Futures Care Homes Limited

Futures Care Home

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**

Summary of findings

Overall summary

The inspection took place on 29 and 30 December 2016 and it was announced. We last inspected this service in February 2016 and found that overall the service was rated 'requires improvement'.

The service provides accommodation and personal care for up to nine people living with learning disabilities and autism. At the time of our inspection, there were six people using the service.

The home has a Registered Manager in post. 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 & Social Care Act and associated regulations about how the service is run.

Our inspection identified serious concerns regarding the management and leadership of the service, and the quality of the care delivery. People were being placed at risk of physical and emotional harm and there was insufficient governance in place to make improvements within acceptable timescales.

The service was not safe. Staff did not receive appropriate training to understand the complex needs of people using the service. Behaviour which may have impacted negatively upon people was not managed correctly, and forms of restraint were being used which placed people at risk of harm. There was insufficient monitoring and reporting of incidents which meant that poor practices had become embedded into the service. There were risk assessments in place for people, but these did not account for the management of this type of behaviour.

People had care and support plans in place but these were not always updated or reviewed with involvement from the person or their relatives. People had their dietary and healthcare needs assessed but some relatives reported missed appointments and had been since assumed responsibility for the healthcare needs of their family member. People did not always have access to activities which were stimulating or kept them occupied. The limitations with transport and staffing hindered people's ability to live a full and active life.

Staff were not supported through regular supervision or appraisal and did not have sufficient opportunities to contribute to the development of the service. They only received basic training which was unfit for the nature of the roles they were employed to perform. Staff did not feel able to share issues or views and did not feel supported by the management team.

The leadership and management at provider level was absent which meant that the registered manager was performing his role beyond the scope of his remit. This had led to a decline in the standards of the service and the registered manager did not have sufficient time to make improvements. There was little quality assurance in place to identify issues and take remedial action. Some complaints were dealt with but others were not recorded or resolved and some relatives and staff felt that their concerns were not listened to.

There were inconsistencies in the maintenance, design and decoration of the service which had an impact on the safely and effectiveness of the environment for people. Elements of the environment were poorly maintained and presented an infection control risk.

This inspection identified that there had been breaches of a number of the regulations of the Health and Social Care Act 2008 (Regulated Activities) 2014 and the overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

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.

The management of behaviours which had a negative impact on others was poor and placed people at risk of harm and abuse.

The environment was poorly maintained and presented an infection control risk to people.

There were not always enough suitably trained, qualified and experienced staff available to meet people's needs.

Is the service effective?

Inadequate

The service was not effective.

Staff were not receiving regular supervision or appraisal of their performance.

Staff were not provided with appropriate levels of training to enable them to carry out their duties effectively.

People did not always have their healthcare or dietary needs met.

Is the service caring?

Requires Improvement

The service was not always caring.

While regular staff were caring, a lack of consistency of staffing meant that people did not always receive a good quality of care and support.

People were not always treated with dignity and respect.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans did not always evidence involvement from people or their relatives and were not reviewed when people's needs changed.

While some complaints were being handled appropriately, there were others that were not being recorded or resolved.

People did have sufficient access to meaningful activities inside and outside of the home.

Is the service well-led?

Inadequate

The service was not well-led.

There was inadequate oversight at provider level to support the registered manager to carry out their duties effectively. Relatives and staff did not have confidence in the registered manager.

Staff did not have opportunities to contribute to the running of the service and team meetings were not being held regularly.

There were no robust quality assurance systems in place to identify improvements that needed to be made and take action within acceptable timescales.

Futures Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 29 and 30 December and was announced. The inspection was undertaken by two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR) which we reviewed. The PIR 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 reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law.

Because the people using the service did not have sufficient capacity to answer our questions, we observed practice around the home including the interactions between staff and people. We also contacted six of their relatives to ask for their views. We spoke with the registered manager and nine members of the care staff.

We reviewed care records for three people who used the service, looked at four staff files and reviewed records relating to medicines, complaints, training, quality audits and maintenance.

Inadequate

Is the service safe?

Our findings

During our previous inspection in February 2016 we identified concerns with risk assessment, the safety of vehicles, staffing levels and recruitment procedures. During this inspection we found that improvements had not been made and that people were placed at unnecessary and avoidable risk by the provider for their failure to address these concerns. We also found that the quality in other areas of the service had deteriorated significantly.

