Futures Care Homes Limited

Futures

Inspection report

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20 December 2016

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 19 and 20 December 2016 and it was unannounced.

The service provides accommodation and personal care for up to twelve people living with learning disabilities and autism. At the time of our inspection, there were ten 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 their care delivery. People were being put 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.

People had care and support plans in place but these were not always updated or reviewed with involvement from the person or their relatives. Risk assessments were robust and detailed but not always followed correctly in practice. People had their dietary and healthcare needs assessed although some improvement was required to ensure that the full range of people's needs were being met. People had been supported to develop daily living skills and enjoy activities in and out of the service, although this was not always consistent.

Staff were not supported through regular supervision or appraisal and did not have any opportunities to contribute to the development of the service. Staff were being recruited to the service without the correct checks and balances which left people at risk of receiving care from staff who were not suitable. Staffing numbers were not always adequate to safely meet people's needs, and impacted upon the quality of care they received. Staff only received basic training which was unfit for the nature of the roles they were employed to perform. There was no formal induction process being followed. While staff were dedicated and caring, there was a lack of consistency which impacted on people's routines and ability to pursue activities.

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 potential shortfalls in the quality of the service, 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.

This inspection identified that there had been a number of breaches 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.

A robust recruitment process was not followed to ensure that staff employed to the service were suitable.

The health and safety of the environment was not being routinely audited.

Is the service effective?

Inadequate

The service was not effective.

Staff were not receiving any formal induction, supervision or appraisals of their performance.

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

The requirements of the Mental Capacity Act 2005 were not being met. Decisions were being made on behalf of people without the correct process being followed to determine whether this was appropriate.

Is the service caring?

Inadequate

The service was not caring.

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

People and their relatives were not supported to have their views listened to.

People were not always treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were detailed and person-centred but there was not always evidence of involvement from people or their relatives.

While some complaints were being handled appropriately, some issues were not being recorded or resolved.

People were supported to undertake a range of 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.

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

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

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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 19 and 20 December 2016 and was unannounced. 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 nine of their relatives to ask for their views. We spoke with the registered manager and seven members of the care staff.

We reviewed care records for seven people who used the service, looked at thirteen staff files and reviewed records relating to medicines, complaints, staff training, quality audits and maintenance of the home. We attempted to contact the provider to discuss our concerns but did not receive a response.

Inadequate

Is the service safe?

Our findings

During our previous inspection in January 2016 we identified issues with staff knowledge of safeguarding procedures, recruitment processes and the communication of risk management strategies across the staff team. During this inspection we found that there had not been sufficient improvement in these areas and identified further areas of concern in relation to the safety of the service.

The service provided care and support to people who had learning disabilities or were on the autistic spectrum. Some of the people using the service had complex needs which might have impacted negatively upon others. Some people displayed physically aggressive behaviours which could have resulted in harm to staff or other people if not managed correctly. The management of these behaviours is a specialised area and requires staff who have a developed understanding of how to recognise and support people proactively to reduce the risk of behaviours becoming violent or aggressive. Records of incidents in the service showed that there had been 102 incidents since August 2016 where some level of physical aggression or violence was shown by people using the service. This is a high frequency of incidents within a residential setting and meant that both people and staff were being exposed to risk of physical or emotional harm on a daily basis.

The physical intervention training had been provided by one of the provider's former directors until September 2016. The course included both theory and practical training on positive behaviour support and physical intervention as a last resort. However the provider had not been able to provide this training since then and this meant that eight new staff employed since September 2016 had not yet completed this training. Given the level of risk within the service this meant that over a quarter of the staff team had not received training to understand this behaviour or the proactive strategies employed to reduce the associated risk. The registered manager had found an alternative accredited training provider and planned for all staff to receive this training in January 2017.

For staff that had received training this involved being able to use forearm holds, breakaway techniques and simple escorting manoeuvres, as these had been assessed as being relevant to the people using the service. However on 15 occasions since August 2016 there were forms of intervention and restraint used which were not taught as part of this training and had not been assessed as being required in the management of aggressive behaviour for any of the people using the service. There were occasions where people were fully restrained on the floor by the arms and legs for periods in excess of 20 minutes. Using unplanned restraint in this way put people at serious risk of physical and emotional harm.

