inadequate

Is the service responsive?

records for this person stated a recommendation by the previous placement to facilitate Skype contact with their family but there was no evidence that this had been followed up.

Staff from the in-house multi-disciplinary team and care staff told us there were not enough activities offered to people due to a lack of appropriately skilled staff. The service improvement plan dated 5 October 2015 stated activity plans needed to be reviewed with the input of people who used the service and shifts needed to be planned to enable activities to happen. This had not been actioned at the time of inspection. The Operations Manager told us the, "Rota is not clear, staff don't know what they are doing, not well organised, people not stimulated in the house" and "we will be reviewing everyone's activities timetables." This meant the service was not providing personalised care in accordance with people's preferences.

The above was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not included in their support planning and care was not designed or delivered in line with people's preferences.

The provider had an accessible and pictorial complaints guide for people who used the service. We saw evidence of one complaint made on 28 October 2015 regarding the quality of food and this had been acknowledged and resolved within the timescales of the policy. The person who made the complaint confirmed with us that they had been happy with the response. The Operations Manager told us that he was aware there were more complaints but he could not find evidence that they had been formally logged in the service. We noted there was one complaint by a family member about the service at Connington House mentioned in the team meeting minutes of 28 August 2015 but this had not been logged or progressed as a complaint.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider could not evidence that proportionate action had been taken in response to any complaint received about the service.

Inadequate

Is the service well-led?

Our findings

We found care records were disorganised and incomplete. Each person who used the service had three or four files so it was difficult to get an overall picture about individuals and it was difficult to locate important information about individuals. This meant it was difficult for staff to be able to obtain relevant information quickly in an emergency situation without spending a long time searching for the information. For example, one person's file noted they were losing weight because this person had periods of eating little which coincided with seizure activity. We saw dietary advice had been provided but we saw no evidence of food intake records or weight monitoring. The clearest information in each person's file was contained within reports written by the in-house multi-disciplinary team which gave a clear introduction to the individual. We discussed this with the operations manager who informed us that a manager from another service had been brought in immediately prior to the inspection to support the service to make improvements, in particular to improve the care plans and to make the staff rota clearer and more specific. The operations manager gave us a copy of an email they had sent to the supporting manager and the deputy manager regarding the actions which needed to be completed.

We reviewed the home manager audit files and saw the manager's environmental audit and documentation audit had not been completed since the service opened. Records also showed the manager's monthly audit had not been completed since March 2015. There was also no record of the provider's monthly visits although there was a sheet to record this in the audit file. Additionally, we saw the home manager had not done any audits of medicines.

We saw a provider compliance audit was carried out in June 2015 and identified 27 issues that had not been addressed by the home manager. The issues identified included incomplete risk assessments, care plans not in a logical order and staff supervisions not taking place. We saw the provider followed up on this when they visited on 5 November 2015 and the record of this visit showed only five of the 27 actions had been completed. The records showed that the home manager had not added to the action plan to indicate what had been achieved towards completing the other actions. We also saw the auditor had noted they would ask for weekly updates from the time of this check. The operations manager told us the home manager had not carried out quality audits and as a result they had drawn up a service improvement plan with actions they were expecting the manager to complete. We saw the action plan from 5 November 2015 contained 17 actions which included the lack of quality assurance. We noted no actions were completed at the time of this inspection.

People who used the service were not asked for feedback. We saw from the record of a staff meeting held on 28 August 2015, the home manager noted that staff had not been holding regular resident meetings. Although we saw there was a staff meeting on the 28 August 2015, the operations manager told us there a staff meeting held on 26/10/2015 but was unable to produce the record of this. We asked the operations manager if feedback had been requested from people and their families to obtain their views about the service. The operations manager told us that as the service had not yet been open for one year this was not done. We noted the last feedback survey carried out by the provider for all of its services was done in March 2015 but Connington House was not included in this as it had only been open for four months. Obtaining people's views early on would have involved them in shaping the service they received.

The above was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider was not ensuring relevant actions were completed on issues identified in audits and was not seeking and obtaining feedback from people and relevant persons in order to improve health and safety of the service and evaluate, shape and improve the service provided.

There was not a registered manager in post at the time of inspection. The home manager had decided to withdraw their application with CQC to become registered and following the inspection moved onto other employment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider did not ensure that service users were treated with dignity and respect. Regulation 10 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The provider failed to produce evidence that all complaints received were investigated and proportionate action taken in response to any failure identified by the complaint or investigation. Regulation 16 (1)**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider did not work in partnership with people to involve individuals in the planning of their care and enable people to express their views or preferences. The provider did not ensure that the design and delivery of care was in line with people's preferences.**

The enforcement action we took:
The registered person must ensure the care of service users is appropriate, meets their needs and reflects their preferences. The registered person must carry out an assessment of the needs and preferences for care of the service user. The registered person must design care with a view to achieving the service users' preferences and ensuring their needs are met. The registered person must enable and support the relevant persons to understand the care choices available to the service user.
Regulation 9 (1)(a), (1)(b),(1)(c), (3)(a), (3)(b), (3)(c) and (3)(h).
We have issued the provider with a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not ensure that care was provided with people's consent and with the Mental Capacity Act (2005).**

The enforcement action we took:
The provider must ensure that care and treatment of service users is only provided with the consent of the relevant person. If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the provider must act in accordance with the 2005 Act.

Regulation 11 (1) and (2).
We have issued the provider with a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Enforcement actions

The registered provider did not do all that is reasonably practicable to mitigate any risks when providing care to people. The registered provider did not ensure there were systems in place to ensure the proper and safe management of medicines.

The enforcement action we took:
Care and treatment must be provided in a safe way for service users. The provider must do all that is reasonably practicable to mitigate any risks. Where medicines are supplied the provider must ensure that there are sufficient quantities of these to ensure the safety of service users and to meet their needs. The provider must ensure the proper and safe management of medicines.

Regulation 12 (1), (2)(b), (2)(g).
We have issued the provider with a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not ensure there were adequate systems in place to monitor and improve the quality and safety of people using the service. The provider did not seek feedback from people for the purpose of continually evaluating and improving the service.

The enforcement action we took:
The provider must ensure systems or processes are established and operated effectively to ensure compliance with good governance. The provider must assess, monitor and improve the quality and safety of the services provided in the carrying on of providing care. The provider must assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. The provider must maintain securely an accurate, complete and contemporaneous record in respect of each service user and of decisions taken in relation to the care provided. The provider must seek and act on feedback from relevant persons and other persons on the services provided in the carrying of providing care. The provider must evaluate and improve their practice in respect of the processing of the information referred to in the previous points.

Regulation 17 (1), (2)(a), (2)(b), (2)(c), (2)(e), (2)(f).
We have issued the provider with a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered provider did not ensure that staff received regular support from supervision in line with the

This section is primarily information for the provider

Enforcement actions

supervision policy or supervision agreements. The registered provider did not have a system in place to identify performance issues and training needs to enable staff to effectively carry out their duties.

The enforcement action we took:

The provider must ensure that persons employed by them in the provision of care receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Regulation 18 (1), (2)(a).
We have issued the provider with a warning notice.