Sequence Care Limited

Park House

Inspection report

Park House
32 Ferme Park Road
London N4 4ED
Tel: Tel: 020 8340 7216
Website: www.sequencecaregroup.co.uk

Date of inspection visit: 5 and 6 August 2015
Date of publication: 28/10/2015

Ratings

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

Overall summary

This inspection took place on 5 and 6 August 2015 and was unannounced. The previous inspection was on 10 October 2013 which was a follow up inspection to check if improvements had been made in the areas of staff recruitment and monitoring the quality of the care. We found the service was meeting those standards at that inspection. At the time of the last inspection this service was a small independent hospital for people with a learning disability. Since then, it has changed to become a care home. There is no longer any nursing care provided.

This care home provides accommodation and care to up to six people who have a learning disability, some of whom also have an autistic spectrum condition or mental health need and associated challenging behaviour. At the time of this inspection there were five men living in the home in single bedrooms with ensuite facilities.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

We found people were cared for by staff who knew their needs well. Staff supported people with their personal care and to take part in activities such as shopping, eating out, visiting family and physical exercise such as the gym, football or walks.

Staff supported people with their physical and mental health needs but one person's health needs may not have been fully met due to the lack of a detailed care plan for some health conditions.

People's care plans contained information setting out how each person should be supported. There was limited evidence of people being involved in planning their own care or having copies of a care plan that they could understand.

People were lawfully deprived of their liberty where appropriate for their own safety and they were involved in this decision making process.

People were supported by professionals employed by Sequence Care Ltd including psychologist, speech and language therapist and art therapist.

Senior staff from Sequence Care Ltd visited the home on a regular basis to carry out audits and tell the registered manager what improvements were needed. They then checked if the improvements were made at the next meeting.

We found breaches of four regulations. People's staffing needs were not being consistently met as they were not receiving all the one to one staffing hours they needed. People were not always protected from the risks of aggression from others. People's medicines were not always managed safely. There were some maintenance issues in the home which needed to be acted on to ensure the home was safe and well maintained. People were not fully involved in planning their care as their views were not recorded in their care plans. The provider, Sequence Care Ltd, had not ensured these concerns were acted on quickly through their auditing process.

You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires improvement

The service was not consistently safe. Staff had assessed risks to each person's safety and any risks they posed to other people. However, we identified that some care plans did not guide staff on how to minimise risks to people's safety.

Staff knew people's needs but two people were assessed as needing one to one staffing and staffing levels did not provide this level of staffing to them.

Staff were knowledgeable about safeguarding people from any abuse but there had been incidents where people living at the service had assaulted each other. People were at risk of not receiving their prescribed medicines safely as the management of medicines in the home was not consistently safe.

The building had not been maintained to a good standard.

Staff had good knowledge of whistleblowing which meant they were able to raise concerns to protect people in the home from unsafe care.

Is the service effective?

Requires improvement

The service was not consistently effective. Staff were trained to support people with all aspects of their care. People's nutritional needs were met. People ate out regularly and there was a variety of food in the home.

Staff supported people to see healthcare professionals regularly and supported them in the service to look after their physical and mental health. One person did not have sufficiently detailed care plans advising staff how to support them with their physical and mental health needs.

Is the service caring?

Good

The service was caring. Staff demonstrated good understanding of people's care and support needs and formed positive relationships with people.

People's privacy was respected by staff. Staff respected and supported people's diverse backgrounds.

Is the service responsive?

Requires improvement

The service was not consistently responsive. Although everyone had care plans there was limited evidence that they were consulted and involved in planning their own care and they were not given a copy of their care plans.

Staff supported people to go out to different places that people liked to go to. People had access to art therapy, speech and language therapy, yoga and massage in the home.

Summary of findings

The service had a complaints procedure which was available in an easy to understand format. People were given information on how to make a complaint.	
Is the service well-led? The service was not consistently well led. The transition from hospital to care home was still in progress so the environment and culture was not yet fully person-centred and homely. Staff were clear about the standards expected of them and felt able to approach the registered manager for advice and support. People living in the home and relatives and professionals outside the home had a good relationship with the registered manager but had some difficulties in communication with the home. The provider carried out regular audits and made plans for improvements but this was not always effective at identifying and mitigating risks.	**Requires improvement** 

Park 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 unannounced inspection took place on 5 and 6 August 2015. The inspection team consisted of an inspector, a specialist professional advisor, a pharmacist 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.

