Spectrum (Devon and Cornwall Autistic Community Trust)

Trelawney House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Trelawney House is a residential care home providing personal care to six people with a learning disability and/or autism. It is part of the Spectrum (Devon and Cornwall Autistic Community Trust) group, a provider with 15 other similar services across Cornwall. Trelawney House is in a rural location. The nearest town is Helston which is approximately four miles away without public transport links.

People's experience of using this service and what we found

The provider had failed to appropriately report and investigate incidents of alleged abuse. This issue had previously been identified in the last inspection of the service on 10 June 2021. The service's new manager had completed a safeguarding referral following an incident of alleged abuse and this had been forwarded to the provider's nominated individual. This information had not been shared with the local authorities safeguarding team, or the CQC, and the provider had failed to take necessary action to manage the risks posed by the alleged abuser.

At this inspection we found that the service was short staffed. This had previously been found during the inspection on 10 June 2021. Four agency staff had been allocated to support the service. However, staffing levels were restricting people's freedoms within the service, where one person was regularly restricted by being locked in their room. Access to the local community was also restricted.

Records showed that the service was regularly aiming only to achieve minimum safe staffing levels within the service, as opposed to the commissioned levels of support designed to enable people to have fulfilling lifestyles and access the community. At night the service was also regularly operated at emergency minimum staffing levels and on one recent occasion the night staffing level had been unsafe. Staffing levels planed for the two days following our first inspection day were judged to be unsafe. There was no information available to staff on staffing arrangements for the following week. We sought assurance from the provider during the first day of the inspection that staffing levels would be increased and a rota developed. This information was then provided.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. This service was unable to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
• The model of care and the environment of the service did not meet peoples' current needs. Prompt action had not been taken to address and resolve these issued which had impacted on peoples' independence.

Right care:
• Known issues in relation to the noise level in the service during the day and at night had not been appropriately addressed. This had severely negatively impacted on people's wellbeing and led to one person becoming increasingly isolated.

Right culture:
• The ethos, values, attitudes and behaviours of the provider and it's leaders did not enable people using the service to experience empowered lives. The provider did not work effectively with partners to ensure people's safety.

Medicines were not managed safely, and the provider had not yet addressed the recommendation issued following our last inspection about where medicines were stored.

Incidents where unauthorised techniques were used to support people when anxious or upset had not been appropriately investigated. Poor record keeping meant it was not possible for lessons to be learned following incidents.

People did not receive the support they needed to eat and drink. Prompt action had not been taken to make necessary alterations to the service to enable a person with declining mobility to maintain their independence.

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. Policies and systems in the service did not support this practice. Conditions associated with authorisations to deprive people of their liberty (DoLS) had not been complied with.

We received mixed feedback about the service's current manager from staff and people 's relatives. The new manager had been unable to resolve issues in relation to the lack of rotas in the service before going on leave and the provider had failed to give the service additional support to resolve this issue.

Accurate records of incidents and the support people had received had not been maintained. Information provided by the current manager after the inspection, and about the staffing level achieved in the weeks prior to the inspection, did not match with information gathered during the site visit.
The provider had failed to address and resolve the breaches of regulations identified during our previous inspection in June 2021.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 23 September 2021). The Commission took enforcement action following that inspection and warning notices were issued in relation to breaches of regulations 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
In addition, the provider was asked to develop action plans detailing how breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 would be addressed.

At this inspection we identified repeated breaches of these four regulations and additional beaches of the regulations were also identified.

The service has now been rated inadequate. This service has been rated requires improvement for the last four consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about how the provider was safeguarding people from abuse. A decision was made for us to inspect and examine those risks.

In addition, we undertook this inspection to check whether the Warning Notices we previously served in relation to Regulation 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.
As a result, we undertook an inspection to review the key questions of safe, effective, caring, responsive and well-led.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified that the warning notices issued following the last inspection in relation to staffing and good governance had not been complied with. In addition, we identified repeated breaches in relation to safeguarding people from abuse and notifying CQC of significant events. new breaches in relation to person centred care, safe care and treatment, meeting nutritional and hydration needs, and premises and equipment, were also identified.

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

Follow up
We will meet with the provider following this inspection to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not entirely responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below

Inadequate

Trelawney House

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by two inspectors.

Service and service type
Trelawney House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 did not have a manager registered with the Care Quality Commission. A new manager had been appointed to the service in July 2021 and intended to apply to the commission to become registered. Registered managers and providers 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.