When we asked the registered manager initially how often physical interventions were used he replied, "Not often, only once or twice recently." However, in our conversations with staff it became apparent that the aggression shown by some people meant that they had to use some form of physical intervention more frequently. For example, we saw that on one occasion physical intervention had been used to take somebody from the bus to the house. There was no reference to this being proportionate or necessary in the person's care plan, and this is not an appropriate use of physical intervention. On another occasion a person was told to 'clean up their mess' after throwing water. This resulted in a significant escalation in behaviour and eventually restraint was used to manage the situation. Speaking to the person in this way was not part

of their agreed care plan and the resulting escalation in behaviour put them at risk of physical and emotional harm.

The provider's policy stated 'staff should be given time after an incident to de-brief and discuss any concerns.' However, there was no formal de-briefing process being carried out, and the lack of supervision for staff meant that there was no evidence of reflection or learning from incidents. At the beginning of the year we noted that an analysis had been undertaken of behavioural incidents to identify trends or patterns to support behaviour support plans. However, this had not been maintained. The registered manager told us that they had identified a new workbook which would allow for a greater analysis of data and provide more information for them to use when developing care plans in the future.

The lack of understanding, consistency, monitoring and training in relation to the management of behaviour that may challenge others put people at risk of physical and emotional harm. The lack of oversight from management meant that this had not been fully recognised or addressed, and had resulted in several occasions where people were inappropriately restrained and the correct procedures were not followed afterwards to monitor them for signs of injury. Following our inspection the registered manager took immediate steps to address this by holding a group supervision and reviewing each person's behavioural support plans.

The inadequate management of behaviour which may have impacted negatively upon others was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed responses when we asked if there were enough staff available to safely meet people's needs. A relative said, "There have been one or two days when staff are off sick but you don't notice much of a difference." However another relative told us, "We've had problems with staffing here since the beginning of the year. They were admitting people without really having the staff to do so and so they were using a lot of agency staff to cover the gaps. That meant a drop in consistency and routine for [person] which is a concern." One member of staff said, "There are enough staff now but there have been times when we're short. It sometimes means people can't go out because there aren't enough of us here. It's gotten better lately though."

We reviewed the service's rotas since August 2016 and found that while there were usually sufficient staffing levels to meet people's needs, there were occasions when this had dropped to below safe levels. For example on the 18 September 2016 only five staff were shown as having worked. An incident between two people occurred during this day and a member of staff wrote on the incident report, "[this was] due to staff sickness so wouldn't usually happen." Rotas showed that sickness levels were high, particularly at weekends when staffing numbers were often significantly lower. Staff sickness was not always being managed in accordance with the provider's policy.

Failing to consistently deploy enough staff to meet the needs of people using the service was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection in January 2016 we found that recruitment procedures were not being followed safely. During this inspection we found that improvements had not been made, and that people were being put at further risk because the provider was failing to follow its own policy when recruiting staff to the service. We looked at staff files for 13 members of staff. Seven of them did not have any employment references in their files and three only had one reference. Failing to seek valid employment references meant that the service could not account for the experience, character or skills of applicants, and left people at risk of receiving care and support from staff who may not have been appropriate.

The service did not complete a full DBS (Disclosure and Barring Service) check for new staff, and we noted that seven staff employed within the last four months had all commenced work without a full DBS check. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed. The registered manager explained that staff would not commence work without an adult first check, and would only then work under supervision. An adult first check can permit a member of staff to work under supervision in exceptional circumstances. However because it was being used routinely, this meant that over a quarter of the staff team were working without a full DBS check at the time of our inspection.

When we looked at the service rotas we noted that there were days when two or three of these staff would be working together on duty. There were no extra staff made available to supervise them. Maintaining constant supervision of all of them would have therefore had a significant impact on staff's ability to provide 1:1 care.

We found that the service were making unsafe recruitment decisions without taking into account the best interests of the people using the service. This put people at unnecessary risk of receiving care and support from staff who may have been unsuitable.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Health and Safety checks were not always being completed to assess the safety of the premises and protect people from any potential risk of harm. There had been no tests of fire equipment, emergency lighting or the call bell system since September 2016. These were checks which had previously been completed on a weekly basis and were necessary to ensure that the building was safe and in working order. A test of the emergency lighting system in January 2016 had revealed defects, and there were further issues identified in February and June of the same year. The registered manager told us that the systems had been fixed by one of the provider's directors, but there were no records of this work having being carried out.