When we asked relatives if they felt their loved ones were safe, we received concerning responses. One relative said, "No, I think [person] has been very vulnerable there." Another relative said, "No we don't think [person] is safe." Staff shared similar concerns about safety. One member of staff said, "I don't think it's safe, no. Staff are being attacked, other [people] are being attacked and I think a lot of staff are thinking of walking."

Prior to our inspection we were notified of two safeguarding incidents where people's safety had been compromised. The first of these incidents involved a knife that had been left in a person's room when they exhibited known behaviours which placed them at significant risk. The second related to a person who was taken swimming by staff who neglected to provide this person with the appropriate medical equipment. This resulted in the person being harmed. Staff had failed to follow people's support plans or observe risk assessments to keep them safe. The registered manager was able to describe action taken to reduce the possibility of such events occurring again, which included further training for staff.

Some people displayed behaviours that impacted negatively on others. We were told of a recent change in one person's behaviour which had required an increase in staffing levels. During the inspection we observed this behaviour and the way that staff managed the situation. Because of the intensity of the behaviour we found that there was a significant impact on other people using the service. Despite this, the majority of the staff team had not received sufficient training in how to manage such behaviours effectively, and only two members of staff had received any training in the use of physical intervention.

The staff we spoke with were concerned that they were not able to meet people's needs or keep themselves or other people safe. One member of staff said, "It's not easy finding two competent and confident staff to manage the situation safely. Other people get attacked and physical aggression here is quite high. I've had to hold [person]'s arms for a few minutes to stop them attacking me and members of the public." Another member of staff said, "I feel like there aren't enough staff that can work with that kind of behaviour. I've been in a situation where I've had to restrain somebody on the floor to keep people safe."

We reviewed records of incidents following two incidents where physical intervention was used. Staff had written on one form that "Staff need to have proper restraint training." Another form said, "Staff need training as the likelihood of aggression is very high." Despite this identified need, the majority of the staff team had not been provided with this training but had been placed in a position where they had to use physical intervention to manage behaviours. The training that was previously available had been delivered by the nominated individual who had since left the organisation. The registered manager had found

alternative training providers, but staff had been working in the meantime without the appropriate training to manage this behaviour safely. One relative described the impact of this on their relative. They said, "[Person] can't eat sometimes because it's too much for them with the behaviour of other people." A member of staff told us, "Other people are having seizures because of the noise and it's just so difficult to manage."

Despite the level of behaviours being shown, we found that the detail in people's support plans was insufficient to enable staff to develop consistent strategies for managing these behaviours. The service had involved the intensive support team where necessary, but were failing to follow instructions or work consistently to the guidelines as specified. Incidents took place and staff suggested ways that these could be avoided in future, but this was not referenced in people's care plans. One member of staff said, "I don't work with [person] so I haven't read [their] care plan to be honest." There were no risk assessments in place for the use of physical intervention and no indication of which types of intervention could be used. One person's care plan described the types of behaviours shown and instructed staff to "Stop [person] from doing this," with no detail as to how this could be done safely.

Both people and staff were being placed at continued risk of physical and emotional harm because of inadequate training, support and management of behaviours that challenged others. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There were still concerns in relation to the maintenance of the vehicle, and this was bought to our attention by three separate relatives. One relative told us, "The wing mirror was held on by sticky tape until it fell off recently, the doors don't close properly and it's too old to be roadworthy. They used to have two vehicles and they just didn't bother to replace the other one." Another relative said, "We've bought up issues with the state of the vehicle in the past and they've been ignored." We noted that the vehicle had passed a recent MOT, however on further inspection we found that it was in unacceptable condition. The bodywork was dented, the internal upholstery was ripped and torn, and the step used by people to access the vehicle safely had been removed. Transporting people in a vehicle that was in a state of disrepair was both unsafe and presented a poor image of the home when people were in the community.

We also identified issues with the plumbing of the building. The provider was a qualified heating engineer who carried out all of the plumbing work inside the service through his own company. In the laundry room the washing machine had broken down on several occasions and needed a new pump. However the work had not been carried out and the engineers were visiting each time the washing machine broke down, removing flooring and then applying temporary fixes. The flooring in the laundry room was in state of disrepair as a result, with floorboards being screwed back each time the system was flushed rather than replaced.