What we did before inspection
We reviewed information we had received about the service since the last 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 used all information available to plan our inspection.

During the inspection
We met and spoke with all six people who used the service. We spoke with eight members of staff, the service's current manager, the regional manager responsible for the service, and the provider's Deputy Head of Operations. In addition, we asked to speak with the providers nominated individual, but they were unavailable. We completed observations of the quality of care and support provided in the service's communal areas during both days of our inspection. This helped us to understand the experiences of people who we were unable to communicate with effectively.

We reviewed a range of records. This included three people's care records and medication records. We looked at a staff file in relation to recruitment and a range of records relating to the management of the service.

After the inspection
We reviewed documents requested during the inspection and completed an analysis of staffing levels currently in place and the effectiveness of these staffing levels. We spoke with three people's relatives by telephone and sought and received feedback from four professionals who worked with the service regularly.

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 requires improvement. At this inspection this key question has deteriorated to inadequate. This meant the service was not safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse
At our last inspection we found the provider's systems and processes to protect people from abuse were not operated effectively. When incidents of abuse occurred, they had not been reported to the local authorities safeguarding team for investigation.

At this inspection we found these processes had not improved and this exposed people to ongoing risk of harm.

● Staff at Trelawney House had a good understanding of safeguarding and whistleblowing procedures. When the provider had failed to act to ensure people's safety, following incidents of suspected abuse, concerns were shared about this with CQC and the local authority. A Whistle-blower had reported concerns about three separate specific incidents of alleged abuse involving agency staff prior to this inspection. These issues in combination with other areas of concern lead to this inspection taking place.
● During the inspection we reviewed records of a serious incident where an agency staff member was heard mocking a person while providing personal care and was observed by staff washing the person's hands aggressively. The person subsequently spoke with staff about the incident. Staff reported this to the manager who instructed staff to remove the agency staff member from the service.
● The manager subsequently completed a safeguarding referral form and forwarded this to the provider's nominated individual, as required by the providers procedures, for review and submission to the local authority. This completed safeguarding alert was not submitted to the local authority. No reasonable explanation had been given by the provider, explaining why this alert was not submitted.
● The commission made a safeguarding alert following the first day of the inspection in relation to this incident. The provider initially failed to give the local authority details of the staff member involved and had not made the necessary referral to the DBS in relation to this incident. This meant the risk posed by this member of staff to vulnerable adults was not appropriately managed and people were exposed to ongoing risk of harm.
● A whistle-blower raised concern about two other alleged incidents they reported had occurred in the service. One incident involved the use of a door being held closed by an agency staff to restrain a person, for whom this technique was not approved. The manager and the provider's representative were both aware of this incident when spoken with but no details of the incident or any subsequent investigation were available in the service's records. The provider's representative told us, staff had used incorrect language in their records and that there had not been an unauthorised restraint. The commission asked to see the records of this incident and the investigation completed into the incident, but this information was not provided.
●The third incident was alleged to have involved an agency staff member speaking inappropriately to a

person they supported. No daily records or incident reports had been completed for the person on that day. The lack of daily care records meant it was not possible to establish how the person had been supported on the day of this alleged incident.

● One person needed 2:1 support while they were awake. However, support grids showed that on seven occasions this person had been allocated only one staff member to support them. Safeguarding investigations had previously identified that this person was regularly locked in their room when staff were not with them. During both inspection days we noted this person was locked in their room contrary to DoLS conditions introduced in response to the previous safeguarding investigations. This meant the person's rights and freedoms were wrongly restricted.

The provider did not have appropriate systems in place to protect people from abuse. This was a repeated breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At the last inspection the provider had failed to provide sufficient numbers of staff to ensure people living at the service were safe. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● At our last inspection the registered manager told us, a minimum of six staff on duty were needed to keep people safe. A handwritten amendment had been made to the service's contingency plan recording the emergency minimum staffing level was six. Rotas showed the service had regularly planned to operate at the minimum safe staffing level of six.

● The present manager had reviewed the service's contingency policy and reduced the emergency minimum safe staffing levels. This policy now indicated that a minimum of five staff would be needed to keep people safe. The policy recognised on these occasions staff would be unable to support people to engage with activities or tasks. We were not provided with an explanation as to why the manager believed fewer, less experienced staff were sufficient to keep people safe. No reduction in people's specific support needs had been identified since our last inspection.

