Spectrum (Devon and Cornwall Autistic Community Trust)

Carrick

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Carrick is a residential care home providing personal care and accommodation for up to five people with learning disabilities or who are autistic. Five people lived at the service at the time of this inspection. One person had their own self-contained accommodation and the remaining four people lived in the main house. The service is part of the Spectrum group who run similar services throughout Cornwall.

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

The service was not able to demonstrate how they were meeting all of the underpinning principles of the statutory guidance Right Support, Right Care, Right Culture.

Right support
One person's support needs had significantly increased, and this had impacted on other people's safety and well-being. Prior to the new manager's arrival in the week prior to the inspection, staff had not received appropriate support and guidance to help them meet this person's needs.

The numbers of staff on duty each day had increased since the last inspection and in the month prior to the inspection the staffing numbers had been safe. However, staffing arrangements at Carrick remained challenging. The service had significant numbers of staff vacancies and had been unable to recruit additional staff. The service had become dependent on a small group of agency staff to achieve the required staffing levels. These agency staff continued to be permitted to work excessive hours each week and had regularly worked over 84 hours per week with limited opportunities for rest. These working practices exposed people and the staff to ongoing risk of harm.

The provider had not made sure that necessary, pre employment checks had been completed for agency staff working in the service.
People were protected from abuse. Appropriate referrals had been made to the local authority when significant incidents occurred. The new manager had a good understanding of local safeguarding procedures.

Right care
Medicines were not manged safely. Records were incomplete and it was not possible to establish if people had received their medicines as prescribed. Staff skills in relation to medicine had not been regularly assessed.
Additional training had not been provided to staff on how to meet people's communication needs. This continued to limit opportunities for people to participate in decision making.
Access to the community had improved for people since the last inspection. People had been offered regular opportunities to go out and people were being supported to engage in more activities. Sensory items were available to people in the lounge and plans were being developed to improve access to the

garden.

Right culture
The culture of the service remains of concern. There was no registered manager in post and limited leadership support had been provided prior to the new manager's arrival in the week prior to our inspection. This, in combination with the small number of agency staff regularly working excessive hours, meant there was a risk of a closed culture developing. This had not been identified and there were no plans in place to mitigate the risk.

The provider has again failed to demonstrate to the commission that there were appropriate systems in place to ensure people were protected from financial abuse. We have shared our concerns in relation to this issue with the local authority.

The provider's quality assurance systems had failed to ensure the service achieved compliance with the requirement of the regulations.
The new manager had impacted positively on staff morale. Staff were complimentary of the new manager's approach and told us, "I have been really impressed with the manager, she is really nice and is a good manager. I know they are looking for a full-time manager and I hope we get someone like that."

The new manager had a good understanding of the Mental capacity act and appropriate applications had been made to the local authority for the authorisation of potentially restrictive care plans.

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 Inadequate. (Report published 17 May 2022). Breaches of the regulations were identified. At this inspection we found not enough improvements had been made and the provider was still in breach of the regulations.

Why we inspected
We received concerns in relation to a significant increase in the number of incidents occurring in the service. A decision was made for us to inspect and examine those risks and the performance of the service. We also undertook this inspection to assess that the service is applying the principles of right support, right care, right culture.

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. This included checking the provider was meeting COVID-19 vaccination requirements.

We have again found evidence that the provider needs to make improvements. Please see the Safe, Responsive and Well-led sections of this report.

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 breaches in relation to Person centred care, Safe care and treatment, Safeguarding, Staffing, Governance and the Fitness of staff to work at this inspection.

Please see the action we have told the provider to take at the end of this report. 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service therefore remains 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service responsive? The service was not always 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**

Carrick

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 2008.

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 carried out by three inspectors over two days. Two inspectors were present in the service on each inspection day. The service's medication management processes were reviewed remotely by a third inspector. The inspection team on the second site visit also included specialist advisor who was a social worker with experience of supporting autistic people.

Service and service type
Carrick 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. However, a manager, registered at another service operated by the provider, was leading the service at the time of this inspection.

Notice of inspection
This inspection was unannounced.