A water hygiene inspection had revealed several defects including some of the larger expansion vessels in the laundry room presenting a risk of legionella. A new valve and drain was therefore needed for regular flushing, which had not been fitted. It had been identified that the hot water return in the taps was below recommended levels and would need to be monitored. While monitoring had been put into place, the records showed that there had been no improvement in this respect and that work had not been carried out to make the improvements as required. The service were rated at 'medium' risk of legionella developing but failed to take appropriate action to address this.

Outside we noted that one pump was being operated through an internal electrical socket which left the cable trailing out of the window and taped to the ground. The registered manager told us he had been requesting for this work to be carried out but did not always receive a response. The issues had not gone

unnoticed by visitors to the service, and one relative told us, "I know the company that do the maintenance work for the care home is owned by the Director. There's a pump that's supposed to have been replaced months ago which they haven't fixed."

We identified a number of other infection control risks such as a toilet cistern having been removed, cracked wall tiles, excessive dust on pipes and a lack of sanitation facilities in some bathrooms such as paper towels. One relative commented on this and said, "One of the bathrooms had a broken toilet and no running water. Their hygiene is poor, there's no paper towels so people can't wash their hands."

Failing to adequately maintain the vehicle and premises to keep people safe was a breach of Regulation 15 of the Health and Social Care Act 2008(Regulated Activities) 2014.

Nobody we spoke with felt there were enough suitably trained, qualified staff available to meet people's needs. One relative said, "They are short because people go sick. They have agency coming in a lot now and they don't know people in the same way." Another relative told us, "I think one of the biggest problems they've got there is that they can't recruit good staff and they've gotten through so many, people just don't want to work there. More often than not they use agency staff at night who aren't allowed to do direct care and don't have the experience or the training to meet people's needs." A third relative said, "There have been times where there have only been two members of staff here. We even had to keep [relative] at home because they didn't have staff who could meet [their] needs."

We looked at service rotas since August 2016 and noted that staffing levels did fluctuate between four and five staff, although the registered manager explained that this was because some people returned home at weekends. We were able to see how staffing dependency was assessed and how the service was meeting the allocated support hours for each person. We noted from the rotas that normally staff work 12 hour shifts; the day shift commences at 8:00am and finishes at 8:00pm when the night shift starts. The night shift finishes at 8:00am. This shift pattern did not include time for a formal handover. Staff told us they would always stay late if needed and always made sure they handed over important information to staff coming on the next shift. While there were usually enough staff to meet this assessed need, the lack of formal training, supervision and on-going support provided to staff meant that people's needs still could not be consistently met.

Failing to provide enough suitably trained, qualified and experienced staff to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We examined four staff files to assess whether a safe recruitment process was being followed; these included established members of staff and recently recruited staff. We saw that the most recently recruited member of staff's record contained an application with information about their employment history without any gaps. All files contained relevant references and proof of identification as required. Disclosure and Barring Service (DBS) checks had been completed to ascertain whether people were not barred from working with people who required care and support. The check for one member of staff was dated 2009. The registered manager said that there was no policy in place relating to the frequency of these checks but that they will be updated every three years in future.

Senior staff were able to demonstrate that there were clear processes in place for the safe receipt, storage and administration of people's medicines. Medicines were delivered from the pharmacy already dispensed in monitored dose packs and these were stored securely. Where any medicine was unsuitable to be stored in these packs it was delivered in the original packaging. The team leader on duty had a comprehensive knowledge of people's medicines, what they had been prescribed for and any other relevant information

relating to individual medicines. All medicines were checked on a daily basis by two members of staff. They told us that only team leaders and senior care staff dealt with medicines procedures.

There were separate folders for medicines that were administered orally and for medicines applied topically such as ointments and creams. People who required topical preparations each had a "topical medicines application record sheet' with a body map to show staff where the cream needed to be applied. Individual medicines administration record (MAR) sheets had a clear photograph of the person prominently displayed on the front to minimise the risk of mistakes in administration. Where people were admitted for respite care, the MAR sheet for their medicines contained information and instructions about their medicines.

MAR sheets were completed appropriately and signed when the medicines had been given. Senior staff explained that they had a 'gap chart' that was completed to check that there were no missing signatures. If any medicines had not been signed for, senior staff would check stocks of medicines in the blister packs or the boxed medicines to ascertain whether the number of tablets suggested that the medicine had been administered and would them check with the member of staff who had been responsible for the medicines that day. Senior staff explained that the procedure would be to contact the doctor for advice, complete an incident form, report to the manager and raise a safeguarding alert.

