Autism Care UK (2) Limited

Rother Heights

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

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

Rother Heights can accommodate up to 28 people. At the time of our inspection 23 people were using the service. The service comprises of a complex of four bungalows and an office block. Each bungalow has six bedrooms with en-suite facilities. There are also two other houses nearby which can each accommodate up to two people.

The service has not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service were not receiving planned and co-ordinated person-centred support that was appropriate and inclusive for them.

People's experience of using this service and what we found
People were not safe. They were not adequately or effectively protected from the risk of abuse. The registered provider had a system in place to safeguard people from the risk of abuse. However, systems to keep people safe had failed and safeguarding referrals were not always made. Staff did not always communicate effectively to ensure safeguarding concerns were reported to the safeguarding authority. Safeguarding referrals were not consistently made to the local authority safeguarding team when allegations of abuse were made, or incidents were witnessed in the service. During this inspection we identified safeguarding concerns which were reported to the safeguarding authority and an incident that we asked the provider to report to the Police.

The service did not consistently comply with their duty to inform CQC of information relating to the safety of people.

Medicines was not always administered safely. Some medicines prescribed 'as required' were not being managed effectively to ensure people received these as prescribed to ensure peoples safety.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. We identified there was an excessive use of restraint taking place, without consideration of people's best interests.

There was a lack of regard for people's human rights. There was a culture in the service where people were

not respected as individuals and their rights were not upheld.

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

We completed a tour of the home and found a number of environmental risks which had been identified by us on a previous inspection had still not been addressed. We found risks in relation to fire safety had still not been adequately managed.

Accident and incident analysis were still not sufficiently taking place and there was no evidence that trends patterns were being identified, or that actions had been taken to reduce hazards in relation to people's care and treatment. Analysis that had taken place was not effective as it didn't show a true reflection of the number of incidents that had taken place or take in to consideration the impact from the severity of incidents to reduce risk to people and improve their well-being.

People were not always provided with access to healthcare professionals.

The provider had not ensured that staff received training to carry out their role. Training that had been completed was not effective. Staff told us they received one to one session with their line manager but told us they didn't feel listened to, so this was also ineffective. We also found there were not enough suitable staff to support people. A large number of regular staff were leaving and there was a high use of agency staff who were not adequately trained to support people who needed specialist interventions to keep them and others safe.

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

Staff told us people were supported to receive adequate nutrition and hydration that met their needs. There was a plentiful supply of food available, but we saw that people's choices of what they would like to eat and where they could eat meals being restricted by staff.

We spent time observing staff interacting with people and found there were some kind and caring interactions taking place, however this was not consistent. We also observed some undignified interactions between staff and people. Staff were waiting for incidents to occur rather that ensuring the correct support was in place to minimise triggers which may cause distress to people. People's behaviour was seen first and foremost, this prevented people from being treated like as individuals in accordance with their own human rights. Staff were custodial in their approach to care for people rather than supporting them to live a full and active life.

Information about people was not kept confidential.

The service rarely applied the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons. People were restricted by lack of choice, control and community participation, there

was limited staff which prevented people from being able to access the community when they chose.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection for this service was inadequate (last report was published 14 February 2019)
At the last inspection we identified eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to submit copies of monthly reports for areas of particular concern. The provider had been submitting this information to the Commission.

At this inspection not enough improvement had been made or sustained and the provider was still in breach of regulations and the service had further declined.

Why we inspected
The inspection was prompted in part due to concerns received about staffing, practice concerns and risk. A decision was made for us to inspect and examine those risks.

This inspection identified eight continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and there were significant concerns about the suitability and safety of people.

This inspection was carried out to follow up on action we told the provider to take at the last inspection.

The overall rating for the service has remained inadequate. This is based on the findings at this inspection.

We found evidence during this inspection that people were at risk of harm from the concerns we found. We made commissioners and other stakeholders aware of our concerns.