Before the inspection we reviewed all the information we held about this service, including the notifications sent in by the provider over the past 12 months, safeguarding alerts, previous inspection reports and information provided to us by the local authorities and professionals involved with people living in the home.

We used a number of different methods to help us understand the experiences of people living in the service. We spent time observing how staff interacted with people in the communal areas. We met the five people living in the home and talked with them.

We looked at three people's care records in detail. We also carried out pathway tracking which involved talking to people and reading care records to see whether the plans for people's care were actually taking place. We checked menus, one staff recruitment file, staff duty rosters, staff training, supervision, appraisal and meeting records, accident and incident records, selected policies and procedures and medicine administration record charts.

We spoke with the registered manager, deputy manager and a team leader. The company calls their care staff rehabilitation facilitators. We met three of these staff. We contacted the families and a professional for people living at the home to ask for their views on the home. We spoke with four professionals and four relatives.

Requires improvement

Is the service safe?

Our findings

There were systems in place to protect people from abuse but not from assaults by each other. We asked three people if they felt safe in this home. Two said they felt safe but one said they did not as they had been assaulted by another person in the home. Two relatives also told us that their family member had been assaulted by someone else living in the home. We looked at the incident reports and found there had been some incidents where there had been some conflict between people resulting in one person being scratched or hit by another. One relative said they were "not confident" that their family member was safe, for this reason. As most people spent the majority of their time together it exacerbated potential incidents between people. Although there were two lounges most people stayed in one lounge with staff. People went out as a group regularly in the service's car and staff told us they sat in between people to minimise the risk of any incidents.

Each person had risk assessments in place to advise staff on the risks to their safety and wellbeing and any risks they posed to others. Staff were able to explain the risks for each person. One person was at risk of self harm. They had a risk assessment and care plan to address this need. The person said they felt unsupported and one of the staff we spoke with was unsure on how to support this person. This failed to ensure that people always received safe care and treatment.

The above concerns contributed to a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014.

People's medicines were not always managed safely. One person told us they did not get one medicine on time, which reflected our findings below. Easy-read leaflets about people's medicines were available for people so they could understand about the medicines they took.

All medicines were stored securely. The temperature of the medicines room and medicines fridge were monitored daily so medicines were stored safely. There was a robust process for the ordering of medicines which was working, except for one medicine which had been over-stocked. All prescribed medicines were available. We checked supplies of all medicines against what was recorded on the Medicines Administration Record. There were no discrepancies, but the number of insulin pens stored was not recorded so we could not audit this.

There was evidence that people's medicines were reviewed regularly by their consultant psychiatrist and GP. Dose changes were implemented promptly and medicines records showed that four people were receiving these medicines as prescribed, as there were no refusals or gaps in recording for these medicines. One person's medicine prescribed twice a day was not listed on his current Medicine Administration Record and was in the fridge in the box with no evidence of it being given. Staff told us this medicine had been given but this was not recorded anywhere. Staff were carrying out daily audits of medicines records but the audits had not highlighted that one medicine was missing from a Medicine Administration Record since 27 July 2015, or that staff were not recording the use in any otherrecord. There was therefore no documented evidence that this person had taken their prescribed medicine for nine days.

An error was made on the first day of the inspection as a staff member had recorded giving a person a medicine that they take on occasions when needed and recorded why it was given, but then this was crossed off. The staff member said this was an error as the person had not been given this dose. They had followed the correct procedure when making a recording error.

There was no date of opening on insulin pens in use, which have a limited shelf-life once opened so there was a risk that these could be used for longer than recommended, and so may not be effective.

The above concerns contributed to a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014.

There were protocols for all of the "as and when needed" medicines prescribed for agitation or aggression. These medicines were very rarely used. The deputy manager explained that staff used these as a last resort only, and each protocol explained when these medicines were to be used and also non-drug interventions and actions that might exacerbate the persons symptoms. When they were used, a note was made to explain why. This was good practice.

Missing persons' profiles were available with photographs of people; to be used in the event that a person went missing. People were protected against the risk of unlawful or excessive control or restraint because the provider had made suitable arrangements. All staff had attended training in positive behaviour support and in dealing with

Requires improvement

Is the service safe?

behaviour that challenged the service. This training advised staff on how to prevent and manage incidents of aggression. Staff told us there had been no incidents where physical restraint was used in the past six months and none of the people in the home needed restraint to be used.