● Prior to the inspection the commission received information of concern in relation to the staffing arrangements at night. As a result, the first day of this inspection began shortly before 07:00 while night staff were on duty in the service. We found the service had operated at emergency minimum staffing levels overnight, as there had been only one waking night staff member on duty with two sleep in staff available if required.

● However, there were shortages of night staff at Trelawney House and records showed the service was regularly planning to operate at the emergency minimum safe staffing levels. Staff reported the service only currently had one full time member of night staff available. A staff member told us, "One waking night staff is off sick, one left, one is on holiday and so [we] only have one waking night staff". This shortage of night staff meant day staff and agency staff were having to be used to cover night shifts. Staff told us, "It should be two waking and one sleeping but we have been running on one waking night [and two sleep ins]" and "It is getting more normal to be two sleep-ins and a waking". On the 27 September records showed the service had been unsafe overnight as only two staff had been present in the service.

● At this inspection, we again found the service had a high number of staff vacancies and that agency staff were routinely being used. Staff said, "We have lost a lot of staff recently" and "We have lost so many [staff], it is an endless string of [staff] who have been leaving". The manager told us, "[There are] nine vacancies in total" and an additional two staff had planned to leave the service during the week of the inspection. This

further reduction in staffing had the potential to further impact on people's choice of activities and the quality of support they received.

● The service did not have an operational rota in place at the time of the inspection detailing on which days and times staff were due to be on duty. Instead, a support grid detailing which staff were due to support people was being used. Staff told us, "The rota file has gone missing, so we have had a handwritten rota for three weeks" and "Apparently the ideal rota got deleted off the system. We have been trying to get it sorted out for quite a while." The manager reported they had attempted to set up a new rota before going on leave but this had been unsuccessful.

● On the first day of our inspection there was no information available in the service detailing when staff were due to be on duty in the following week. Staff told us this was challenging as not knowing when they would be working meant they were unable to plan when they would need to be at work to support people. This is discussed further in the Well Led section of the report.

● The support grid in use, showed staffing levels for the following two days would be unsafe. This was raised with the provider as a specific safety concern during the first day of the inspection. The provider's representative subsequently provided assurance that staffing levels would be improved. On the second day of the inspection, we found following our intervention that safe staffing levels had been achieved between the two inspection days.

● Due to the limited information available in respect of staff records only staffing arrangements in relation to the 11 days prior to the beginning of the inspection have been reviewed. Information from the support grids was combined with information from the provider's staff signing in books and digital clocking in system, to establish the staffing levels achieved during each morning and evening shift. We found staff were regularly working additional shifts and extra hours in order to try to keep people safe. Staff told us, "Sometimes it's ok here, but its hard work. I'm doing seven shifts this week so doing 57 hours, this is common with staff. Agency are doing up to 70 hours a week" and "I think [agency staff] have one day off per week". On four occasions, only five staff had been on duty to support the six people the service supported. On a further 11 occasions there had been six staff on duty.

The provider had continued to fail to ensure there were sufficient staff available to meet people's needs. The provider had not taken sufficient action to address and resolve issues identified at the last inspection. This meant the provider remained in breach of the requirements of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the manager told us two additional agency staff had been allocated to support the service. It was too early to judge whether this had improved outcomes for people using the service.

● The provider's recruitment practices were safe. Necessary pre-employment checks had been completed for new permanent staff to ensure they were suitable for employment in the care sector.

Using medicines safely

● Records did not demonstrate people had received their medicines safely and as prescribed. MAR charts were incomplete and included numerous gaps in the recording of the administration of peoples' medication. No records had been completed on the support one person had received with their medicines on 26 September.

● A total of six staff had received training in the administration of medicines. However, two staff had completed this training prior to 2017, and we did not see evidence to demonstrate staff competence to manage people's medicines had been regularly reviewed and assessed. Medicine's audit had been completed but these systems had failed to ensure records were accurately maintained.

The provider had failed to accurately document the support people received with the medicines. This

contributed to a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were still kept in a locked cabinet in the staff office. No action had been taken to address the recommendation issued following the last inspection, that people be offered the option of their medicines being stored in their own rooms, in line with best practice.

Assessing risk, safety monitoring and management
● One person's mobility was declining, and staff were concerned for their safety while using the stairs. They told us, "[Person's name] has fallen down the stairs multiple times so it is best to have one staff in front and one behind when [they] are on the stairs". There were no falls risk assessments in place for this person on the first day of our inspection and the lack of detailed daily records meant it was not possible to establish how often the person had fallen. Another staff member told us the person had twice needed hospital treatment following falls in the last year. The manager completed a falls assessment for this person only after the second day of our inspection.

