Spectrum (Devon and Cornwall Autistic Community Trust)

Rose House

Inspection report

Wheal Rose
Scorrier
Redruth
Cornwall
TR16 5DF

Date of inspection visit:
08 July 2021

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19 April 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Rose House is a residential care home providing personal care for up to two people with learning disabilities. At the time of our inspection one person was using the service.

The service is a detached two-storey property with an enclosed garden area at the rear. It is located in a rural area near Redruth, Cornwall.
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.

Based on our review of the Safe, Responsive and Well Led key questions:

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
Due to lack of staffing and more recently, a lack of experienced staff, the person's choices, control and independence were not maximised. They were regularly unable to take part in their preferred activities.

Right care:
The person was subject to several restrictions to keep them safe. Being unable to go out, or use their garden freely, increased the number of restrictions impacting on their life.

Right culture:
The ethos, values and attitudes of senior managers did not ensure the person using the service could lead an inclusive or empowered life. Relatives and staff reported that as a result, the person's skills and abilities were regressing.

People's experience of using this service and what we found
The provider had not ensured the person's needs were consistently met. Low staffing levels at the service meant it had not always been staffed at commissioned levels. When this happened, the person living in the service could not go outside which placed increased restrictions on their liberty. They were unable to regularly take part in their preferred activities and pastimes. Relatives and staff told us this impacted on the person's wellbeing. At the start of the inspection, the new manager was struggling to find enough staff to cover future rotas. They confirmed that any new permanent or agency staff would have to start supporting the person straight away without any opportunity to shadow experienced staff.

The existing staff were leaving and new staff had not had the opportunity for a sufficient handover to fully understand the person's needs. Some of the new staff working at the service had not completed the required practical training to support the person if they became distressed. On the day of the inspection, the staff present had not had opportunity to read the guidance available on how to support the person when they were distressed and had not had opportunity to gain experience of how to support the person outside or in the community. New staff had not had a sufficient handover period to gain sufficient understanding of how the person communicated.

Information provided by the service had not been used to improve the service or care provided. The provider had not ensured that concerns raised with them by relatives, the staff and registered manager had been fully resolved. All reported that communication with the provider was poor.

The provider had not acted to ensure there were sufficient staff in the service or that a comprehensive handover from the outgoing staff was possible. The provider had not ensured the person living in the service was able to achieve good outcomes or was able to live in a service that was in good repair.

Safe medicines management procedures were in place and were followed by staff. We requested evidence new staff working at the service had up to date medicines training, but none was provided.

We were assured that safe infection control practices were being followed in the services.

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

Rating at last inspection
The last rating for this service was Good (published 12 September 2019).

Why we inspected
The inspection was prompted due to concerns received by the commission. These were about the environment in the service, low staffing levels and the impact low staffing levels were having on the person living in the service. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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.

At this inspection we identified breaches in relation to safety, staffing levels and experience, the opportunities available to the person living in the service, the environment and the governance of the service.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 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?

Inadequate

The service was not safe.

Details are in our safe 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.

Rose 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
Two inspectors

Service and service type
Rose 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was leaving the service and a new manager had started working at the service two days before the inspection site visit.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the

service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
The person living in the service was not able to share their views with us, so we observed how they spent their day and how staff interacted with them. We spoke with two members of staff, an agency staff member, the registered manager and the new manager.

We reviewed a range of records. This included the person's care records and a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, staffing data and recruitment records. We spoke with one relative and received written feedback from a second relative. We also spoke with three further staff members.

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 good. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

● The service had not been fully staffed for several months. The registered manager had been requesting an increase in staffing levels since November 2020. In April 2021, they sent an email to senior managers explaining, "I have worked really hard with rota management and certain team members have done lots of overtime to minimise the shortfalls but it has been incredibly difficult, particularly when anyone has annual leave and inevitably there has been a shortfall at times. I am also meant to be off rota but have been one of the 3:1 support team 90% of the time over recent weeks. It is also becoming increasingly untenable, with two pregnant team members, because if Rose House drops to 2:1 they cannot realistically be one of those two, due to the nature of [the person]'s support plan and protocols; thus rota management is now almost impossible, this without the other two imminent departures." Some agency staff had been provided to the service in June 2021, but at the time of the inspection, the low staffing levels had still not been resolved.

● The Provider's Business Contingency/ Continuity Plan showed they had assessed the service as requiring three staff at all times. It further stated that two staff members could be used in 'extreme emergency situations'. However, the service had been staffed with two staff members on occasions that did not fit the provider's description of 'extreme emergency situations'.