Enforcement
We identified eight continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Follow up
Following the inspection, we wrote to the provider requiring them to take urgent action to address these risks and protect people from further risks.

Due to the level of our concern, we made an urgent application to the Magistrates Court to immediately cancel the registration of this service. The Order was granted on 10 July 2019 and the remaining people living at the service were moved out that day.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Rother Heights on our website at www.cqc.org.uk.

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.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Rother Heights

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
Three inspectors visited on each day of the inspection and a specialist pharmacy inspector visited on the second day of the inspection.

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

The service had no manager registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

The inspection activity started on 19 June and ended on 20 June. Three inspectors visited all of the bungalows and one house on 19 June and 20 June and a specialist pharmacy inspector visited two bungalows on the 20 June 2019.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We sought feedback from partner agencies and professionals and through our own on-going monitoring such as information received

by the provider. We used all this information to plan our inspection.

During the inspection
During the inspection we spoke with 12 staff, one temporary manager, one operational lead, two area managers, two quality leads and one admin assistant. We looked at a nine care plans, all of the staff training information, accidents and incidents, five medicines records, and governance systems and processes.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with several commissioner and other stakeholders, and the local fire safety authority.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same.

Inadequate: This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Systems and processes did not operate effectively to prevent the abuse of people. We received information from the local authority's' contracts and commissioners which highlighted many concerns about the safety of people using the service. The concerns were considered as part of the inspection.
- People were not safe and were at risk of harm. Staff didn't always recognise or report abuse. We found many examples of incidents where the provider should have reported to the local safeguarding authority and CQC but had failed to do so.
- Following our inspection, we asked the provider to report one concern to the Police as we felt that a person had being inappropriately restrained. We made referrals to the local safeguarding authority and asked the provider to make further referrals to partner agencies to ensure that people were safeguarded appropriately from harm.
- We identified that during the months before our inspection many safeguarding incidents had occurred at the home and the provider had no oversight or awareness and some of these were very serious and people had been harmed.

At our last inspection the provider had failed to robustly assess the risks relating to the health and safety of people. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection no improvement had been made and the provider was still in breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management: Learning lessons when things go wrong

- Risks associated with people's care and treatment had not always been identified and managed safely. For example, one person was targeting other people they lived with and this was not risk assessed to ensure people were kept safe. We asked the provider to report this to the local authority safeguarding team and to take immediate action to ensure people were safe.
- There were daily incidents involving physical aggression taking place toward people and staff. We were told people and staff were afraid of getting hurt. This meant people who were at risk of presenting with behaviour that may challenge did not have their needs met. The risks had not been effectively analysed to see how they could be reduced or if current measures were effective and the least restrictive, or safe.
- At the last inspection we identified significant risk in relation to fire safety, these had not all been suitably addressed. Staff continued to wedged fire doors open and one fire door was broken, and one was missing.

We spoke to the fire service who confirmed that the provider had not complied with their recommendations from their visit following the previous inspection.
●Hazardous substances remained accessible to people despite this being raised as a concern at the last inspection, this shows that lessons were not being learned and people remain unsafe.
●There was a lack of analysis of accidents and incident taking place. For example, we found in one month one person had 35 incidents', 17 of these staff had used restraint. The provider had failed to analyse the incident as they were only aware of 10 incidents' in their analysis. This meant they didn't have a full and clear picture of the incident's occurring.
At this inspection we found evidence that people had been harmed. Systems were either not in place or robust enough to ensure people were safe. We asked the provider to take immediate action to keep people safe.