Risk assessments had been developed to identify any potential risks to people and implement control measures to reduce these as far as possible. The risk assessments we saw were detailed, individualised and robust enough to provide staff with consistent instructions and approaches when managing each risk. Risk assessments had been developed for specific activities such as using the trampoline or hot tub, and each section of the person's care plan had an a corresponding risk assessment which considered how risk could be mitigated to support the person to lead as full a life as possible. One member of staff said, "We take risks every day but that's part of the job. What we need to do is manage the risk and make sure it isn't holding people back."

People's medicines were stored and managed appropriately, although the corresponding information in care plans was not always present or accurate. One person's care plan mentioned that 'medicines are an issue' and we noted that they had been involved in a number of incidents relating to medicines. However there was no management plan or risk assessment in place to provide staff with a consistent approach or response. Some incidents had occurred as a direct result of the person being told to wait for their medicines, but it was not clear whether this was an agreed approach. We looked through the MAR (medicines administration record) charts for three people and saw that these were being completed correctly with no unexplained gaps.

The staff we spoke with were able to describe some of the ways in which they kept people safe. One member of staff said, "We make sure they have the correct staffing, that they're using all the right equipment and that

we've all read their care plans." Another member of staff said, "We look after them throughout the day and make sure they've got everything they need."

Inadequate

Is the service effective?

Our findings

Staff did not receive regular supervision or appraisal. The registered manager explained that time constraints had meant that it had not been possible to supervise staff, and that this would be resolved by the appointment of a new manager to the service. We noted that one member of staff had not received a supervision since November 2015. In all of the files we looked at for staff employed since our last inspection, we found that none of them had received any formal supervision. There were no annual appraisals completed for any staff. While the staff we spoke with told us they felt supported, the lack of formal supervision and appraisals meant they were unable to gain feedback on their performance or share their views or concerns. The service was not following their own policy which stated 'employees should be supervised six times a year or more in case of performance concerns.'

The staff we spoke with told us they received an induction into the service; however there was no formal system being followed when inducting staff. One member of staff said, "We work with other staff for a couple of weeks first." Another member of staff told us, "There were two weeks where I was an extra person before I started on my own." While staff were able to learn from observations of practice, the lack of a structured induction meant that the service could not evidence that staff were following a robust programme to understand their roles and job requirements. This was contrary to the provider's policy which stated 'All employees will participate in the organisation's induction programme.' This meant that people were at risk of receiving care from staff who had not been provided with sufficient information and support to carry out their roles effectively.

The staff we spoke with told us they received adequate training to enable them to carry out their duties effectively. One member of staff said, "I do use all my training, like the medication training is useful for senior staff." We looked through the training matrix used by the registered manager to identify when staff had completed training and were due for updates. This was incomplete and the majority of staff files we looked at did not contain any certificates, which made it difficult to ascertain exactly which training they had completed. While some of the staff team had completed training the provider considered essential, we noted that the majority of the courses were taught on a single 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 staff understanding of areas like safeguarding and mental capacity was limited.

A member of staff we spoke with had completed training in autism, and another had completed training in Makaton, which was used by a person to communicate. However, one person had diabetes and a specific mental health needs which no training was provided for. Following an incident where physical intervention had to be used to prevent one person from harming another, one member staff wrote, '"we need training in mental health.'" This was not followed up and no staff had been trained to understand or develop strategies to manage these conditions. Failing to provide staff with a comprehensive level of training which was appropriate to the needs of people using the service meant that they were not being supported to carry out their roles effectively.

The failure of the service to provide staff with adequate induction, supervision, training and on-going support left people at risk of receiving care from staff who were not equipped to carry out their duties effectively. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not receive training to understand the Mental Capacity Act 2005 or 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. 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).

Capacity assessments had been completed for each person in areas such as finances, communication, daily living, medicines and activities. However the correct process had not been followed to make decisions in people's best interest. There was no evidence of involvement from the person, the person's family or relevant professionals. Both the capacity assessment and the best interest decision had been made by staff within the service. This meant that the service was making all decisions on people's behalf without appropriate or robust assessments being carried out to support the decision. This put people at risk of having their rights not fully upheld.