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

During the inspection
We met everyone who lived at the service and spoke briefly with one person about the quality of care they received. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We used our quality of life tool to investigate people's lived experience of care. We also spoke with five members of staff and the acting manager. We reviewed a range of records. This included people's care records, staff rotas and the provider's policies and procedures. Medication records were reviewed remotely.

We continued to seek clarification from the provider to validate evidence found. We looked at incident reports, daily care records and quality assurance information. We also spoke with two people's relatives to gather their feedback on the service's current performance.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

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

At the last inspection we found restrictions to people's freedoms due to the availability of vehicles had increased the risk of incidents occurring which exposed people to risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection vehicles were available to enable people to access the community. However, there had been a significant increase in one person's support needs which had impacted adversely on the other people living in the service. This meant the service remains in breach of the regulation.

●This inspection was completed in response to a number of notifications, received from the service, detailing incidents of aggression and violence between people who lived there. The information provided did not give enough assurance that action was being taken to ensure people were safe at Carrick.
● At the last inspection we noted there had been a reduction in number of incidents involving one person following changes in how their support was provided. In the period following that inspection, this person's support needs had increased significantly. Incidents had occurred where the person had harmed themselves and others. On the first day of our inspection staff told us this person had been upset for four and a half hours earlier in the day.
● Incident and daily care records showed the person had experienced high levels of incidents throughout June. There was limited evidence available to show what additional support had been provided or changes made to how the service operated in response to these changes in the person's needs.
● During the second day of our inspection people attempted to avoid spending time with another person the service supported and exhibited signs of anxiety and possibly fear in response to their actions.
● Staff recognised that the actions of individuals could impact on the wellbeing of others the service supported. Staff reported people had been upset and distressed by other actions and that they felt some people were no longer comfortable in their own home.
● Prior to the arrival of the new acting manager, a week prior to the inspection, there was limited evidence that additional support, guidance or training had been provided to the staff team to enable them to meet this person's increased needs. Some staff had become fearful for their safety and lacked confidence in their ability to meet people's needs.
● Accidents and incidents had been appropriately documented via the provider's digital reporting system. These records had been reviewed by the provider's behavioural team. Prior to the new manager's arrival comments had been added to these records demonstrating they had been reviewed. However, this had not led to additional support and guidance being provided to the staff team in response to the significant

increase in one person's incidents and the harm caused to themselves and others.
● When staff had been involved in particularly complex incidents, limited additional guidance and support had been provided to help them process and learn from their experiences. Staff told us this lack of support had impacted on both their confidence and ability to meet people's needs.

The provider had failed to take timely and appropriate action to manage risk associated with changes in people's support needs. This was a breach of the requirement of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The new acting manager was an experienced member of the provider's team who had begun working in the service in the week prior to our inspection. Following their arrival in the service, the new manager had successfully sought support and practical guidance for staff from the provider's behavioural team.
● On the second day of the inspection one of the provider's behaviour team was present in the service. They were shadowing staff while attempting to gain a better understanding of the meanings of the person's specific behaviours and to differentiate between actions taken to meet sensory needs and those actions which indicted the person was upset or anxious. Staff were engaging positively with the support and guidance provided and told us, "We are working together more as a team, we are moving forward, taking what we have been told and moving with it". As the support had not been in place in a timely fashion, this approach had not been implemented for long enough to assess whether it would sustainably reduce the risk of harm.
● There were two vehicles available to enable people to access the community. The issue, which at the last inspection had restricted people's access to these vehicles, had been resolved and there were staff available on most shifts who were able to drive. One staff member told us, "At the moment we have three drivers plus one additional driver when [staff member's name] returns".
● A Personal Emergency Evacuation Plan was available for each person who lived at Carrick. These documents detailed the support each person would require if an evacuation became necessary.

At the last inspection we found risks in relation to scalding and hot water temperatures had not been appropriately managed. This was a part of breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection these issues had been addressed and the service was no longer in breach of this aspect of the regulations.
● Regular checks had been completed to ensure that water temperatures in the service were safe.

Staffing and recruitment
At the last two inspection we found agency staff were working excessive hours and routinely completing six, 14-hour shift each week. Such long working hours represent an inherent risk to people and the staff who supported them. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, agency staff were continuing to work excessive numbers of hours. This exposed people to ongoing risk of harm and meant the service remains in breach of the regulation.

