Autism Care UK (2) Limited

Rother Heights

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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 10 and 13 December 2018 and 8 January 2019 and was unannounced. The inspection was bought forward due to concerns we had received.

The last comprehensive inspection took place in November 2017, when the provider was rated as good. At this inspection we found the service had declined and was rated inadequate. You can read the report from our last inspections, by selecting the 'all reports' link for 'Rother Heights' on our website at www.cqc.org.uk.

Rother Heights is a care home. People living in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care service had not been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. The values of choice, promotion, independence and inclusion, which the guidance promotes were not being provided for people who used the service at Rother Heights. This meant the people they supported with learning disabilities and autism were not able to live as ordinary a life as any citizen.

Rother Heights can accommodate up to 28 people. At the time of our inspection 26 people were using the service. The service comprises of a complex of four bungalows and an office block. Each bungalow has six bedrooms with en-suite facilities. There are also two other houses nearby which can each accommodate up to two people.

At the time of our inspection 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 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. However, the registered manager was not at the service at the time of our inspection and there were two regional managers overseeing the service.

Risks associated with people's care and treatment were not always identified or managed safely. This put people at risk of not receiving the right support to meet their needs and showed the registered provider was not doing all that was reasonably practicable to mitigate risks associated with people's care and treatment.

We completed a tour of the home and found a number of environmental risks which had not been identified prior to our inspection.

We found risk in relation to fire safety that had not been managed.

Accident and incident analysis was not taking place effectively and there was no evidence that trends or

patterns were being identified, or that actions had been taken to reduce hazards in relation to people's care.

Medication systems were not followed; therefore, it was not evident people received their medication as prescribed.

People were not effectively protected from the risk of abuse. The registered provider had a system in place to safeguard people from the risk of abuse. However, we found staff did not always communicate effectively to ensure safeguarding concerns were reported to the safeguarding authority. During this inspection we identified two safeguarding concerns which were reported to the safeguarding authority.

The provider did not ensure that there were enough numbers of suitable staff to support people to meet their needs. We saw staff took breaks without replacing their role and people were not supported by the assessed number of staff required to meet their needs.

The provider ensured that staff received training to carry out their role. However, training was not effective. Staff told us they received one to one sessions with their line manager but there was no evidence to support this.

People's needs and choices were assessed but care and treatment was not always delivered in line with current legislation and standards.

People were not always provided with access to healthcare professionals.

People were not supported to have maximum choice and control of their lives and staff did not support people in the least restrictive way possible.

Staff told us people were supported to receive adequate nutrition and hydration that met their needs. However, this was not evident from records or food available in the service.

We spent time observing staff interacting with people and found they were not always kind and caring. Staff were task focused and waited for incidents to occur rather that ensuring the correct support was in place to minimise triggers which may cause distress to people. Staff did not always recognise when people needed support and did not always engage appropriately with family members to ensure their relatives needs were met. Information about people was not kept confidential.

We found people did not receive care and support that was responsive to their needs. Care plans we looked at were not always followed in line with people's current needs.

From our observations people were not being actively supported. Active Support changes the style of support from 'caring for' to 'working with', it promotes independence and supports people to take an active part in their own lives. Active Support enables people with learning disabilities to live ordinary lives.

Audits were in place to ensure the service was working to the providers expected standards. However, checks completed as part of the providers audit systems by staff were not always taking place. Where the checks had been completed they were not effective and did not identify the concerns we had raised as part of this inspection. The registered manager did not have an oversight of the service and the responsibility of completing the checks was left with the house managers.

The provider had a complaints policy and procedure in place. However, we found people were not always

listened to and were not confident that if they raised a concern it would be dealt with.

We found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were breaches in; Regulation 9; person-centred care. Regulation 10; dignity and respect. Regulation 11 need for consent. Regulation 12; safe care and treatment. Regulation 13 Safeguarding service users from abuse and improper treatment. Regulation 15; premises and equipment. Regulation 17; good governance, and regulation 18; staffing. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections are added to reports after any representations and appeals have been concluded.