The provider had failed to ensure falls risks were appropriately managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people could behave in a way which put themselves or others at risk. These risks had been assessed and staff had been provided with guidance on possible triggers for these behaviours and detailed guidance on how they should support people when anxious or distressed.
● Personal emergency evacuation plans were available detailing the support people would need in the event of an emergency.

Preventing and controlling infection
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. However, we did not observe high contact point cleaning during either day of the inspection.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong
● The provider did not have an appropriate and robust system in place to ensure lessons were learned following incidents and when staff reported abuse.

This contributes to a breach of regulation 17 (Good governance) 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 requires improvement. At this inspection this key question has deteriorated to inadequate. This meant the effectiveness of people's care, treatment and support did not achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● At this inspection we found people's care and support was not always assessed and designed in a way which improved quality and safety. We found the same issues at the inspection in June 2021. One person's mobility was declining, and they had become unable to come down the stairs from their room upstairs independently. The provider had recognised prior to our September 2020 inspection, that the person needed a downstairs room so that they could have reasonable quality of life. Staff recognised that the stairs restricted the person's freedoms and commented, "The change of bedroom has been talked about for some time". No action had been taken to resolve this issue at the time of our inspection. This meant the person's ability to move around independently had been unreasonably restricted.

This contributed to the ongoing breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Please see the well led section for additional details.

●The providers assessment processes had been ineffective in identifying and recognising the likely impacts of people moving into the service on others. Issues in relation to ongoing noise levels in the service and the impacts on people's wellbeing are discussed in detail in the caring section of this report.

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). When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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.

● The provider was failing to comply with two people's DoLS conditions at the time of our inspection. A reporting condition, designed to ensure plans were developed to address one person's changing support needs, had not been completed within set timescales.
● Another person's DoLS conditions had been recently updated following safeguarding investigations and shared with the manager. Staff were unaware of these updated conditions and, during both days of our inspection, staff were observed engaging in practices contrary to the person's updated DoLS conditions.
● During the second day of the inspection, we noted the manager had some knowledge of the updated DoLS conditions, but no action had been taken to change staff practices. As a result of the seriousness of these issues, the commission wrote to the provider urgently, to seek assurance these DoLS conditions would in future be complied with.
● Some assessments of people's capacity to make decisions had been completed and best interest decision making recorded. However, these processes tended to relate to generalised issues, for example consenting to planned care, as opposed to a specific decision that needed to be made.

The provider had failed to comply with DoLS conditions issued by the authorising authority. This was a breach of regulation 11 (consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Training had not been regularly updated to ensure staff had a good understanding of current best practice in the care sector. The training matrixes shared by the manager following the inspection showed that a staff member had not completed any training since 2013 and that a second staff member had not completed any training since 2016. This document identified that training for seven of seventeen staff was out of date, including in relation to safeguarding adults, health and safety awareness, first aid and fire safety. In addition, the manager had received no training from the provider. This meant people were being supported by staff who did not have the skills to meet people's needs.
● Experienced staff recognised there was a significant range in the skills and knowledge of agency staff in relation to positive behaviour management techniques. One established member of staff commented, "You can tell who had on-line and who had face to face training. Those who did on-line training are less confident."
● A one-day 'Induction to Spectrum' training package had been developed to give agency staff a basic understanding of the provider's values, before they began working in individual services. The provider did not have full access to records of any training agency staff had completed. When asked by inspectors, agency staff were reluctant to provide details of their previous experience in the care sector. A relative told us, "I am not impressed with all the agency staff I have seen. They are learning their way, but I know staff are not happy that agency staff do not know what they are doing".

The providers failure to ensure staff skills were regularly updated forms part of the breach of the requirements of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had not received supervision from the current manager but a staff meeting, and leadership meeting had been completed.
● In response to the COVID pandemic, new spectrum staff completed a two-week online training programme before they began working at Trelawney House. On arrival in the service new staff normally shadowed an experienced member of staff for a small number of days before they were permitted to provide

support independently.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff did not support people to eat and drink in accordance with their recognised care needs and this put them at risk of not getting enough to eat and drink. One person's care plan identified they needed to sit at a table and be accompanied by staff to prompt them to eat during their meals. Staff were aware of this need. However, the person was served a meal, not at a table. They were left alone and were not provided with staff support to prompt them to eat. The person did not engage with their food until prompted by a passing member of staff and then only engaged for a short period and ate little. The commission wrote to the provider following the inspection to obtain urgent assurance that there would be staff support for the person so that they would eat and drink enough.