People had been prescribed medicines to be given on an 'as required' basis, usually referred to as PRN medicines. For example, these could be for pain relief or rescue medicines prescribed to be administered when someone with epilepsy had an uncontrolled seizure. We saw that PRN protocols were in place that clearly set out the circumstances when staff should administer the medicine. During our inspection we observed that this process was well managed for one person and senior staff monitored the situation and were prepared to administer the medicine if required.

Inadequate

Is the service effective?

Our findings

During our February 2016 inspection, we found that staff were not always provided with a structured induction or supported by way of supervisions and appraisals. During this inspection, we found that although some improvements had been made, they were not sufficient in fully addressing the concerns. In other areas where the service was required to provide effective care and support there had been a further deterioration in the overall standard.

We asked people's relatives whether they felt that staff received the correct training to carry out their duties effectively. One relative told us, "I think they could always do with more training there." Another relative said, "I think staff are extremely concerned and apprehensive about working with the [people] because they haven't had the training and the staff change too much to provide any kind of stability. Some of the staff can't speak any English so can't fill the forms out. How do they expect [person] to make [their] needs understood?"

Some staff told us they felt they had received appropriate levels of training in areas the provider considered essential. However the majority felt that they were not provided with sufficient training to be able to understand and support the full range of people's needs. One member of staff said, "Training could definitely be improved. We all need the breakaway training because of the clients we've got. We need more training on moving and handling and first aid. They need to really get the basics right." Another member of staff said, "I have done all of the training but there's some that hasn't been refreshed in a long time." However another member of staff was positive about the level of training they had received since joining the service. They said, "We've had training that is specific to the people we care for- like Percutaneous endoscopic gastrostomy (PEG) feeding and epilepsy. I've done a lot of professional qualifications too like NVQs." (PEG) feeding is a procedure in which a flexible feeding tube in put into a person's stomach to feed them in case of difficulty swallowing.

Staff completed all the training the provider considered essential in one day. This included sixteen different areas of training that consisted of a short computerised presentation of each unit. While this was adequate to provide a basic overview of each, we found that staffs' understanding of areas like safeguarding and The Mental Capacity Act 2005 was limited. The registered manager had identified additional training in key areas that would provide staff with a more comprehensive overview of each area and recognised that the training did not equip staff to carry out their duties effectively. Failing to provide adequate training meant that people were at risk of receiving care and support from staff who could not understand or meet their needs as required.

There had been some improvement in the level of supervision for staff. However, staff supervision was still infrequent in contrast with the provider's policy which stated that "staff will be supervised at least six times a year." One member of staff said, "I had one [supervision] recently but that was the first one for a few months." Another member of staff said, "Supervisions are very hit and miss and they did pick up with the new manager but that didn't last, and so we haven't had any since." Staff records confirmed that while many staff had received a recent supervision, this was often their first since the beginning of 2016 and was as a

result of a regular manager starting. Appraisals of staff performances had not been carried out. This meant that there was a continued failure by the provider to ensure staff were adequately supervised and their performance was monitored. This left people at risk of receiving care and support from staff who were not able to carry out their duties effectively.

The failure to provide sufficient levels of on-going training, supervision and support to staff was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We saw that people's healthcare needs were identified in their care plans, and there was evidence in people's care plans that appointments were being booked and attended regularly. However two relatives told us that they had needed to assume responsibility for their relatives' healthcare needs. One relative said, "There's been missed hospital and dentist appointments and I always have to make sure that [Person] is going. The [healthcare service] will call me and tell me that [Person] hasn't been to their appointment. When I call and ask why nobody seems to know a thing about it." Another relative told us, "We don't always know what happens in terms of health appointments or care plans and we just deal with health appointments ourselves now. The service had a letter inviting [Person] to attend an important appointment and they lost it. We don't trust them."

One person had a care plan in place relating to their needs around eating and drinking. We saw from records that the speech and language therapy (SALT) team had carried out an assessment and there were risk reduction strategies identified in the SALT report. The information in the "How to help me" section of the person's care plan was not detailed. For example, the care plan stated, "please provide me with soft foods and cut up any food items small on my plate." There was no further information about the texture required for the soft food or any details about what types of food was safe to be eaten if cut up into smaller pieces. The SALT team had given an example to avoid hard foods such as apple, but this was not recorded in the care plan.