The provider has provided an action plan and a new management team has been put in place to support the service to drive improvements.

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.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks associated with people's care and treatment were not always identified or managed safely.

Accident and incident analysis had not taken place and there was no evidence that trends or patterns were being identified and actions taken to reduce hazards in relation to people's care.

The provider did not ensure that safe arrangements were in place for managing people's medicines.

Safeguarding concerns were not always reported in a timely way.

There were not always enough staff available to meet people's needs.

Is the service effective?

Inadequate

The service was not effective.

Staff told us people were offered a well-balanced diet. However, the records and food available did not support this.

We found the service was not meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

Staff had received training but this was not effective. Staff were not appropriately supervised to fulfil their roles and responsibilities.

Staff did not effectively monitor people's healthcare needs, and referrals to healthcare professionals were not always made.

Is the service caring?

Inadequate

The service was not caring.

We observed that care and support was task orientated, institutionalised and restrictive and was not personalised or

individualised.

People were not always supported in a person-centred way which respected their privacy and dignity.

Information about people was not always kept confidential.

Is the service responsive?

Inadequate

The service was not responsive.

Care records identified people's needs. However, staff did not follow these and they were not up to date, so did not always reflect the person's current level of need.

People did not always take part in meaningful social stimulation and activities that met their needs.

There was a complaints system in place, however people did not feel listened to.

Is the service well-led?

Inadequate

The service was not well led.

Audits were in place to ensure the service was operating in line with the providers expected standards. However, the checks that were in place as part of the providers audit systems did not always take place and when they did, they were not always effective and did not identify the concerns we had raised as part of this inspection.

There was a lack of leadership and the registered manager had no oversight over the operational running of the service.

Rother Heights

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 took place on 10 and 13 December 2018 and 8 January 2019 and was unannounced. The inspection was carried out by three adult social care inspectors and an expert by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The second and third day it was carried out by two adult social care inspectors.

Prior to the inspection visit we gathered information from a number of sources. We also looked at the information received about the service from notifications sent to the Care Quality Commission by the registered manager. We ask the registered provider to submit a provider information return [PIR]. 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. We also spoke with other professionals supporting people at the service, to gain further information about the service.

We spoke with 10 people who used the service and six relatives of people living at the home. We spent time observing staff interacting with people.

We spoke with staff including care workers, senior care workers, the area manager and other members of the management team. We looked at documentation relating to people who used the service, staff and the management of the service. We looked at people's care and support records, including the plans of their care. We saw the systems used to manage people's medication, including the storage and records kept. We also looked at the quality assurance systems to check if they were robust and identified areas for improvement.

Inadequate

Is the service safe?

Our findings

At our last inspection of November 2017, this domain was rated as good. At this inspection we found this key question had deteriorated and was rated as inadequate.

We completed a tour of each bungalow and found people were not protected by the prevention and control of infection. For example, we found laundry rooms in each bungalow were in poor condition with worn surfaces and cupboards which could not be kept clean. Mops were all stored in one container together with the mop heads together. This could lead to the spread of infection. Bathrooms were unclean and the bath in Mill bungalow had cracks on the bottom of it. We saw en-suite bathrooms were not kept clean or well maintained. One en-suite shower in Fence bungalow was in an appalling state with black damp patches on the shower chair and stains on the floor. Another en-suite bathroom in Mill bungalow had a stained shower chair and the rail used to support the person was beginning to rust. The provider did not employ domestic staff and the service was in need of a deep clean.

We observed most staff wore jewellery, false painted nails and watches and were not bare below the elbow. We also saw a number of staff kept coats on so were not able to effectively wash their hands and wrists when they had supported people with personal care. Stone rings also put people at risk potential harm.