The provider had failed to effectively meet people's nutritional needs. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● Areas of the service remained in need of updating. The previous two inspections identified that the carpets on the first-floor landing were heavily stained and in need of replacement. At this inspection we found that this issue remained un-resolved. At the last inspection the registered manager told us these works had been delayed by lock down restrictions but that carpets had been ordered and would be fitted soon. At this inspection the current manager again reported the carpets were due to be replaced. However, no evidence was provided detailing when these works were due to be completed.
● Flooring throughout the service was visibly dirty with small items of debris present in corners of communal spaces. The cleaning of high contact areas to manage infection control risks associated with COVID-19 was not observed during the inspection.

The provider had failed to ensure that the premises were kept clean. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the last inspection two static caravans had been installed in the service's grounds to provide accommodation for agency staff. Although there had previously been plans to install outdoor play equipment in this area, people had not routinely used this area before the caravans were installed. The installation of the caravans had not adversely impacted on the recent improvements made by relatives and staff to the outdoor areas people accessed regularly.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were supported to access external health and care services as necessary. Hospital passports had been developed and were used to ensure medical staff had a good understanding of the support needs of people in their care. One person was admitted to hospital during the second day of our inspection and was accompanied by staff to provide support and reassurance.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to requires improvement. This meant people were not supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

● This inspection began just before 07:00 in the morning as the commission was concerned about night staffing arrangements and wanted to check that issues identified during the July 2019 inspection in relation to noise levels at night and in the early morning had been resolved.
● At this inspection we found people were regularly disturbed at night as a result of other's behaviours and routines. On arrival on the first day of the inspection the service was initially relatively quiet but from 07:40 onwards there were significant noise levels present which prevented people from sleeping. Night staff told us it had been a disturbed night. One person told staff they were tired and had not slept well, because of noises made by another person whose room was on the opposite side of the building.
● Night staff records showed there were limited opportunities for people to sleep at night because of noise levels in the service. On both nights prior to our inspections noise levels overnight had been significant and people's sleep had been disrupted. Staff told us, "[Person's name] is opposite [two people's names], they do get disturbed at night. I would say five out of seven nights [person's name] does not sleep. [The person] normally shouts quite loud, banging on the floor…." and "They (the people living at Trelawney House) are all tired". Other staff reported this situation had "got worse", that disturbed nights had been, "more frequent recently" and that this was impacting on people's wellbeing.
● Relatives told us that lack of sleep meant people were often tired and therefore unwilling or unable to participate in activities in the service or during home visits. Relative's comments included, the "Sleep issue is a real issue for [My relative]. It has been going on for a good 3 years, you and I would not be able to put up with it. [My relative] starts worrying about it" and "Last week, three nights, it was a very disturbed week. [We] had a home visit, [person's name] was phenomenally tired and it does affect what [they] want to do. It is not rare, [my relative] does not get regular sleep." One person's relative told us because of the issues with noise levels at night they had asked for their relative to be moved to another service.
● During the inspection we observed a range in the quality of interactions between people and the staff who supported them. We noted examples of both Spectrum and agency staff interacting positively and compassionately with people while providing support and having fun together. However, we also observed occasions where staff failed to act in response to people's needs during both days of our inspection. We noted that one person for whom two to one support was commissioned was locked in their room without staff being available to provide immediate support if needed. In addition, staff reported, during the inspection, a number of incidents where staff behaviours, including incidents where staff had shouted at each other, had caused people anxiety and impacted on their wellbeing.
● The significant staff turnover meant some staff had only a limited understanding of people's specific

individual needs and preferences. Staff reported the high level of staff turn-over had impacted on people's sense of security. One staff member told us, "[Person's name] is anxious, there have been a lot of changes, [The particular staff member] leaving as they are extremely close. [The person] gets quite focused on maintaining [their] routine and knows that there are gaps [in the rota]". During the second day of our inspection this person was anxious to talk with this ex-staff member, who had offered to stay in contact as a friend.

● Relatives recognised the impact of staff turnover and told us, "The problems with staffing are not helping the situation with [My relative], four new agency staff. I think [My relative] has found it disruptive" and "There is a huge turnover of staff which is a significant issue."