Failing to ensure that people had access to healthcare services as required and implementation of the recommendations made put them at risk of failing to receive the support needed with their needs. This was a breach of Regulation 12 of the Health and Social Care Act 2005 (Regulated Activities) 2014.

The registered manager and staff referred to one of the downstairs rooms as a 'sensory room' which had been identified as a need during our previous inspection. This was one of the empty bedrooms downstairs where there were activities items such as games stored. We noted that there was no sensory equipment in this room, only that the windows were equipped with dark blinds. Staff confirmed that it was called the sensory room but was not used as such. A member of staff told us that the room was mainly used for staff meetings. We noted that there was a hard-backed chair in the room with a label stuck to it saying 'Do not use.' The door of the room was not locked and the room was accessible to people so was not an appropriate place to store broken or unsafe furniture or equipment. In addition this room was shabby, had torn wallpaper and had a small freezer containing bread and milk in the corner of the room. The lid of the freezer was cracked and damaged which would make it difficult to clean and posed an infection control risk.

We noted throughout the building that the environment was not well maintained. The décor, including wallpaper and skirting boards, was shabby and would have benefitted from being painted and decorated. This was a further breach of Regulation 15 of the Health and Social Care Act 2005 (Regulated Activities) 2014. Some staff had received training to understand the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards (DoLS). 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.

Capacity assessments had been completed for each person in areas such as finance management, communication, daily living, medicines and activities. There was some evidence of input from the person concerned, the person's family or relevant professionals although they had not always signed to confirm their involvement. 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). The registered manager had submitted DoLS applications to the local authority which had not been progressed any further. We saw from people's care records that there were some MCA assessments in place but there were no copies of these DoLS submissions on file. We confirmed with the local authority following this inspection that DoLS applications had been submitted and were awaiting authorisation. The registered manager said that they would be meeting with "an independent assessor from the local authority's DoLS team" on 4 January 2017 to review everyone's MCA and DoLS assessments.

Staff told us that they recognised ways that people provided consent if they did not have verbal communication skills. A member of staff said, "People give consent by body language, smiles and claps." They gave examples of some of the things one person would have the capacity to make a decision about and things they would not. They said, "[Person] would have the capacity to pick a bag of crisps or another snack but not for the bigger things." They understood the process of completing MCA forms to assess the person's mental capacity to make a particular decision.

People had enough to eat and drink. Most of the relatives we spoke with replied "yes" when we asked if their family member was provided with drinks and meals, and we observed staff offering people drinks and snacks throughout the day. However one relative stated, "The weekly budgets for food have been reduced so the quality of the food has decreased as a result."

Requires Improvement

Is the service caring?

Our findings

During our inspection we found that staff were working under conditions which made it difficult to promote a caring, person-centred environment. When we asked relatives whether they felt their loved ones were well cared for, we received mixed responses. One relative said, "The staff are all quite pleasant and caring but they're under pressure and there's a lot of changes in staff. [Relative] will get used to somebody and then they'll go." Another relative said, "They keep changing staff and you do need continuity with [relative] and some of them don't know [them] as well." A third relative told us, "I do think [Person] is happy here and I do want things to improve. The staff are absolutely wonderful, flexible and caring people. But there just isn't the management in place."

A member of staff also said that they were using lots of agency staff. Initially this was usually for night shifts but was now more frequent on days. They said, "We are recruiting and but it takes time." They also explained that, because of the complex needs and behaviours of the people living at the service, the use of agency put more responsibility onto regular staff. We looked at service rotas since August 2016 and noted that the use of agency staff had increased in the week prior to our inspection. This meant that people were not always receiving care and support from consistent staff who knew and understood their needs.

The service did not have any formal method for people or their relatives to have their views and opinions shared and acted upon. The service did not hold residents meetings or use the key worker system to provide people with an opportunity to express their opinions. Some relatives expressed their dissatisfaction at the lack of communication around the care and support of their loved ones. One relative said, "Communication is non-existent and always has been since [registered manager] has been there. We're not informed of any changes and we tend to find out things through the carers. We usually have to push for reviews or they don't happen."

During our observations we found that staff did have a caring approach and knew the people using the service well. Most staff felt they provided a good standard of care but were restricted by issues with staffing and management. One member of staff told us, "I think we are caring, responsible staff and the general care is good. I'd just like them to have more variety in their lives." Another member of staff said, "I think we deliver truly outstanding care here."