● The existing staff team had all left or were due to leave within a week of the inspection, but until the new manager started (two days prior to the inspection), new staff had not been transferred into the team. At the start of the inspection, the new manager was struggling to cover the future rota. Throughout the course of the day when we visited, they managed to increase the number of staff available to work at the service, though not all were available to start immediately. They confirmed that in order to have the correct number of staff on the rota, new staff would need to be put straight on shift without the opportunity to shadow experienced staff. An update on 16 July 2021 showed they still only had three permanent staff available at the service.

● There was continued inadequate staffing on the day of our inspection visit and we did not have confidence that this would be resolved. At the start of the inspection visit, until 1pm, there was one staff member, one agency worker and the new manager at the service. They had started working at the service two days before the inspection and had not previously worked with the person. The person's needs and communication were complex and, though they were familiar with some of the person's needs, the staff present at the service did not have in depth knowledge of for example, the person's routines, communication or sensory needs. At 1pm, a staff member who had worked at the service for several months came to work; however, they were pregnant and therefore were unable to provide direct support to the person.

Systems to effectively deploy staff to ensure people were supported by the correct number of appropriately skilled staff had not been effective and were not robust. This is a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Recruitment records showed appropriate checks were undertaken to help ensure the right staff were employed to keep people safe.

Assessing risk, safety monitoring and management
● Staff were not all trained to respond to the person if they became distressed. Some staff confirmed they had only completed theoretical, rather than practical training. The registered manager told us when practical training had restarted following pandemic related restrictions, there were not enough staff to cover the rota and release staff to attend training. A staff member who had been working in the service for seven months, told us as a result, they would not feel confident if required to physically restrain the person.
● On the day of the inspection, staff were unfamiliar to the person. One staff member confirmed they were not familiar with how to support the person if they became distressed, or what steps to take to help de-escalate the situation, as they had not had the opportunity to read about this in the person's records, or have a handover from more experienced staff.
● When the person left the service, there were risks to their safety which included leaving staff support and running into the path of vehicles. Due to the lack of handover time available to new staff, they did not all have opportunity to gain experience with existing staff members. One staff member told us, "Reading about it and actually doing it are different things. We have been able to show the (new) manager but I don't think it's safe for the new staff to do it without a proper transition. [The person] trying to leave staff is likely to happen. If [the person] sees an opportunity, they will take it."

Failing to ensure there was a sufficient number of staff who were trained to provide safe care is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was an individualised emergency evacuation plan in place for the person.
● Risk assessments were in place to support staff understand how to help reduce any risks to the person.

Systems and processes to safeguard people from the risk of abuse
● The provider's safeguarding process meant registered managers, despite being legally responsible for how the service is run, were not able to raise safeguarding alerts directly with the local authority or the commission.
● A staff member asked the provider to raise a safeguarding alert about the low staffing levels in the service because of the impact they were having on the quality of life of the person living in the service. They stated, "Effectively [the person] becomes a very energetic young [person] who is totally trapped indoors 24/7." No safeguarding alert was raised, and the staff member told us they received no feedback from senior managers.

Using medicines safely
● Procedures were in place to help ensure medicines were managed safely in the service. Staff understood and followed these.
● Staff were knowledgeable about the person's medicines and when they needed to take 'as required' (PRN) medicines.
● Staff told us they supported the person to understand the reason for their medicines and answered any questions they had.
● We requested evidence new staff working at the service had up to date medicines training, but none was provided.

Preventing and controlling infection

● 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.
● The provider was not currently admitting people 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 promoting safety through the layout and hygiene practices of the premises.
● 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
● Staff told us that following an incident, a description of the incident was submitted to an online system delivered by Spectrum. This meant other staff who were present were also able to add information or comments.
● Staff meeting minutes showed the staff team discussed any incidents that had happened, looking for ideas for the future or solutions.

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 Good. At this inspection this key question has deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's 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.

- The existing staff team who were leaving, understood the person's communication needs and enabled the person time to process information.
- The new staff team had not been given sufficient opportunity to learn about the person's communication needs before supporting them. A staff member explained, "There are some fairly complex sounds that mean specific things. We have had new staff misunderstand in the past, you need experienced staff there to explain. If a staff member misinterpreted [the person], there is a lot of frustration for them, they will keep asking and then may throw something out of frustration. It is very important that you understand them and what they are asking of you."