The system to manage medicines was not always safe. We found some gaps on medicine administration records (MARs) which indicated that medicines were not signed for as administered. The gaps had not been reported or investigated to see if they were recording errors, or if people had received their medicines as prescribed. We found MARs were not always appropriately stored. We found MARs left at the back of cabinets in one house and in another house, one month's MAR was missing, so we were unable to check if people had received their medicines as prescribed.

Medicines that required storing at a certain temperature were stored in a dedicated medicines fridge. The temperature of one fridge had not been taken to show the correct temperature was being maintained. We looked inside the medicines fridge and found that water had pooled in the bottom which was soaking into boxes of inhalers that were stored there, these medicines were spoiled.

The medicines storage room was cluttered and dirty. There was a sharps bin stored on top of the medicines cupboard. Sharps bins are specially designed rigid boxes which have a secured lid. The lid on the sharps bin had broken and there was a risk of the box falling each time the medicines cabinet was opened. Staff said they were aware it was a hazard but no action had been taken to address it.

Risks associated with people's care and treatment had not always been identified and managed safely. For example, one person was using bed rails and had no person-centred risk assessment in place to ensure they were used correctly. There were no bumpers on the bed rails, which could have posed a risk of entrapment. Another person required the use of a hoist from time to time to assist them to mobilise. The person's care records did not detail the size and type of sling or the loop configuration to use. We asked staff which loops were used and one care worker said, "I think it's the blue ones but we see which looks most comfortable at

the time."

Accident and incident analysis was not effective and there was no evidence that trends or patterns were being identified and actions taken to reduce hazards in relation to people's care. We saw that incident forms had been completed but not always in enough detail to minimise further incidents.

Relatives we spoke with had mixed views on how staff met the needs of people. Some told us they thought their relative was safe. However, others felt risks were not always managed and were not confident their relative was always safe. For example, on relative explained that staff did not understand [their relative] and were not able to manage behaviours that may challenge. They said, "Staff just sit and watch."

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure people were protected from the risk of infections, was not doing all that was reasonably practicable to mitigate risks associated with people's care and treatment including medicines management.

We completed a tour of the service and found environmental risks had not been identified. For example, the entry to some en-suite bathrooms there was a raised edge which could have created a tripping hazard. Plaster on some walls had been damaged and not repaired and some damaged furniture had not been replaced such as a set of drawers and there was split and worn fabric on sofas. We saw kitchen areas in a poor state of repair and cleaning products which should be stored in line with Control of Substances Hazardous to Health (COSHH) guidance, were not securely locked away. Items which had broken were stored outside the bungalows such as old furniture, fridges and air cooling fans.

We also identified fire doors that did not close properly, some had been removed and others were tied open so would not close automatically when the alarm went off. Staff told us they had identified this but nothing had been done to ensure people's safety.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not always ensure that the premises were properly maintained.

Staff said they had training in safeguarding vulnerable adults. Training records confirmed this. Staff could describe how they would report concerns. However, during the inspection we identified this training had not been effective. On the first day of our inspection we witnessed a safeguarding incident occur, which was also witnessed by staff. The staff did not acknowledge that the incident was inappropriate and should have been reported as a safeguarding. We asked the provider to report to the local authority safeguarding team.

Systems and processes did not operate effectively to prevent the abuse of people. We received information from the local authority's' contracts and commissioners which highlighted many concerns about the safety of people using the service. The concerns were considered as part of the inspection.

We identified that during the previous months many safeguarding incidents had occurred at the home. We were told people using the service required a lot of support because of their care needs or because they showed behaviours that may challenge. There was a lack of understanding regarding best practice when supporting people with behaviour that may challenge. Therefore, staff did not always respond appropriately to people who displayed behaviours that may challenge. Staff did not recognise that people's behaviour could be a form of communication and required support to manage their behaviour positively.