At our last inspection the provider had failed to robustly assess the risks relating to the health and safety of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
●The service was dangerously short staffed, and this was having an impact on people's wellbeing. The provider was using a high number of agency staff who were not suitably trained to safely support people with their needs and their freedom was being restricted.
●All the staff and one manager we spoke with told us people were not safe due to inadequate staffing levels. Staff said, "I don't feel like we are able to meet people needs because of the staffing levels. People are not safe, especially on a weekend when we use a high number of agency staff." Another staff member said, "It's awful, we have a major issue with too much agency use." And, "We are currently 25 staff down and retention [of staff] is a real issue. And, "I don't feel like I'm meeting people's needs because of the situation with staffing." And, "[The service] is unsafe on nights as we do not have enough staff and mostly agency staff covering nights."
● We brought our concerns to the providers attention and asked them to monitor and review their staffing levels to ensure people received safe care and treatment.
●We found that where people were assessed as requiring one to one hours for part of the day, they did not always have staff available to provide them with one to one support. People were prevented from accessing activities in the community as agency staff were unable to take people out. This restricted people freedom and choice and there was no flexibility to meet people's needs.

At our last inspection the provider had not provided adequate numbers of suitable staff. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection no improvement had been made and the provider was still in breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Before the inspection we received concerns that aspects of the administration and recording of medicines were unsafe and this was putting people at risk. We checked this during the inspection and found medicines were not managed in a safe manner.
●People were prescribed medicines to reduce anxiety on a when required basis to be given on the approval

of a team leader, when other measures to calm and reassure a resident had failed. However, steps had not been taken to reduce a person's anxiety before administering 'when required' medicine.
●A team leader told us that they did not check what steps staff had taken to reduce anxiety before approving the administration of 'when required' medicine.
●People receiving 'when required' medicines had not been reviewed by a doctor to check their medicines were still appropriate.
●The provider was not following national guidance on how to manage a person who became violent or aggressive.
●We found people were given medicines before other techniques had been tried. This goes against the NHS pledge in Stopping Over-Medication of People with a learning disability, autism or both (STOMP).

At our last inspection the provider had not ensured the proper and safe management of medicines. This was a breach of regulation 12 (Medicines) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection no improvement had been made and the provider was still in breach of Regulation 12 (Medicines) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
●Since our last inspection the service had employed a cleaner and on the day of the inspection the environment was cleaned to a higher standard. However, some weeks prior to our visit we were informed of concerns about infection control and the cleanliness of the services. The local authority visiting the service checked mattresses and found them to be heavily stained and not fit for purpose. The provider replaced the mattresses but did not have an effective system in place for checking infection control. Once this was identified the provider put a system in place to check mattresses, however checks were not completed on a regular basis or audited regularly to identify issues.

At our last inspection the provider had failed to robustly assess that premise were clean. This was a breach of regulation 15 (Premise and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection whilst we found some improvements had been made to the cleanliness of the service, it wasn't sufficient to meet this breach. The provider was still in breach of Regulation 15 (Premise and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remains inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff continued to not be suitably trained to meet people's needs. We found that a large proportion of staff training had expired leaving them out of date on areas such as first aid training.
- New staff were receiving their mandatory training, however although they were trained they didn't have enough experience to deal with people's behaviours and this left people and staff vulnerable to being hurt. Staff felt that some training didn't give them enough knowledge to meet people's needs and had needed to carry out physical intervention such as restraining people when their training was out of date.
- Staff said, "I have been saying I want my training done as it makes me and everyone else vulnerable. To be able to do your job effectively you need to be trained. And "I'm not NAPPI [non-abusive psychological and physical intervention] trained, I don't want to use [the techniques to restrain people] because I could get hurt. I let the managers know some time ago [that my training had expired]."
- A significant number of staff were not trained in NAPPI which put people at risk of harm as staff were using restraint without appropriate training or updates.
- Staff told us they received supervision, but they didn't feel like they were listened to or taken seriously by managers, so supervision was ineffective.