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

- In the months prior to the inspection, the person had not received personalised care that met their needs. Staff had worked with the person to understand their wishes and preferences. However, due to low staffing levels, the person had not been able to go out as frequently as their care plan specified. Staff told us this had had a negative impact on the person and placed unnecessary restrictions on them. Comments included, "It is minimal how often [the person] goes out, and the less they go out, the more difficult it is to get them out. Before, we aimed for [the person] to go out every day and overall, they really enjoyed it. They started wanting to stay out for longer" and "We had made such good steps with developing activities and then [the person] began regressing."
- The provider had a Positive Culture policy which had a stated aim, "To ensure the wellbeing of each individual and achieving positive outcomes." The person's care plan also stated, "It is important that [the person] accesses the outside as much as possible. This is part of the agreement for [the person] living at Rose House but also vital for their health and wellbeing." These plans had not been achieved for the person living at the service. A staff member explained, "We had a beautiful long weekend and [the person] couldn't go out of the door because we didn't have enough staff. The bottom line is that [the person] was not receiving what they needed and deserved." A relative added, "The previous team put action plans together and planned things [the person] would like to do. They've been very good; it's included learning and development. They've worked with […] and really involved them in what they want to do and plans for the

future. I'm really upset because I can see it all unravelling."
● The whole staff team, who had previously worked at the service, had either left or were leaving the week after the inspection. Due to holiday and sickness of existing staff, and the fact that new staff were only just starting at the service, there was little opportunity for handover from old staff to new staff. These staff had not previously worked with the person and were unable to provide details of the person's preferences or needs, or how they preferred their support providing. A relative commented, "They can't get staff who know […] because they don't exist."
● Due to the lack of handover time, new, incoming staff, did not have the experience to ensure the person was able to go out, even when there were three staff available. A relative told us, "Some of the new team never had an opportunity to shadow the departing team and others only had a few days. This has impacted on the service user's happiness, mental health, wellbeing and receiving his full care package."

The provider had not ensured the person was consistently supported in line with their needs and preferences. This is a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff supported the person to develop and maintain domestic skills such as cooking and cleaning; and enabled them to maintain regular contact with family members. Staff had sought the person's views about the service and the support they received.
● Regular staff meetings had been held in the service. These had been used to discuss the person's needs, any incidents and related learning as well as ideas to improve the service.

Improving care quality in response to complaints or concerns
● Relatives told us the staff team and registered manager had been responsive to any concerns they raised.
● The service had not received any complaints.

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 last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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.

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

● Parts of the service were in disrepair. The front door and a toilet cistern were boarded up and light switches and keyholes had been covered with rudimentary boxes. This had been put in place because of the needs of the person living in the service but had not been done in an aesthetically pleasing way that promoted an individualised or homely feel. Paintwork was dirty and chipped and plaster was falling off walls and door frames in several places.

● The provider had not ensured that concerns raised about the service had been resolved effectively or promptly. The registered manager and staff had raised concerns about the maintenance of the building. over a number of months, but limited action had been taken until the week of the inspection. Staff members told us, "Maintenance in the house is disgusting" and "The house has had cracks in it since I started in December."

The provider had not ensured the premises were properly maintained. This is a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Insufficient action had been taken by the provider to ensure the service was fully staffed, even though concerns about low staffing levels had been raised on a regular basis with the senior management team. A staff member told us, "Head office are not doing their jobs properly and the people that are impacted are the people we look after. The only person they are hurting is the person they are meant to be caring for."

● The registered manager had raised concerns about the fact the whole staff team were due to leave in four weeks. A senior manager assured them that the staff team would be replaced on a phased programme to ensure they had a comprehensive handover. This had not happened. A staff member told us, "I don't believe it is a long enough handover. We handed our notice in in June and given new staff time to get to know […]. It didn't happen until this week." A relative told us, "I am disappointed in the organisation. The whole thing could have been avoided. The registered manager and team were brilliant but left out of frustration. They are using agency staff so whoever comes in won't know […]."

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

● The provider's Positive Culture policy had a stated aim, "That Spectrum is a recognised leading provider of autism specific services." This aim was not reflected in the service the person living at Rose House had received. The provider had not ensured the person living in the service was able to achieve good outcomes. The registered manager had raised concerns with senior managers about the impact of the low staffing on

the person; stating, "[…] is absolutely not getting the kind of person-centred care they should right now and this has been the case for some time." Staff told us that frustration related to ongoing insufficient staffing levels had led to them leaving. Staff comments included, "My view is that my role was to give […] the best quality of life and I was unable to do that."

● The provider had not acted to ensure there was a comprehensive handover from the outgoing staff. The resulting lead in time for the new manager and team to get to know the person and understand their complexities and routines was not sufficient. Feedback from a relative included, "Spectrum have lost six experienced, hardworking and caring members of staff and the service user is the one suffering as a result. They have clearly been distressed during the last week and until the new team get to know them, they will not be able to go out into the community or the garden for safety reasons. This has already impacted on their mood and resulted in challenging behaviour."