However we did note occasions where staff did not support people in a way that promoted their dignity and respect. One member of staff mentioned that a person was 'wet and needed a change' in a communal area of the home. Another member of staff repeated "I can't deal with this" twice while staff were trying to manage a person's behaviour. We raised these issues with the registered manager who acknowledged them and vowed to speak with the staff members in question.

Inadequate

Is the service responsive?

Our findings

During our last inspection in February 2016 we found that people did not always have sufficient opportunities to access the community and were not always occupied and stimulated. During this inspection we found that no improvement had been made in this area.

We were consistently told that people were not always able to enjoy activities outside of the home because of limitations with transport, staffing and staff training. One relative said, "The residents are struggling with an old vehicle which is hardly roadworthy. People don't have holidays any more even though it's in their funding package." Another relative said, "[Person] likes to go out and they do take [them] out to places but it seems to be mostly group trips together because it's the only way they can do it." A third relative said, "Whether [Person] gets out depends entirely on the vehicle and the staffing. Other people take priority so [Person] stays [at the service]."

The staff we spoke with told us that they did take people out as much as possible but would have appreciated more opportunities to improve upon this. One member of staff said, "They go horse riding, bowling, down to the beach and swimming sometimes. We do things in the house to keep busy too. But to be honest I'd say the overall quality of their lives has decreased because of the problems with the vehicle." Another member of staff said, "I think to access activities that actually benefit people we need more hours." A third member of staff said, "The other people miss out on their activities all the time and I think that makes them feel quite vulnerable."

We found that one person required use of the service's mobility vehicle for extended periods throughout the day, which limited the other people's ability to go out on activities. We were told during one stage of the inspection that people were due to go bowling in the afternoon, but this was later cancelled as another person's needs took priority. Giving people an indication that they were due to go out and then cancelling plans may have had an adverse effect on their anxiety and well-being, and did not provide a consistent, responsive service for people. While some people were able to walk or use public transport, the location of the service limited their opportunities to access a wider range of community activities. We were told repeatedly that a second vehicle had been requested and promised by the provider, but not delivered. This meant that people did not have the opportunity to pursue meaningful hobbies and interests on a regular basis.

There was improvement required to the care planning process, and care plans were not always sufficiently person-centred or up to date to allow staff to deliver consistent, effective care. An initial assessment was completed when people first came to the service which detailed their needs and was used to create a more comprehensive care plan. However, we looked at three people's care plans and found that the quality and consistency of these were in need of further development. For example one of the care plans examined contained information that was out of date, giving the names of previous members of staff who had left the service, recorded as the named staff to contact for information about the person.

We also noted that there were a number of places in this care plan where, staff were instructed to support or

assist the person, for example "support me to clean my teeth" and "assist me to shave." There was no guidance for staff as to what the person was able to do for themselves and what input was required from staff. The care plan lacked detail of what constituted support or assistance; for example, whether staff had to physically clean the person's teeth for them or whether they could brush their own teeth with verbal prompting if staff assisted by putting the toothpaste on the brush and handing it to the person. Without sufficient detailed guidance for staff, there was a risk that the person received inconsistent care and support in ways that did not reflect their preferences.

Care plans were not always updated to reflect people's needs. For example, we were told that one person's needs had recently changed and that this was presenting a challenge for the staff. However there was minimal reference to this change in the person's care plan or behaviour support plan. We noted that advice and information that had been suggested following incidents were not included, for example when a particular location had been identified as a potential trigger for somebody's behaviour.

There was limited evidence of how people had been involved in the care planning process or how their relatives had been consulted in relation to the content of their care plans. One relative said, "We've been asking for [a long time] for a change to [Person]'s care package and were told that he didn't need this change. Well now they've decided [they] do but there have been incidents in the meantime which could have been avoided." Another relative said, "We have a review through social services and they will call me if anything happens, but I haven't been involved in the care plan itself."

The failure to create accurate, detailed and person-centred care plans, as well as the lack of consistent stimulation and occupation for people, was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that there was a complaints procedure in place, and that two complaints were recorded in 2016. One of these was a staff grievance, rather than a complaint. The other complaint related to some damaged property. The provider had reimbursed the family for the damaged items and paid for a replacement of a personal item for the person living at the service. While this demonstrated that some complaints were being dealt with through the formal process, there was no system in place for logging more minor complaints and evidencing action taken in response to these. All of the relatives we spoke with knew how to make a complaint but did not express confidence that their complaints would be resolved effectively. One relative said, "We've brought up issues about [item] many times but nothing gets done." The registered manager acknowledged that there needed to be more robust recording and response to complaints and that this would be improved in the future.