At our last inspection the provider had not provided adequate numbers of suitable staff. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection no improvement had been made and the provider was still in breach of Regulation 18

Ensuring consent to care and treatment in line with law and guidance

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.
In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

●We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. We found where conditions were in place the provider was not monitoring if the conditions had been met. For example, one-person DoLS condition said they should access community-based activities weekly. We checked this was happening but because there were poorly written records we couldn't be sure people were regularly accessing the community.
● We found that restrictions were placed on people without prior checking they were in the persons best interest. For example, one person's en-suite bathroom was kept locked and if the person needed to use it they had to ask staff. This was a restriction on the person's freedom and choice. We asked that the provider look at all restrictions placed on people and ensure they were in line with people's best interests.

At our last inspection the provider had not provided adequate numbers of suitable staff. This was a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection no improvement had been made and the provider was still in breach of Regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● We saw there was ample food available and the provider was meeting the needs of individuals who ate a special diet in line with their culture.
●We found that people were not able to choose what food options they wanted.
●One person asked for cereals for breakfast and was told they were having fruit instead as it was better for them. The person was not offered a choice. Another person was told they could not eat or drink in their bedroom, and their food was moved away from them. Staff said this was not because there were any risks from the person eating in their room, but it was just the way things were and they needed to sit in the dining room. The dining room was busy and loud and not a pleasant environment for people to enjoy their meals.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support
●Care was not always suitably assessed, and care was not delivered in a person-centred way. We found one person had moved into the services without the provider first checking if they were compatible with the people already living there. Staff told us they were concerned about conflict between people and told us people simply didn't get along and would 'target and wind each other up.' They told us there was daily conflict between people which left them being upset and afraid. We asked to provider to inform the local authority safeguarding team about this and take immediate action to reduce the risk.
● Restrictive interventions were being carried out with a number of people and there were no restrictive intervention reduction plans in place. This goes against National Institute of Clinical Excellence (NICE) guidelines on Violence and Aggression.
● We found instances where there was key information missing from people's care plan which was essential to support them.
●People were not always supported to access healthcare services when they needed them for example, one person had lost a considerable amount of weigh, but the weight loss had not been picked up for some months despite the person being weighed, after they lost over a stone and a half in weight they were referred to health care services to investigate the cause.

At our last inspection the provider had not provided person centred care. This was a breach of regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection no improvement had been made and the provider was still in breach of Regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs

●We found since our last inspection there had been some improvements made to the environment. Although decorating had been completed to a poor standard and many areas identified at the last inspection had not been addressed.

●People's bedrooms were personalised with things that were meaningful to them such as soft toys and photographs. One person said they liked their bedroom and the decoration of it.

Inadequate

Is the service caring?

Our findings

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained inadequate.

This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity: Supporting people to express their views and be involved in making decisions about their care

● There was a lack of regard for people's human rights. There was a culture in the service where people were not respected as individuals and their rights were not upheld. Some staff continued to refer to people in an impersonal way. For example, we heard people referred to as PWS's (meaning 'person we support'). One care worker said, "I'm on [name] today [meaning supporting that person] This was impersonal and uncaring and no improvement since our last inspection.

●We observed interactions and found people were not always treated and supported well. For example, one person was sat in their bedroom with staff sat close by, however there were no interaction taking place and the person had their head in their hands and looked upset.

Supporting people to express their views and be involved in making decisions about their care

●Three people were all sat in a small communal lounge with staff for most of the day. Staff told us people didn't get on and one person was frightened of the other and they were being targeted. People were not being supported to do individualised activities and when staffing was available to take people out they were going in groups although it was clear this wasn't suitable or safe.

●There was another lounge area that staff told us one person liked to use, however the television had been broken for about a month, so the person had stopped using the area and had to sit with other people if they wanted to watch the television.

●There were no in-house activities taking place for most people with a higher level of need. We did observe one person cleaning their bedroom.

Respecting and promoting people's privacy, dignity and independence

●People's privacy and dignity was not being maintained. We observed staff changing a person's underwear with the bedroom door open, the person was naked from the waist down and was easily seen from the lounge. We asked the provider to report this to the local safeguarding authority.