A relative told us, "There have been loads of staff here," but we found at times there were not sufficient staff working directly with people to meet their assessed needs. The staffing level at the time of the inspection was three staff on duty during the day and two awake on duty at night. There was a mix of male and female staff. Two people told us that staffing levels had been reduced from four to three a few months previously. The provider told us this was due to a reduction in the number of people living at the home. On three days a week there was a fourth person working during the day such as a speech and language therapy assistant. We found that two people had been assessed by their local authority as needing one to one staffing for several hours a day. We discussed one to one staffing with the registered manager and three staff members who all had different explanations regarding one to one staffing. Three staff and one person who required the one to one staffing told us that one to one staffing was not provided on a daily basis to one particular person. Two staff said that one person did not have one to one staffing when their local authority and records in the home stated that they should have. We looked at a staff roster and shift plans. The shift plan record showed two people as having a named staff member but staff explained this was for specific care that they needed and did not indicate that one staff would be with them at all times. We found that a staff member was not always allocated to those people for the required number of hours one to one support each day, which put people at risk of unsafe care.

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

The building was not managed to ensure safety as there were repairs needed. Health and safety audits were undertaken to identify any risks. There had been an audit the day before the inspection on infection control and the environment. This found good infection prevention practice and some maintenance issues which required attention.

There were some holes in two bedroom walls and the floor in another bedroom doorway, and marks on lounge walls. The lounge was safe. The television was secured to the wall for safety reasons. The dining area seats were ripped which could be difficult to keep clean. A specialist upholsterer had been instructed to manufacture a new seat which was due for fitting.The floor area around the dining area chairs was dirty. There were three of the fifteen light bulbs that were not working and flooring that needed repair or replacement in one bedroom and lounge. The registered manager told us this work was planned and provided evidence after the inspection that the bedroom and landing floor was replaced. We also found that electrical wiring checks were overdue.

The above concerns were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

Our findings

Three out of four people's relatives told us they thought staff had the skills and knowledge to meet their relative's needs. We found that the provider trained staff in the knowledge and skills needed to work in the service including training related to the specific needs of people living in this home. Examples of this were training on autism and Asperger's syndrome, understanding learning disabilities and complex diagnosis, and positive behaviour support. Staff had five days' initial training before starting to work in the service.

Staff told us supervisions took place monthly and we saw a record of this. Staff said they felt supported by the provider.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. These were in place for all five people living in this home. People had been involved in this decision making process and all the authorisations had the name and signature of the person. Four people were provided with staff support whenever they went out of the service to help them keep safe. One person was able to go out alone when they wanted.

We were only able to ask one person if staff sought their consent before providing care and support. They said no because they had not been involved in writing their care plan. During our observations we saw staff asking for consent and asking people what they would like.

People had enough to eat and drink but did not always have a varied choice. There was a good supply of fresh food in the fridge, and the freezer was well stocked so there was a variety of foods available. Two relatives told us they thought the food was good. There was a menu plan and records were kept of what people ate so that staff could monitor any dietary concerns. People tended to eat the same meal rather than select what they wanted from a choice each day. However, during the inspection we saw a staff member offer a choice of fishfingers or pie to people and they were all able to choose. One person said they did not have enough choice. People had toast and cereal or porridge for breakfast. Two people were encouraged to prepare this themselves. A staff member told us on Fridays people have a takeaway meal together. People also ate out regularly. During the inspection everybody went out to lunch and we saw from records that three people regularly ate lunch out and really enjoyed this.

One person had been assessed as being at risk of choking. This person had been assessed by a speech and language therapist who advised staff on how to support the person to eat safely. Staff were able to explain what they did to support this person and minimise this risk. Three people had specific dietary needs due to health conditions.

Staff knew people's physical health needs. Staff supported people to see healthcare professionals when they needed to. Relatives said that staff ensured people saw the GP when unwell.

Staff supported most people well with their physical health. Staff had recently received training in diabetes management from a diabetes specialist nurse who had devised a comprehensive diabetes management plan which had increased staff knowledge. One person's blood glucose was not being monitored as often as needed and at the correct times (before food) in accordance with their diabetes management plan. One person had four physical health conditions identified in their risk assessments but there were no care plans for three of these to advise staff on how to support the person with these conditions.