The failure to follow the principles of the Mental Capacity Act was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The design and decoration of the service was inconsistent. We found that people's rooms were vibrant, personalised and colourful, and the environment was tailored to meet their sensory needs. One person's bathroom had been converted into a sensory room to provide them with a safe space for calming and relaxation. There was a hot tub and trampoline in the garden for people to use, and we noted that there were photos of people and examples of their artwork on display.

However other areas of the home were run down and grubby. There were stains on walls in communal areas, wear and damp patches around radiators, and poorly fitted and maintained carpeting. We spoke with one relative who expressed concern that their relative had been assured that their room would be decorated and this had not yet been completed. When we went to see the person we found that their room was half-finished and that there were gaps in the wall, ladders with sheeting which covered a large portion of their living space. The delays in finishing the work had caused unnecessary disruption to the person's environment for a period of over two weeks.

Another relative said, "The state of [person]'s room is terrible, they don't have any cleaners and it doesn't seem like they take much care of the environment." The registered manager assured us that the incomplete work would be completed and that a new member of staff had been appointed and started in the service to oversee the repair and redecoration of the home.

People's healthcare needs had been identified and we saw records which confirmed that people were being supported to attend appointments as required. However one relative we spoke with expressed concerns that appointments were being missed, and told us "Appointments get missed for [person]'s healthcare because they're just not on top of it. I have to oversee that myself now." We noted during our observations in the service that one person was communicating that they had a toothache. However the member of staff

working with them had not recorded this and did not take any action to book an appointment or attempt to resolve this for them. While the service were mostly identifying people's healthcare needs, further improvement was required to be more responsive to health concerns.

People's dietary needs were identified as part of their care plan, and people had enough to eat and drink. We saw that individual preferences and allergies had been highlighted and that people's specific requirements were being met. People were allowed access to the kitchen and staff had worked with some people to improve their daily living skills and encouraged them to help with the preparation of meals.

Inadequate

Is the service caring?

Our findings

While most staff demonstrated caring attitudes to people using the service, the culture and practices had been undermined by inadequate management resulting in deterioration in the overall quality of care provided. When we asked relatives about the quality of care we received mixed responses. One relative said, "If you'd asked me 2 or 3 months ago I was happy although there have been problems before that. To be honest there are problems with consistency and staffing. When [person] has enough staff there and [they] know them, things run very smoothly. But both staff are off sick a lot and then activities don't happen, [person] gets unsettled and things fall apart." Another relative described the care as "disappointing. They make a lot of promises but few have really been delivered." A third relative said, "The staff are really caring but nothing is structured there and there are real issues with communication and consistency."

People and their relatives were not supported to have their views heard. There were no residents meetings, meetings or relatives or opportunities to provide views through surveys. One relative expressed concern about one person using the service because they did not have family available to advocate on their behalf. They said, "[Person] is a shadow of themselves, they don't have any family to speak on their behalf so they get moved about the home and miss out on things because I think it's just easier for them." Another relative said, "Quite often we have observed that [the service] seems to be run more for the convenience of staff rather than the clients."

While we mostly found the staff team to be caring and understanding of people's needs, some recruitment decisions had resulted in staff being employed who may not have been suitable to work with people with complex communication needs. We encountered communication issues with two members of staff which we found would significantly have impacted upon their ability to provide effective care. The lack of support available to these staff meant that they were not being provided with the right supervision, training or performance review to enable them to develop the necessary skills and competencies to improve. This meant that people were being put at risk of receiving care from staff who were unable to provide suitable support to people through effective communication.

The inadequate staffing also impacted upon the quality of care people received. One relative said, "What happens is that staff will be attending to the others and [person] is left to their own devices when they're short staffed. [Person] needs just as much support and attention and yet [they] always tend to lose out when they're short staffed." Another relative said, "[Person] seems to be kept in the home a lot, and that seems to be just because there aren't enough staff."
During our observations we found that people were being treated with dignity and respect by staff. Some relatives we spoke with felt that people had their privacy respected and were treated appropriately by staff. However others raised concerns in relation to the way that their family member's possessions were being treated, the condition and cleanliness of their environment and the inconsistency of staff. The use of restraint and the lack of consistent and skilled staffing meant that people were at continued risk of having their rights and their dignity compromised. A culture of poor practice had been allowed to develop which had impacted upon the quality of care that they received.