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

● People were sometimes involved in making decisions about their care and how they spent their time. However, plans people had been involved in developing were not always followed. We observed an occasion where a 'now and next' communication tool was used to help a person understand they would be going out for lunch. However, support to complete this activity was then not provided, and the person did not leave the service on the day of the inspection.

● There were systems in place designed to enable people to provide feedback on the quality of support they had received.

Respecting and promoting people's privacy, dignity and independence

● People's privacy, dignity and independence was not always promoted at Trelawney House.

● Commissioners and professionals had identified concerns in relation to male staff supporting one female person when bathing. As a result of these concerns a DoLS condition had been introduced that required the person to be supported by at least one female member of staff when bathing to ensure her dignity was protected. This condition had not been complied with and the staffing allocation in use at the time of our inspection included occasions when this person was supported exclusively by male staff.

● As detailed in the effective section of the report the provider had not acted promptly to make changes to the lay out of the building in response to a person's declining mobility. This failure had limited the person's independence and made them much more dependent on staff.

● Support and encouragement for people to do things for themselves had declined since our last inspection. Staff now often offered to make drinks for people as opposed to supporting and encouraging people to complete these tasks.

Noise levels at night prevented people from having adequate sleep and people's dignity had not always been respected. In addition, the high turnover of staff meant people's individual needs were not fully understood or met by staff. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

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 insufficient evidence to rate. At this inspection this key question has deteriorated to requires improvement.

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

● People's care plans were lengthy documents which were not fully understood by the staff. Staff told us, "The care plans are very detailed and offer good guidance but as they are so detailed it takes a while to absorb all the information".
● Where specific support needs had been recognised and appropriate guidance provided, this was not always understood and followed by staff. For example, one person's care plan, last reviewed in June 2021, identified that due to their declining mobility and associated pain the person should no longer use the service's minibus. However, this person's relative had complained about the use of the minibus for a trip home in October 2021 saying, "Its near cruelty [Person's name] getting into the van".
● Guidance provided by involved professionals had not been adopted promptly and incorporated into people's care plans.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Daily care records had not been consistently and accurately completed. We found a significant number of records were missing. This meant it was not possible to establish what support people had received each day. The manager had identified that records were not being appropriately maintained, but had been unable to resolve this issue. Professionals reported that the lack of consistent recording was a significant challenge to supporting people and told us, "Recording has been a long standing issue noted in MDT (Multi Disciplinary Team) meetings with professionals, making it difficult to understand the function of behaviours that challenge and potential triggers".
● Staff understood the importance of completing accurate daily care logs but recognised these had not always been completed. Staff told us, "A lot of recording issues are because agency staff have not had passwords to get in (to the IT system), but that has been sorted and we have asked them to catch up."
● The provider operated a digital record keeping system and staff had access to a paper-based recording system for use when the digital system was non-operational. This occurred relatively frequently as a result of poor connectivity and limited availability of IT devices. The manager told us, "The internet [access] is very poor". Paper based records had not been completed when required and did not provide the information missing from the providers digital recording system.

The failure to accurately plan and document details of the care provided forms part of the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation

● Noise levels during parts of the day were a significant issue which impacted on people's wellbeing and ability to use their communal spaces. Two people did not get on well together, one person would scream and become anxious when the other person entered a shared communal space. This also had the potential to upset other people using the service.

● During the first morning of the inspection we observed one person screaming loudly when the other person entered the room. The first person was overheard stating they did not like the other person, who was actively insulting them. Staff attempted to manage the situation with a combination of distraction techniques and reassurance, but it was clear these two people did not like spending time together. This not only impacted on them but also on the other people living in the service.

● Professionals had identified that a third person was particularly sensitive to noise levels and when distressed or in pain would shout or bang on their floor, which was immediately above the service's communal space. The interaction of this person behaviours with those of the two people who did not get on together meant the services communal space was routinely very noisy.

● A fourth person had also been assessed as being sensitive to noise levels, they had become increasingly withdrawn and were spending more time isolated in their room. Staff described how they now only tried to encourage this person to come downstairs when the other people were out. However, they reported the person now often became distressed when supported to access communal areas of the service.

● Professionals were aware of these adverse interactions between people living at Trelawney House and told us, "Some of the residents have behaviours that challenge that impact on each other, and this means that at times the home can be chaotic and very loud." Staff recognised that individual's behaviour had adverse impact on others and told us, "I would say it has been like this for a year or so but it is getting worse."

The provider had failed to manage the impact of individual's behaviour on others within the service and this had led to some people becoming increasingly isolated. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff supported people to maintain relationships that were important to them. One person received a letter from a relative during the inspection, staff read the letter to the person and supported the person to compose a reply.