There were regular incidents involving physical aggression taking place toward staff and people. However,

there was no effective analysis taking place to look at themes, trend or patterns when challenging behaviour occurred. Staff told us that following incidents debriefs weren't taking place. Debriefing is another way of learning from incidents and supporting staff and the person afterwards. This meant people were not always safeguarded from abuse. We identified a lack of effective communication within the staff team which led to some safeguarding referrals not being made in a timely manner. Following our inspection, two further safeguarding referrals which had not previously been considered were reported to the safeguarding authority.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment. This was because the registered provider did not have effective systems to safeguard service users from abuse and improper treatment.

There were not always enough staff available to meet people's needs. We observed when staff interacted with people they were not able to support and respond to people in a person-centred way. We saw that staff left the bungalows to take frequent unplanned breaks. On the first day of our inspection Mill bungalow should have had eight staff available to support people in line with their assessed needs. However, we found that one person was on a training course which left seven staff. We spoke with staff who told us they regularly worked short.

The provider used agency staff to fill shortages. Staff told us that this made their job harder as agency staff didn't know how to support people in line with their assessed needs. Staff said, "Agency staff are here to purely make the numbers up, they can't get involved when incidents occur. This leaves the regular staff and people vulnerable because there's not enough staff around to support them."

We also found that where people were assessed as requiring one to one hours for part of the day, they did not always have staff available to provide them with one to one support. For example, in one house five of the six people had one to one hours for the full fourteen-hour day shift and the other person only had seven one to one hours per day, therefore for the other seven hours during the day there were no staff supporting this person. If they required support staff had to cease providing one to one hours for the person they were supporting, this left people at risk and meant their needs were not always met. This also restricted the person's choices as there was no flexibility with the one to one hours.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. The provider did not ensure adequate staff were available to meet people's needs.

The provider followed a robust recruitment process. We looked at three staff files. The files showed appropriate checks had been undertaken prior to employment. This included a Disclosure and Barring Service (DBS) check. A DBS check provides information about any criminal convictions a person may have. This helped to ensure people employed were of good character and had been assessed as suitable to work at the home. Each file also contained references and proof of identity.

Inadequate

Is the service effective?

Our findings

At our last inspection of November 2017, this domain was rated as good. At this inspection we found this key question had deteriorated and was rated as inadequate.

Staff received training that should have provided them with the knowledge and competencies to be able to support people and meet their needs. However, we found the training received was not effective as staff were not meeting people's needs. For example, staff received training in supporting people with behaviours that challenge, the training records identified nearly all staff had completed training in management of actual or potential aggression (NAPPI). We witnessed staff restricting people to prevent harm to others, rather than working in a person-centred approach to support the person in the least restrictive way. It was a very oppressive environment. Staff told us that the training was not effective or sufficient to support them to manage people's behaviours that may challenge.

Staff said they had lost confidence when supporting people and said there was no one checking that the training was effective. For example, we saw one person displayed some behaviours that could challenge. Staff were observed speaking to the person in a stern voice and standing in front of them to restrict their movements. When a member of the inspection team walked passed the person staff stood directly in front of the person with their arms spread out like they were attempting to protect the inspector although the person was engaged in playing a computer game. The person was just playing on their computer game and the use of this restrictive intervention felt oppressive and unnecessary.

Staff told us they had supported people with challenging behaviour when the training had expired and felt this had left them at risk of being injured. Staff said that once training had been complete there was no management oversight of incidents to ensure the training was effective or if staff and people were kept safe.

Staff did not receive training that ensured the service was person-centred. Person-centred planning is an empowering approach to help people achieve their goals and to live the life they want. It helps people to plan and organise the systems and support they need to lead a life that makes sense to them. To support a person-centred approach, staff need to have effective training, support and values.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing. Staff did not receive training that was effective to be able to meet people needs in a person-centred way.

The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS), and to report on what we find. Staff did not have a sound understanding of the Mental Capacity Act 2005 (MCA).