Failing to provide consistent person-centred care and ensure that people were treated with dignity and respect was a breach of Regulations 9 and 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with were positive about the support they provided to people. One member of staff said, "I'll give you an example of [person], who came to us needing a lot of support and has just grown and grown. I think we do provide a really high quality of support to people." Another member of staff said, "I think we really do improve the quality of their lives overall. We give people the chance to do things they want to do and I'm proud to say that."

Some relatives made positive comments about the care their relatives received and the impact this had on their lives. One relative said, "[Relative] has historically been very challenging but they've got the patience here to work with [them] and see things through. I've seen a big change in [person] and they're a lot more patient now, a lot more happy. The staff are lovely people here and nothing is too much." Another relative told us, "I have to say that [person] is really settled and staff are really caring."

Requires Improvement

Is the service responsive?

Our findings

Each person had an assessment carried out by the service which was then used to develop a comprehensive person-centred plan. We asked people's relatives if they had been involved in the care planning process. One relative said, "We've had a meeting about [person]'s care since they moved in." Another relative told us, "We do have reviews and they tell me if anything has changed or I need to know about anything." However another relative said, "If something happens then they will let me know but in terms of general communication, it could be better and regular updates are not taking place."

The assessment process was not always robust enough to prevent inappropriate admissions to the service which put people and staff at risk. A relative said, "My concern is that they're taking on people who are far too challenging for the staff to cope with and they don't have the experience or the ability to deal with that level of challenging behaviour." Another relative told us, "One of the people had a serious impact on others living there. The staff were not paying attention to that person and didn't seem able to meet [person]'s needs."

In September 2016, a person who had needs requiring specialised training and understanding of their conditions had been placed on an emergency basis in the service. One of the staff we spoke with told us that the team had collectively raised concerns regarding the placement and the impact on other people already in the service. The person was initially assessed as being appropriate for a self-contained area of the service where impact upon the rest of the people would be minimal. However this was not possible in practice and people and staff were exposed to a number of serious incidents throughout the duration of their placement. While the registered manager had taken appropriate steps to resolve this before our inspection, the service failed to follow the correct assessment process to determine whether they could safely meet the person's needs. This had put people at unacceptable risk of harm.

However, the plans we saw for the current people living at the home were detailed and person-centred. Each person had a section titled 'this is my profile' which provided essential information in relation to their most important needs. Care plans were then divided into sections such as likes and dislikes, healthcare, daily living skills and finances. Each person had a key worker who was responsible for reviewing the information monthly to ensure that it was reflective of the person's current needs. The daily notes for each person then corresponded to each section of the care plan. For example staff were asked to record which activities the person had taken part in, any involvement with finances and any healthcare issues that needed to be addressed.

During our inspection we found that people were often out in the community or engaged in activities within the home. A relative said, "They do a lot with [person] and [they] do always seem very busy." Another relative added, "There's always something going on here, but I must say whenever I visit it seems like most people are out." People were supported to access a wide range of activities including college courses, shopping trips and clubs. However we were told that there were occasions when insufficient staffing meant that people could not always go out. One relative said, "[Person] is funded 2:1 in the community but has sometimes been taken out with somebody else. There have been times where [person] hasn't been able to

go out at all because there aren't the staff." We found that because some staff did not have intervention training or full DBS clearance, this meant they could not support people in the community. While there was a positive culture of supporting people in the community as much as possible, some improvement was required to make this more consistent for people.

We received mixed responses when we asked whether relatives knew how to make a complaint. One relative said there was "a lack of communication when we've asked for something to be done. Things don't get fixed or resolved and we're still waiting for some things to be sorted." Four complaints had been received since the previous inspection and had been resolved appropriately by the registered manager. However we were told about numerous other concerns which had been raised which had not been recorded, and the complaints procedure was not always being followed. Because of the time constraints the registered manager was working under, issues were not always resolved in a timely fashion. Another relative told us, "The [registered manager] is overrun and doesn't get any support. He's a nice guy but he's trying to run two care homes and it just doesn't work. Things get left."

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. We tried to contact the Director of this service but did not receive a response.

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 and 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. A new manager had started on the first day of our inspection with a view to registering once established, which would enable the current registered manager to adopt an operational role across both services. While we found that the registered manager was caring, dedicated and knowledgeable, the nature and demands of two complex services had meant that there had not been adequate time to make improvements.