Another person also had a detailed care plan for their health condition which was being provided and staff were confident they met this person's health needs. Their relative agreed.

The provider had a psychiatrist and psychologist who supported people with their mental health needs. There was varied feedback about people's mental health needs. Two relatives told us that staff supported people well with their mental health needs. A professional said that one person's mental health had improved since living in the home and their medicines had been able to be reduced. One relative said they were not always notified of appointments and did not agree with the mental health care plan. We were told that this was being addressed. People's mental health was appropriately monitored.

Good

Is the service caring?

Our findings

Most people said they liked the staff. One person said, "I like it here. The staff are nice to me." Two others agreed that they liked the service and said staff were "friends." Staff had formed good relationships with people and people were clearly comfortable with staff.

One person said they were not happy in the service and felt their needs were not being met. We spoke with the registered manager and a professional involved with this person who confirmed they were aware of this person's concerns and were trying to find a more suitable service for them.

Three families told us staff were caring and that their relative was happy in this service. One said, "I think they are caring." Two commented that staff, and the atmosphere in the service, was "cheerful." One said staff had "always been helpful" and that staff understood their relative's needs. Another relative said, "I do think he is happy there, and he feels it is his home which I thought would never happen."

The provider employed a speech and language therapist to assess people's communication needs and support staff with communication. One member of staff was designated 'communication champion' and told us that they had taught one person some sign language to help communication as staff did not speak their language. Some people had a pictorial book to help them communicate.

Staff knew each person's different communication methods and their preferences about how they liked to be spoken with. They spoke with people in a compassionate and respectful way.

When people were upset or anxious staff supported them by taking them to a quiet room or going out with them to help them calm down.

People's diverse needs were respected. Discussion with one staff member showed that they respected people's different sexual orientation so that gay and bisexual people could feel accepted and welcomed in the service.

One family told us that staff supported their relative to go to their place of worship when they wanted to go. Staff had a positive approach and supported people with their sexuality needs, giving them support and advice when they needed it.

Staff supported people's right to privacy. People spent time alone in their rooms when they chose to and staff did not go into people's rooms without good reason. People's rights to dignity and privacy were respected when they needed support with their personal care. For example, a staff member told us that one person was supported and prompted in the bath by a staff member who stayed in the bathroom for the time they needed to, then supported them by prompting and checking on their safety from outside the door.

Requires improvement

Is the service responsive?

Our findings

People received care and support that they were generally happy with but we found that they were not always fully involved in planning their care. The registered manager said that people were involved in making decisions about their care and we saw staff support people to make choices and decisions. However, this was not so evident in the care plans and records of care.

One person said they were bored. We checked the records of what three people had been doing in the previous nine days. We found this person had not taken part in many activities with staff despite being funded for one to one staffing for several hours a day and did not have much to do.

Two people's representatives said people would benefit from a more structured timetable of activities. We saw one person's timetable but this was not being followed and they did not have a copy as it was kept in their file.

Two people prepared their own breakfast. Staff told us the other three people would not be able to do this. These people had limited opportunity to become more independent in preparing food.

Each person had twelve or more care plans that addressed their needs. Examples of areas covered in care plans were communication, safeguarding, budgeting, personal care, dietary needs and health. However, most of these care plans did not have evidence that people had been involved in the care planning process. In the section of the care plan 'Service Users' Views', there was either nothing recorded or views written in the third person. Two examples were "[name] is capable of participating in certain aspects of his personal care independently" and "For [name] to be able to manage his own health and maintain a good healthy life style." This was not how people in the home would express their views. Two people could write but had not been supported to write their views. The 'yes' and 'no' tick boxes to indicate whether or not people had been offered a copy of their care plans were not ticked in their care plans we looked at. We asked one person and they said they did not have a copy. People had a person centred book which showed some involvement by the person but those we looked at were not fully completed.

Care plans were not in a format that some people could understand. They were not written in plain English and there were no pictures or photographs in the three plans we looked at to help those who could not read.

Some people had pictorial timetables in their files but these were not given to them or displayed where they could see them. There was a poster on the wall advising people what to do if they felt angry but is was not in an easy read or accessible format for most people to understand.