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 and they were not. Where people lacked mental capacity, applications had not been made to the local authority for DoLS assessments to be considered for approval. For example, staff had decided to place restrictions giving specific times when people could have meals. We could see no evidence to show how this decision had been made or if it was in people's best interests. During the inspection we saw some of the practices at the service did not support people to have maximum choice and control over their lives.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent. People were not supported in the least restrictive way.

We found people's needs were not always met by the adaptation, design and decoration of the home. The registered provider had not considered the needs of people who received a service. For example, one person's bedroom had no natural light the window had been boarded up. This meant the person had no view and would not know what time of day it was to understand if it was time to get up. When we asked the staff why it was boarded up, they said, "It is for [person's name] dignity as they take their clothes off." Other methods could have been used to preserve their dignity without boarding up the window. This did not meet the guidance registering the right support as there was no consideration of the person's choice or inclusion.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care. People did not receive care that was personalised.

Staff told us people received adequate nutrition and hydration, although on the first day of our inspection this was not evident in all the bungalows. We found in one bungalow the food supplies were extremely low. Staff told us it was the shopping day. There was not even any milk for drinks and for most of the day there was limited choice of food, snacks and drinks. It was also not clear how long the food supply had been low. We did see staff went shopping late afternoon and we saw the food being taken into the bungalow. Staff told us due to low staffing numbers they had not been able to get to the shops. We observed lunch in another bungalow and the experience was completely different, people were having lunch together it was a very pleasant experience and people were enjoying the food.

Inadequate

Is the service caring?

Our findings

At our inspection of November 2017 this key question was rated good. At this inspection it had deteriorated to inadequate.

We spent time observing staff interacting with people and found they did not always support people in a caring way. Staff did not look for opportunities to positively engage with them. For example, one person was playing on their computer game and offered the staff member supporting them to have a go, the staff said, "It's your game, you play it." They did not take it an opportunity to engage with the person in a person-centred way.

Relatives we spoke with gave us mixed feedback some felt staff were caring, whereas others told us staff were not caring. For example, one relative said, "I am not happy with Rother Heights and are looking at other options, that is how bad the situation is getting. The fees are huge and the service they receive and the care could be a lot better."

Staff lacked consideration for people and referred to them in an impersonal way. For example, we heard people referred to as PWSs (meaning 'person we support'). One care worker said, "Someone will need to come with you down that corridor as a PWS is down there." Staff called out people's names when they moved around the home, to alert others that they were coming into another room. Another member of staff when we entered a bungalow said, "We have one [meaning a person they supported] on a behaviour." This was impersonal and uncaring.

Staff did not always maintain people's privacy and dignity. We observed one person being weighed in a communal lounge area and the staff member shouted out their weight. We observed another person walking in a communal area with their trousers falling down exposing them. We asked staff to maintain the person's dignity.

We observed one person's bedding on the floor in the corridor and asked staff the reason why it was there. Staff told us that the person was 'having an incident' and would throw their bedding on the floor during this time. So, staff put the bedding on the corridor floor to prevent this. This did not ensure that the person's property was respected and showed a lack of understanding in how best to support the person.

Information about people was not always kept confidential. We saw people's personal information displayed on notice boards and kitchen units. This information was in relation to people's weight, dietary needs and activities for the week. We also saw clipboards in communal areas which held people's personal information. This was still the case on the third day of our inspection after raising this on the first day.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect. People did not receive care that respected them or maintained their dignity.

Observations of staff support showed they had insufficient understanding of people's needs and were not

always supporting them with respect. There were high levels of challenging behaviour at Rother Heights. Challenging behaviour is defined as being culturally abnormal behaviour of such intensity, frequency or duration that the physical safety of the person or others in likely to be placed in serious jeopardy, or behaviour which is likely to limit use of, or result in the person being denied access to ordinary community activities. Staff appeared to see the person's behaviour first and foremost, rather than understanding that they were trying to communicate an unmet need.