●We observed one person wearing clothing that was heavily stained with food. Staff didn't offer to change the persons clothing and they wore this on for the rest of the day. Another person was taken to a health care appointment with a heavily food stained jumper, the person was not offered to get changed before they went and was still wearing this later in the afternoon.

●Information about people was not always kept confidential. We saw people's personal information left in communal areas. We also observed staff call out and discuss people in front of other people and staff, which did not respect people's privacy.

At our last inspection the provider had not delivered care with dignity and respect. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection no improvement had been made and the provider was still in breach of Regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained inadequate.

This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

●We looked at care records and found they were not always fully detailed to support people required to meet their needs. However, even when plans contained the required detail to guide staff we saw staff did not always provide the support detailed in care records. For example, People had behaviour support plans in place which gave staff instruction on how to support people before, during and after an incident, to help reduce and manage any behaviour which challenged. Staff were not always following what was laid out in the plans.

● Staff failed to understand people needs and there was a lack of understanding regarding best practice when supporting people who displayed challenging behaviour. We were told of examples where staff used physical interventions to restrain people when other less restrictive measures should have been tried.

●We observed an incident where staff were clearly not following a person's behaviour support guidelines, and this was increasing the persons anxieties and causing them further distress. Three staff were involved in the incident and this felt intimidating and unnecessary. We discussed this with the manager who witnessed the incident, they agreed that it had not been appropriately handled. We asked the provider to take action to ensure people's support was being delivered in line with their needs.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

●People communication needs were not always met. People did not always receive communication in a way that supported their understanding. There was a lack of signage in the home to help people make sense of their environment. Some care plans we looked at also gave staff conflicting information on how to communicate with people. For example, one person's care plan said they used their tablet to communicate. However, another entry stated they did not use this as they had broken it and used picture prompts. Therefore, it was not clear the best way to communicate with this person.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

●We observed most people were not given the freedom to do things they wanted to do. When people were able to go out they weren't always supported to take part in individualised activities. We observed people

spending long periods of time in communal areas with people they didn't get along with.

People were not always receiving their 1:1 time and this was not planned flexibly to ensure it was centred around the person. This did not promote or protecting people's human rights and right to freedom and choice.

● The service often ran short staffed or with high levels of agency who were not able to take people out into the community. When people did access the community, they were supported by staff who were not skilled or confident in dealing with managing behaviours which placed people at risk.

At our last inspection the provider had not provided person centred care. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection no improvement had been made and the provider was still in breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

●The provider did not sufficiently act on concerns or complaints. Relatives raised concerns with CQC that their concerns were not taken seriously or acted upon by the provider.

End of life care and support

●End of life care planning was on the providers action plan but it was not a priority area.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Inadequate: This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At the last inspection this key question was rated as inadequate. At this inspection this key question had remained inadequate.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The culture within the service was not person centred and did not focus on achieving positive outcomes for people.
- The rights of disabled people had not been upheld in connection with expectations of the equality and human rights legislation.
- We found the service was not shaped around the needs and preferences of people that used it. There was a lack of appropriate governance and risk management framework and this resulted in us finding multiple breaches in regulation.
- There were no effective systems in place to develop and improve the service, based on the needs of the people who used it, their families and staff.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At the time of our inspection the service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.
- Since our last inspection several members of the provider's senior management team had been involved in offering support to the service. However, nobody was leading the service effectively to resolve the issues found on our last inspection.
- The governance of the service was had failed and this was evidenced by the continued poor standards of care we found.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider understood their legal requirements, however, the extensive nature of the breaches of the Regulations we have identified and the widespread and significant impact of these demonstrated a failure of leadership and governance.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● No member of the management team had day to day oversight of the service and the culture within the service was not reviewed.
● Staff we spoke with continued to feel that the management team did not listen to them. Staff told us they had raised issues with the management team, but no action had been taken.
● Support was not given to staff to direct and lead them to work as a team and drive improvements. Inexperienced and untrained staff were left in vulnerable positions without the correct number of adequately trained staff to carry out their role.