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's care plans included information about their specific communication needs and preferences. A number of people the service supported used some Makaton signs to aid their communication. However, staff told us, and the training matrix confirmed, only one member of staff had completed Makaton training. The lack of this knowledge limited staff ability to communicate effectively with the people they supported and meant people had the potential to be disadvantaged.

The providers failure to ensure staff had the skills to communicate effectively with people forms part of the breach of the requirements of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Additional specific communication tools had been used to help people process and understand complex

information. A social story had been developed to help one-person process information about a staff members departure from the service.

Support to follow interests and to take part in activities that are socially and culturally relevant to them

● The service is located in a rural location with no public transport links meaning people were usually dependent on staff and the availability of drivers to access the local community. Staff had worked together to enable people to access some activities despite low staffing levels. During both days of our inspection the majority of people spent all their time in the service and were not supported to engage with the community by travelling out of the service.

● One person worked in a garden centre locally which they enjoyed, and another person was regularly supported to attend a community group. Staff told us they varied the start times of their shifts to ensure sufficient staff were available, at particular times during the day, to enable people to leave the service for scheduled activities.

● Staff recording of people's engagement in activities was again incomplete. We found records maintained by one person who liked to keep their own daily records were more informative than those maintained by the staff team. Professionals told us, "Activity levels in the home is also a concern and missing records has meant that it is difficult to ascertain how much activity each resident has" and "Although staff assure you [activities] have taken place. Due to lack of recording, when professionals are required to understand why a person is disengaging from activity, it cannot be ascertained".

Improving care quality in response to complaints or concerns

● The provider did not have robust systems in place to ensure all complaints were recorded and investigated.

● The manager had re-introduced a complaints log on 3rd October 2021. Two complaints had been received on the day the complaints log had been reintroduced and were in the process of being investigated.

The failure to accurately record details of the activities people engaged and to document complaints prior to 3rd October 2021 with forms part of the breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

At the previous two inspections this key question was rated as requires improvement. At this inspection this key question has deteriorated to Inadequate. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not support the delivery of high-quality, person-centred care.

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

At our previous inspection we found that the providers systems for reporting safeguarding incidents in a timely manner were ineffective. Safeguarding incidents that occurred at Trelawney House had been reported to the provider's senior management team but not appropriately shared with the Local Authority or the Commission.

At this inspection, as detailed in the safe section of the report, we found the provider had again failed to make necessary and appropriate safeguarding referrals. A safeguarding referral form completed by the manager following an incident of alleged abuse had not been forwarded to the local authority by the provider. When asked about this the provider's representative was unable to provide an explanation as to why this alert was not made.

● Following the second day of the inspection the commission wrote urgently to the provider seeking assurances that DoLS conditions would be followed, appropriate support provided at mealtimes and staffing levels increased to ensure people's safety. The provider's initial response to this letter did not give the necessary assurance in relation to all of the issues raised. It was necessary for the commission to seek further assurance from the provider that they understood the seriousness of these issues and would act immediately to resolve them.
● The provider's record keeping systems were ineffective. Daily care records were not accurately maintained and documents necessary to establish the staffing levels achieved in the service were unavailable when required by CQC. Professionals told us the lack of accurate records meant it was difficult to identify causes of particular behaviours.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;
● The service's registered manager had resigned and was working out their notice period at the time of our last inspection. A new manager had been appointed and had begun working in Trelawney House in July 2021.
● Relatives and professionals reported it was difficult to communicate with the new manager. Relative's comments included, "The new manager is very different" and "I have had meetings or discussion with the

new manager, she talks over you, she does not listen and is very rude." While professionals told us, "Email communication with [the new manager] is not generally easy I have found, and in verbal conversation it can be hard to gain clear answers from her".

● Staff had mixed views of their new manager. Some staff were grateful for the opportunities the new manager had offered them, while others felt they were being excluded. Most staff reported that the new manager did not always listen. Staffing comments included, "The new manager has been thrown in at the deep end", "The new manager, I don't think she is much of a people person" and "The new manager is not everyone's cup of tea, I have not had any issue with her but I can see why some people do".

● Low staff morale was an ongoing issue at Trelawney House that had not improved since our last inspection. One relative told us, "I know there are 10 staff who were not happy, and I pointed out the danger of losing additional staff. My big concern is that experienced staff are leaving, and I know staff are anxious about coming to work, it is not all about the shortage of staff in the industry". During the inspection two staff resigned from their posts. They told us that did not feel valued by the provider and this had contributed to their decision to resign.