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

Two professionals and one person living at the home told us that people were supported day to day as well as in formal review meetings to express their views about living at Park House and the quality of their care. One person said that they had choice and control about their day to day living, could choose what they wanted to eat and helped make breakfast. One relative said that their relative was "listened to" and said, "This is something that makes the place so very good."

People had opportunities to go out regularly. On the day of our inspection three people went out for the day as a group with three staff to the gym, for lunch and to an air show. Another person went to visit their family and the other person had no planned activities but asked staff to go out for lunch with him which they did.

One person worked at the company head office one day a week. Another person attended a day centre four times a week which he said he enjoyed. The provider employed a psychologist, speech and language therapist, art, yoga and massage therapists who all visited the home to work with people if needed. Two people had weekly yoga and massage. One relative said their relative went out regularly to places such as Southend, the fair or a park. One person said they liked to go out in the service's car every day. Another person said they had been to Southend with staff and would like to do that again. He said, "I want to go to Southend and swim in the sea."

Relatives and professionals said they had not made any complaints but had raised concerns or made suggestions which had been acted on by the registered manager. One relative gave an example where staff had listened to their concern about being communicated with, resolved it and

Requires improvement

Is the service responsive?

communicated with them well ever since. There was a complaints procedure in a pictorial form aimed for people living in the home to understand how to complain. One person living in the service said they did not feel listened to.

One person said, “I am happy here, it’s my home isn’t it” and two relatives said their relative was very happy living in the home. One told us, “as long as he is happy enough and he would tell me if he’s unhappy.”

Requires improvement

Is the service well-led?

Our findings

This care home was an independent hospital until last year where some people were detained under the Mental Health Act. The people currently living in the service had been assessed as not needing nursing care. The transition to a care home has meant a change to the culture. This change was still in progress at the time of our inspection. Two signs on the wall and some staff were still referring to people as patients or "informal" which is a term meaning a person who is in a mental health hospital as a voluntary patient. There were notices on the lounge wall which were information for staff and not appropriate in a home environment.

Staff said there was good staff morale and they were supported well by the registered manager and deputy.We found that sickness levels were low as was staff turnover so there was a stable staff team.

Staff said they enjoyed working for Sequence Care Ltd.They thought the training was good.One said, "I love working for them; I feel supported; they do not cut corners, they maintain buildings in a very good state; management is very supportive of its staff and we receive any training when we need it".

The support plans and care records were kept up to date. The provider's audits highlighted any areas that needed to be improved and set out actions for the registered manager to follow. . There was learning from incidents to prevent recurrences with the exception of avoiding occasional incidents of aggression between people which could have been resolved through working more individually with people at times so that people were not together in a group for long periods. The provider acted on identified concerns but governance systems were not always effective at identifying, monitoring and mitigating against some risks to people's health, safety and well-being.

Two professionals involved with people living in the service told us that the registered manager listened to people's views and worked hard to provide a good quality service to individuals in the home. One representative said they were unhappy about an incident where a person in the home received unsafe care. The registered manager had taken appropriate action to reduce the risk of the incident happening again but had not explained this to the person's representative.

Professionals told us there were some difficulties communicating with staff in the home. Two professionals said staff did not send them reports of incidents promptly and three said that they had on occasions emailed and not received a reply. Three said that if they phoned to discuss anything or request information staff would often not have the information and refer them to the registered manager. We also found that staff did not all have the correct information about people's staffing needs and asked us to refer to the registered manager. Professionals were satisfied in their dealings with the registered manager but communication had been more problematic recently when the registered manager was not at the service as frequently as he was supporting another service.

We recommend that the home improves their communication with the professionals involved with people living in the home.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment How the regulation was not being met: Some risks to people's health and safety had not been assessed and action taken to mitigate the risks. Regulation 12(1)(2)(a)(b) Medicines were not all managed in a proper and safe way. Regulation 12(1)(2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 - Staffing How the regulation was not being met: Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not being deployed to meet the assessed staffing needs of people in the service. People were not always receiving the staff support they needed. Regulation 18 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014 – Premises and equipment How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

People were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 – Person centred care How the regulation was not being met: People had not been fully involved in designing their care plan with a view to achieving their preferences and ensuring their needs are met. Regulation 9 (1)(3)(b).