Continuous learning and improving care
● There was a lack of effective quality monitoring taking place to ensure the service was working to the registered providers expected standards. When checks were completed they were not always effective, or robust and did not always identify the concerns we had raised as part of this inspection. We found the house managers completed day to day audits, however, these had not been completed regularly and their managers had not checked them to ensure the audits were robust.
● In addition to audits carried out by house managers, the provider's quality team had completed an audit in January 2019, following our last inspection. The outcome was that only one house had been rated good and the rest poor. No follow up action had been completed to ensure issues raised were rectified. We spoke with members of the quality team and they told us that a further audit would be completed after six months.
● We found significant shortfalls in relation to safeguarding, peoples care and support, the use of restrictive practices, staffing levels, safety, and staff training and support.
● During our inspection we found that no one had overall responsibility for the service. The lack of oversight resulted in people receiving care and support which was not person centred, in line with their needs and was not safe.
● The provider failed to analyse accidents and incidents in a robust and effective manner. This was also a concern at our previous inspection. The lack of effective monitoring meant that people were placed at risk of harm and at risk. We observed people receiving care which was not safe due to lack of effective monitoring.

Working in partnership with others
● The provider did not work in partnership with other professionals and key organisations.
● Feedback received from the service commissioners was not positive. They told us that they had significant concerns about this service as no improvements had been made since the last inspection. Commissioners we spoke with told us the service had deteriorated considerably and one commissioner said, "We do not believe the service can meet the needs of individuals safely and as such we are finding alternative placements for people they will be moved by the end of the week."

At our last inspection we issued a warning notice to the provider for governance. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection no improvement had been made and the service continued to have multiple failings. This was still in breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took immediate action to inform stakeholders and commissioner of the severity of our concerns and continue to work closely with them to evaluate and monitor the location.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people received care that was person-centred and met their needs.

The enforcement action we took:

Due to the level of our concern, we made an urgent application to the Magistrates Court to immediately cancel the registration of this service. The Order was granted on 10 July 2019 and the remaining people living at the service were moved out that day.

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

The enforcement action we took:

Due to the level of our concern, we made an urgent application to the Magistrates Court to immediately cancel the registration of this service. The Order was granted on 10 July 2019 and the remaining people living at the service were moved out that day.

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

The enforcement action we took:

Due to the level of our concern, we made an urgent application to the Magistrates Court to immediately cancel the registration of this service. The Order was granted on 10 July 2019 and the remaining people living at the service were moved out that day.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 12 HSCA RA Regulations 2014 Safe care

personal care	and treatment Care and treatment was not provided in a safe way. Risks were not managed, there was no proper and safe management of medicines and infection, prevention and control was not followed to protect people from risk of infections.

The enforcement action we took:

Due to the level of our concern, we made an urgent application to the Magistrates Court to immediately cancel the registration of this service. The Order was granted on 10 July 2019 and the remaining people living at the service were moved out that day.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure people were protected from improper treatment and abuse.

The enforcement action we took:

Due to the level of our concern, we made an urgent application to the Magistrates Court to immediately cancel the registration of this service. The Order was granted on 10 July 2019 and the remaining people living at the service were moved out that day.

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

The enforcement action we took:

Due to the level of our concern, we made an urgent application to the Magistrates Court to immediately cancel the registration of this service. The Order was granted on 10 July 2019 and the remaining people living at the service were moved out that day.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure there were effective and robust monitoring systems in place.

The enforcement action we took:

Due to the level of our concern, we made an urgent application to the Magistrates Court to immediately cancel the registration of this service. The Order was granted on 10 July 2019 and the remaining people living at the service were moved out that day.

Regulated activity	Regulation

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

The enforcement action we took:

Due to the level of our concern, we made an urgent application to the Magistrates Court to immediately cancel the registration of this service. The Order was granted on 10 July 2019 and the remaining people living at the service were moved out that day.