● There was no rota in place at the time of our inspection. The base document from which rotas were developed had been lost and the manager had failed to develop an appropriate new rota before going on leave. This meant staff were having to use support grids to plan and manage staffing arrangements in the service.

● The provider and the regional manager were aware of the lack of rotas at Trelawney House. They had failed to ensure this issue was addressed before the new manager went on leave and had failed to provide additional leadership support to the service to resolve this issue during the manager's absence.

● During the first day of our inspection only support grids from 19 September onwards were available in the service. On the second day of the inspection the manager told us they had taken the previous support grids home to ensure these documents were stored securely. The manager subsequently told inspectors copies of these documents were on her computer. When asked the manager was unable to access these records. As a result, we requested that the original support grids, be shared following the inspection.

● We received information from a whistle blower alleging, alterations had been made to the service's support grids to make it appear additional staff had been on duty in the weeks prior to our inspection. On 14 October the manager forwarded to the commission four documents purporting to be support grids covering the period 5 September to 2 October 2021. We compared this information with documents collected during the site visit including the support grids that had been used during the weeks beginning 19 and 26 September.

●We found the information provided did not match the information available in the service at the time of the inspection. We identified over 20 incidents, during two weeks, where staff names had been added to the support grids provided after the inspection. On each occasion, there was no evidence in either the service's signing in book or the provider's time recording system to demonstrate these staff had been on duty in the service. These significant inconsistencies meant it was not possible to clearly assess staffing levels in the service prior to 19 September.

● The provider's quality assurance and support systems were ineffective and had failed to drive improvement in the service's performance. The regional manager responsible for oversite of Trelawney House at the time of our last inspection had resigned and another regional manager had been allocated to the service. Although this regional manager had been in regular communication with the manager, they had not visited the service prior to the inspection.

Continuous learning and improving care

● The lack of accurate record keeping in the service meant the provider was unaware of the full extent of incidents and events that occurred in the service. This meant the provider's behavioural team had an incomplete picture of events that had occurred making it difficult for learning to be identified.

● The provider had failed to take prompt and appropriate action to address and resolve the breaches of regulation identified during our last inspection.

Working in partnership with others
● The provider did not work collaboratively with the commission, the local authorities safeguarding team or professionals involved in people's care.
● On the first day of our inspection, there was no rota or staff allocation grid in place detailing staffing arrangements from 3 October onwards. Staff did not know what shifts needed covering or on what days they would be working during that week. This was of significant concern as it increased the risk of unsafe staffing arrangements. As a result, the commission contacted the provider to request that a full staff allocation for the week beginning 3 October be provided by 12:00 on 1 October. This information was not provided on time and no additional support had been given to the Trelawney staff team by the provider to complete this task. The required information was not supplied until the inspector contacted the service directly later in the afternoon of 1 October.
● Information requested by the local authorities safeguarding team following our inspection about the alleged abuser was not provided promptly.
● Health professionals consistently reported experiencing difficulties in accessing information requested from Trelawney House or the provider.

The provider had again failed to ensure people were protected from abuse, had failed to work collaboratively with partners and its systems and processes had failed to drive necessary improvements to the service performance. This means the service remains in repeated breach of regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 new manager had some understanding to the duty of candour and had kept people's relatives informed when significant incidents occurred.
● At our last inspection the provider had failed to notify the commission of an incident where a person had sustained a head injury which required medical treatment. This was a breach of the regulations. At this inspection we again found the provider had failed to submit necessary notifications. A person had again suffered an injury which required hospital treatment for which no notification was made. In addition, no notifications had been submitted in relation to the alleged incidents of abuse by members of agency staff.

The failure to submit necessary notification to the commission is an ongoing breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009:

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff supported and encouraged people to participate in making decisions about what to do in the service each day. However, the staffing situation meant people were often not able to plan activities away from the service.
● Where people had reported to staff that they had been the victim of abuse, the provider had placed no value in this information. The provider had failed to involve victims in subsequent investigations into incidents that had occurred.
● Staff told us there were significant pressures on them to complete additional shifts to meet people's needs. Where risk assessments, had identified it was not safe for specific staff to work with specific people, because of the staff member health needs, these risk assessments had not always been respected. In

addition, staff told us leave authorised by the previous registered manager had not been honoured by the provider.