We observed most people were not given the freedom to do things they wanted to do. We observed people spending long periods of time alone in their room due to there being a shortage of staff to support them to carry out a meaningful activity.

Not all staff were kind and caring. During a visit to one house we observed a member of staff raising their voice and speaking to a person with an intimidating tone in an attempt to get them to carry out a task. We fed back to the provider who took the appropriate action. However, other staff had also witnessed the incident and did not report this as a concern.

From our observations over the three days of our inspection we found staff did not meet the values of the right support. People did not have a choice, they were not included or their independence promoted. This meant people were not supported to be able to live as ordinary life as any citizen.

Staff were not effectively communicating with people and were not providing person centred care to meet people's needs in relation to choice, freedom and disability so were not meeting the protected characteristics under the Equality Act 2010.

Inadequate

Is the service responsive?

Our findings

At our inspection of November 2017 this key question was rated good. At this inspection we found this area had declined and was rated inadequate.

We looked at care records and found they were detailed and identified the support people required to meet their needs. However, staff did not always provide the support detailed in care records. For example, People had behaviour support plans in place which gave staff instruction on how to support people before, during and after an incident, to help reduce and manage any behaviour which challenged. Staff were not always following what was laid out in the plans. For example, one person was sat on the settee, they were not engaged in any activity and appeared to be bored as no one was talking to them or engaging with them. When they got up to move to another room staff followed them without interacting with them but shouted to the person in the next room, "[Persons name] is coming through." The person was not displaying any behaviours, they were seeking interaction, but their needs were not met.

We did not observe any meaningful activities on the first two days of the inspection. Staff told us they struggled to get out in the community due to staffing constraints, they were using agency staff and it was left to the permanent staff to manage. One staff member said, "We are at crisis point." For example, one person's care plan detailed they responded well to sensory activities such as dancing and music therapy. We noticed that the person spent a lot of time in their room and provided with no social stimulation. We observed the person come out of their room and they were not happy, it was not clear if this was caused by the lack of activities and frustration or staff not being responsive to the person's needs. However, the person needs were not met.

We found most people were left without stimulation, staff said they were aware that people were bored, and some people were spending long periods of time in their room. We saw one person was laid on their bed in the middle of the day using their iPad. However, staff told us the amount of time the person was allowed on their iPad was restricted. Staff told us, "It is restricted because if we let them they would be on it all day." However, there were no other meaningful things for them to do for the rest of the day. We saw another person who was sat in the conservatory without any stimulating activities to do. Staff were not positively engaging or interacting with the person or finding things that they might enjoy doing. We also found people were staying in their rooms to avoid other people as the staff were not able to meet their needs and as such could present with behaviours that challenge.

People's care plans reflected their physical, mental, emotional and social needs including protected characteristics. However, we found staff did not follow the plans. For example, people did not regularly access the community or partake in meaningful activities that met their social needs.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider did not always ensure that people received person centred care which met their needs.

Staff we spoke with confirmed people had been taken for GP and dental appointments. However, we were unable to evidence if people had annual health checks and had access to a GP and other health specialist when required such as a dentist or optician due to a lack of records.

The provider had a complaints policy in place. We saw some complaints had been responded to appropriately. However, one complaint that had been raised with us about the environment had not been acknowledged. The staff had recorded that they had 'displayed challenging behaviour'. Their complaint had not been looked at or resolved. This meant people were not listened to or issues resolves satisfactorily. We discussed this with the acting manager who agreed this would be addressed.

The service was for younger adults and at the time of our inspection the service was not supporting any one at the end of their life. Staff we spoke with felt it would not be applicable but had not considered that people may become ill and have a life shortening illness, they had also not considered supporting people if a close relative became ill. Therefore, there was no information in plans of care that reflected people's preferences or choices for their end of life care.

Inadequate

Is the service well-led?

Our findings

At our inspection of November 2017 this key question was rated good. At this inspection we found this area had declined and was rated inadequate.