Inadequate

Is the service well-led?

Our findings

There was no nominated individual appointed for this provider. Providers registered with the Care Quality Commission are required to nominate an individual responsible for supervising the management of the regulated activity. The previous nominated individual was no longer performing their role and despite assurances that another Director would assume this post, this had not taken place at the time of our inspection.

This was a breach of Regulation 6 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The use of restraint in the service should have resulted in notifications being made to safeguarding authorities and to the Care Quality Commission to alert us to their use. None of the incidents in question were reported because the registered manager believed that only incidents between people using the service were reportable in this way.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider did not display the judgements from previous inspections on their website as required under the terms of their registration.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in post who was managing both this service and one of the provider's other services in the local area. Since our last inspection two managers had left and the registered manager had identified another manager from within the service who intended to register with the Care Quality Commission once fully inducted in their role.

None of the relatives we spoke with had confidence in the registered manager or his ability to improve the service. One relative said, "I don't think [registered manager] is very professional and hasn't been particularly good. We don't get told anything and in fact I feel we've actively being left out of things sometimes." Another relative said, "The management is poor or non-existent. We were hopeful that things will change." A third relative said, "I've had my issues with [registered manager]. On the whole he is helpful and he has put things in place to help [Person], but I've also asked for improvements; and some are made and some aren't. I think he has a difficult job and running two homes is difficult. It's just that managers don't stay very long."

While some staff felt that the registered manager was "trying his best under difficult circumstances", most told us that they didn't feel adequately supported or valued. One member of staff said, "He [registered manager] is not very professional. There's just a lack of consistency in his approach or appreciation of what we do. We have nobody to turn to." Another member of staff told us, "It's hard at the moment, there's no

staff, no management backup and no consistency for people. To be honest I think [registered manager] is trying to cover too much."

During the inspection we asked the registered manager about the service and were told that there was a "poor staff culture". However this did not adequately reflect the lack of managerial oversight and support which had led to a decline in the level of support available to staff. We were consistently told that morale was low, staff did not have faith in the provider and did not think they would stay with the company. The pressures of working long shifts with difficult behaviours and inadequate systems and support available was not fully realised by the registered manager, and had resulted in a clear divide between management and staff. This meant a lack of positive, consistent and proactive support for people and response to valid concerns.

The lack of any formal management structure above the registered manager meant that he was not being provided with effective support to carry out his duties effectively. He had formulated his own job description and there had been no official appointment into an operational role or clear indication of the scope of his responsibilities within the organisation. We found that this absence of clear management hierarchy had led to an unacceptable decline in the overall standards of the service. This put people at continued risk of failing to receive an adequate standard of care.

People's relatives were similarly critical of the registered provider and the way in which the service had been left in decline. One relative said, "It's our [relative's] lives and to be honest I just feel like they're milking as much money as they can." Another relative told, "The provider doesn't care, it makes them money and that seems to just be the priority." A member of staff said, "We're made a lot of promises that aren't kept. We're told we'll be given things and they're just not provided." The provider did not make the necessary resources available to enable people to have their needs fully met. The service had been allowed to significantly decline in standards since our last inspection and action was not being taken in response to both our concerns and those of the local authority. Essex had placed a restriction on future admissions to the service in October and raised many of the same concerns, but there had not been sufficient commitment to making these improvements.

There was no auditing or quality monitoring which was sufficiently robust to capture the extent of the concerns in the service. One quality monitoring audit had been carried out since the beginning of the year but had failed to identify many of the concerns we raised. There was no evidence of action being taken in response to the areas identified for improvement. Failing to identify areas for improvement and development meant that people were being placed at continued risk of receiving poor quality care.

Staff did not have frequent opportunities to contribute to the development of the service because regular team meetings were not held. One member of staff said, "We had a meeting when [previous manager] was here but that was the first one for years and the last one since [they] left." We looked at the team meeting minutes which had been held in November 2016 and saw that items discussed included shifts, expectations and updates on people using the service. The registered manager told us that time constraints had made it difficult to hold regular meetings but these would be more frequent once the new manager was in post.

The failure to improve the overall leadership and governance of the service since our last inspection was a continued breach of Regulation 17 of the Health and Social Care Act 2008.