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 a clear management structure had led to an unacceptable decline in the overall quality of the service. This put people at continued risk of failing to receive an adequate standard of care.

We saw that some required improvements to improve the lives of people using the service had not been made. For example in some areas of the home there was insufficient internet connection for people to access information online. This would have provided a better quality of life for some people who used this as a tool for communication or relaxation. Also, a second vehicle had been requested to address concerns

that people were not always able to access the community, but this had also not been forthcoming. This meant that the registered manager was unable to access financial resources that would have helped to maintain and develop a therapeutic and person-centred environment.

A relative told us, "The day to day management is excellent but sometimes things don't always happen because I think he [registered manager] is a little bit overloaded." Another relative said, "My concern is that [registered manager] is spread very thinly and there needs to be two or three management staff and he's the only person I can call to get issues resolved." A third relative explained, "There seems to have been a fundamental breakdown in communication and things are not dealt with or resolved. We ask for things and they just don't happen." None of the relatives we spoke to were aware of who else they could speak to besides the registered manager. While the registered manager spoke of a strong commitment to making the required improvements, we found that there was a fundamental lack of understanding of the scale of the issues within the service and the time required to address them.

The demands of the day-to-day management of both services had meant there was no effective governance in place. There had only been one quality audit carried out since our last inspection which had highlighted some of the areas for improvement, but failed to identify the majority of concerns we found during our inspection. Remedial actions were listed but had not been followed through with actions. There was no routine auditing of care plans, staff files, incidents or daily records. In October 2016 the local authority had identified significant concerns with the quality of care which meant that had restricted further admissions to the service. Despite the seriousness of these concerns, there had been little improvement in any of the areas identified.

The provider's policies and procedures had been purchased from a third party and so were not always reflective of the governance of the service. In several areas the service was failing to follow its own policies and procedures because these were generic in nature and had not been developed to account for the nature of the service.

Most of the staff we spoke with were positive about the support they received from the registered manager. One member of staff said, "Yes the manager is really supportive." Another member of staff said, "I can call [registered manager] any time and he's there to help, he's a good manager." However two members of staff felt that they did not always receive the support they required. One member of staff said, "[Registered manager] just seems to shrug things off."

Staff were not provided opportunities to contribute to the development of the service because there were no team meetings or ways for staff to have their views heard. The registered manager acknowledged that "team meetings haven't happened" due to time constraints. This meant that staff did not have a chance to handover issues, discuss concerns or share practice. Failing to put effective systems in place for communication meant that people were being placed at risk of inadequate care and support. One relative told us, "Staff don't seem to hand things over to each other." One member of staff told us that the staff team had written a letter to the registered manager to outline concerns about the safety of the service following an unsafe placement of a person with complex needs. There was no response to this or attempt to mitigate the issues raised. This showed that staff's views were not valued and acted on.

The failure to develop effective systems for management and governance of the service had left people at increased risk of harm due to the lack of oversight or commitment to making improvements to their quality of care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 18 Registration Regulations 2009 Notifications of other incidents The service failed to notify the Care Quality Commission of all safeguarding incidents.

The enforcement action we took:

We imposed an urgent condition to restrict further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service failed to develop systems for the safe management of challenging behaviour which put people at risk of physical and emotional harm.

The enforcement action we took:

We imposed an urgent condition to restrict further admissions to the service.

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 service were failing to meet the requirements of the Mental Capacity Act 2005 and making decisions in people's best interests without following the correct process.

The enforcement action we took:

We imposed an urgent condition to restrict further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was inadequate governance at both service and provider level to identify and make improvements to the quality of the service within acceptable timescales.

The enforcement action we took:

We imposed an urgent condition to restrict further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The service did not protect people by following their recruitment policy to ensure that staff employed to the service were suitable.

The enforcement action we took:

We imposed an urgent condition to restrict further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The service were not displaying the rating from their previous inspection on their website.

The enforcement action we took:

We imposed an urgent condition to restrict further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 6 HSCA RA Regulations 2014 Requirements where the service provider is a body other than a partnership The provider had failed to appoint a person who would act as the nominated individual for the service.

The enforcement action we took:

We imposed an urgent condition to restrict further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough trained, skilled, experienced and supervised staff available to meet the needs of people using the service.

The enforcement action we took:

We imposed an urgent condition to restrict further admissions to the service.