At the time of our inspection 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 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. However, the registered manager was not at the service at the time of our inspection and there were two regional managers overseeing the service.

There was a lack of effective quality monitoring taking place to ensure the service was working to the registered providers expected standards. When checks were completed they were not always effective, or robust and did not always identify the concerns we had raised as part of this inspection. The quality monitoring checks were a tick box exercise and did not clearly identify concerns and actions taken to address them.

We found significant shortfalls in relation to safeguarding, peoples care and support, the use of restrictive practices, staffing levels, safety, infection control and cleanliness. The registered provider did not ensure that there were robust systems in place to check that the quality of care provided was safe and of a consistently good quality. Lack of effective oversight meant people were living in an environment which was poorly maintained and were at risk of receiving care, which was not of a good standard and didn't meet their needs.

There was a lack of governance and oversight to ensure the service was operating to the required standard. In addition to the audits carried out by the registered manager, the area manager and quality team were also meant to carry out visits on behalf of the registered provider. These had also not identified the shortfalls.

We found the service was not shaped around the needs and preferences of people that used it. There was a lack of appropriate governance and risk management framework and this resulted in us finding multiple breaches in regulation. There were no effective systems in place to develop and improve the service, based on the needs of the people who used it, their families and staff.

There was a lack of effective systems in place to monitor how incidents and complaints were acted on and this had led to people being placed at risk of harm and receiving care and support that was not always safe.

Staff we spoke with told us they felt frustrated in their role. One staff said, "I want to give people the one to one time they deserve. It's frustrating for them and for us too."

We found serious failures by the provider to use adequate governance processes which could have revealed

the services deficits prior to our visit. This meant issues were not identified so lessons could not be learnt when things went wrong.

We found the culture of the service was poor. For example, we witnessed a staff member verbally intimidate a person and other safeguarding since our inspection have also been reported to the local authority. The registered manager and the provider had not kept under review the day to day culture of the service. Including the values and behaviours of staff and whether they felt proud to work in the organisation. Staff told us they did not feel listened to and had raised concerns that had not been addressed.

Relatives told us they did know who the registered manager was but felt it was not well managed. Although they said the house managers were good and always tried to help. One relative said, "Rother Heights call themselves 'Autistic Care' but none of them seem to understand Autism? It is certainly not a specialist service provided."

Another relative we spoke with did agree it was well managed they said, "Yes, I know who the manager is. I have filled in questionnaires from time to time."

Support was not provided to staff to develop staff teams, and drive improvements. Inexperienced staff were left in vulnerable positions without the resources or correct staffing levels. One member of staff told us they had been put forward to carry out additional duties without being trained or coached how to appropriately carry them out. They said they were frustrated and felt that too much pressure was being put on staff and the managers didn't effectively support them.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Audit systems were not effective in identifying improvements required.

Following the first day of our inspection we requested the provider take action. They have submitted an action plan and put in a management team to support the service to ensure all actions are addressed to improve the service. On the third day of our inspection we found the action plan was being implemented but it was in the very early stages. However, the provider continues to update us on progress every week and has put a voluntary suspension of any further placements until the improvements have been completed.

Ratings from the last inspection were displayed within the home and on the provider's website as required. From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people received care that was person-centred and met their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure people received care and support that protected their dignity and respected them. Staff did not provide care that met the relevant protected characteristics. (As defined in the Equality Act 2010).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent to care and treatment was not always obtained and the requirements of the regulations were not followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. Risks were not managed, there was no proper and safe management of medicines and infection, prevention and control was not followed to protect people from risk of

infections.

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 The provider failed to ensure people were protected from improper treatment and abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises and equipment was not properly maintained or suitable for the purpose for which it was being used.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff on duty to meet people's need. Staff were not effectively trained and did not have the competencies, skills and experience necessary for the work they performed.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was no governance or oversight to ensure the quality of the service provision was monitored and improvements made.

The enforcement action we took:

We have issued a Warning Notice.