● The day before the inspection, the dining room had been decorated. At that time, the person was being supported by staff who were inexperienced at supporting them outside, so were restricted to staying inside the property. The decision to decorate the service, placed further restrictions on them as they were unable to access the room being decorated. A relative raised concerns about the timing of the decision to decorate, telling us they felt the decorating had been done in response to a visit from the local authority and had not taken the person's needs into account

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

● The provider had not acted as a strong advocate for the person's rights. A relative told us they were concerned because the garden had not been made secure enough. This meant the person was still restrained even when in their garden. They provided feedback about the service in September 2020, stating "It has been two years since […] moved into Rose House and I am disappointed that works to make the garden area secure and to give […] more freedom have still not progressed." This had still not been resolved at the time of the inspection.

● Most staff gave negative feedback about the provider. They told us they had not had contact with or from senior managers whilst working at the service. Comments included, "Sometimes I feel like they don't care. They don't value staff and how hard we are trying to work. They don't come to the service. I have only seen the person who delivers the stationery and money. We don't see anyone. The managers and the teams need more support from Head office", "The Spectrum website talks about the chief executive often visiting homes to meet with the service users and team members but this has not happened at Rose House" and "I have done the best I can do by saying I'm not going to be part of this organisation. I have left hoping it'll prompt action."

● Staff raised concerns that, despite regularly working over their hours, they were then asked to collect and drop off agency staff who were working at the service but had no means of transporting themselves. The registered manager had explained to senior managers, "The team at Rose House are now almost daily expressing their frustrations and those that have done a lot of overtime are noticeably exhausted."

Continuous learning and improving care

● The provider's Positive culture policy stated, "We will listen to your ideas and wherever practicable, use these to improve our services." However, despite the staff and registered manager regularly raising concerns about low staffing levels and the maintenance of the service via different methods, the provider had not used the information available to make the required improvements. The registered manager sent senior managers an email stating, "I have already raised the majority of my points in the appropriate way (and on several occasions) through my line manager and during business continuity meetings. However, the issues are still apparent and not being addressed."

● Relatives did not give positive feedback about their experience of discussing improvements with the

provider. They told us, "When I have taken anything to head office, they have said that the registered manager should have done it. I had to chase it, but they always try to blame the manager. They have never accepted anything I have said as their fault, they always blame the staff. There is a pattern."

● One staff member told us they had attended an exit interview before leaving the service. They described a list of suggestions they had shared with a senior manager. They then commented, "I felt they weren't really listening. It felt like lip service." Another staff member told us, "People in head office don't listen"

● There were several indicators of closed cultures within the service. For example, the service supported people who were less able to speak up for themselves without good support from the service and the impact of the low staffing levels created further risk factors. These included people not being safeguarded against discrimination, harm and abuse, staff work excessively long hours or overtime and consistent staff shortages. The provider had not taken sufficient action to mitigate the risk of these indicators affecting people's care and support. The failure to understand, recognise and take action to mitigate the risk of a closed culture left people in receipt of poor-quality care.

● Since May 2021, the commission has inspected six other services belonging to the same provider. We have raised concerns about staffing levels at each inspection. The concerns found during this inspection showed the provider had not used learning from these inspections to improve the service.

Working in partnership with others

● The registered manager told us there were no formal arrangements to regularly meet and share experiences or updates with other registered managers within the organisation. They also told us they did not receive regular updates about the organisation and so no longer knew other registered managers within the company. This increased the risk of a closed culture developing in the service.

● A relative told us that communication with staff at the service had been very good but that communication from senior managers had been poor. They commented, "They don't follow things up, it just gets left. I never get a response when I ask why it hasn't been followed up."

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

● A relative told us senior managers had assured them new staff would be starting over a staggered period and this had not happened.

The provider had not taken sufficient action to ensure the person received a high quality service. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The new manager was honest with us about the challenges they faced covering the rota and enabling the person to go out.

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 not ensured the person was consistently supported in line with their needs and preferences

The enforcement action we took:

Required the provider to report to us about this on a monthly basis.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure there were sufficient trained staff to provide safe care.

The enforcement action we took:

Required the provider to report to us about this on a monthly basis.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured the premises were properly maintained.

The enforcement action we took:

Required the provider to report to us about this on a monthly basis.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not had taken sufficient action to ensure the person received a high quality service.

The enforcement action we took:

Required the provider to report to us about this on a monthly basis.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Systems to effectively deploy staff to ensure people were supported by the correct number of skilled staff had not been effective/were not robust.

The enforcement action we took:

Required the provider to report to us about this on a monthly basis.