● The provider continues to experience significant staff recruitment challenges and no new staff had been recruited since our last inspection. Rotas showed there were six and a half full time staff vacancies at Carrick at the time of the inspection.
● Agency staff were regularly working in the service. Agency staff routinely worked six, 14-hour shifts each

week. Staff working these excessive hours meant people and the staff members themselves were exposed to risk of harm. We again identified an occasion were an agency staff member had worked 96 hours in a single week and two other occasions where agency staff members completed 14-hour care shifts on eight consecutive days. Working these excessive hours was unsafe and as it impacted on both the quality of support people received and on staff's ability to rest and recharge.

● The provider had completed risk assessments in an attempt to manage the risks associated with agency staff to working these excessive hours. However, these assessments did not appropriately mitigate the risk of staff falling asleep on shift. As noted at our previous inspection when this occurred it was treated as a staff disciplinary issue as opposed to the predictable consequence of permitting staff to work these excessive hours. We noted two occasions in the month prior to the inspection where agency staff became unwell and were unable to return to work after a single rest day having completed periods of six or more consecutive 14-hour days.

The provider had again failed to ensure enough staff were safely deployed in order to meet people's recognised needs. This was an ongoing breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Necessary pre employment checks had not been fully completed for staff employed by the agency and working in Carrick. Records showed required references had not been gathered from these staff member's most recent employers in the care sector. This meant the provider was unable to demonstrate agency staff had been recruited safely.

This was a breach of the requirements of regulation 19 (fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The five people who lived at Carrick needed support from four staff during the day with seven hours each day when five members of staff were required. This level of staffing was necessary to enable people to access the community when they wished. The service manager confirmed that three experienced staff remained the minimum safe staffing level at Carrick.

● On both inspection days the service was fully staffed. Staff told us there had been an increase in the number of staff on duty each day. Their comments included, "There tends to be more staff", "Staffing has been much better", and "Staffing is the best it has been for a long time, agency staff seem to be a lot better. I would say staffing is a lot better at the moment."

● Rotas confirmed there had been an increase in staffing numbers in the service. We did not identify any occasion were the service had operated at or below the minimum safe staffing level in the month prior to the inspection.

Using medicines safely

● Medicines were not always managed safely. Staff supported people to take their medicines. Medicines administration was recorded on medicines administration records (MARs) but there were gaps, so it was not possible to tell if people had received their medicines as prescribed.

● Staff received training on medicines handling but were not regularly assessed to make sure they had the required skills, knowledge and competence.

● MARs did not contain enough information to make sure that medicines were given safely and effectively. For example, to take with or after food or to swallow whole rather than chewing or crushing. Where medicines taken on an as required basis had a maximum dose that should be taken in a 24 hour period, times were not recorded on MARs. This meant people were at risk of taking too much medicine. However, there was no evidence that people had received more than the maximum dose.

● Guidance was not always in place for some 'as required' medicines. One person needed an 'as required' medicine to help with pain relief. There was no guidance in place to inform staff when this person might need the medicine. This meant the person was at risk of not get their medicine when they needed and experience unnecessary pain.

The provider failed to ensure that medicines administration records were accurate, that protocols were in place for 'when required' medicines and that staff were assessed as competent to deliver medicines support. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At the last inspection we identified concerns in relation to the management of people's financial affairs and requested more information from the provider. This information was not provided. This was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we again asked for information about the management of one person's financial affairs. Some information was provided. However, this did not provide enough assurance that the person was appropriately protected from financial abuse. The service remains in breach of this regulation.

● Whistle-blowers have previously raised with us the concerns that one person living at Carrick was being financially abused by Spectrum. At this inspection we asked repeatedly for details of the financial links between Spectrum and this person. No detailed explanation of the financial relationship between the two parties was given to us. This issue had been raised directly with the providers chief executive, but no appropriate explanations had been provided.
● The commission remains concerned that this individual is exposed to the ongoing risk of financial abuse. Information gathered during this inspection indicated that this financial relationship may not been in the person's best interests. As a result, we have shared this information with the local authority as a safeguarding alert.

The provider failed to provide the requested information about the management arrangements for this person's finances meant it was not possible to establish they were protected from financial abuse. This was an ongoing breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The local authority had recently taken on responsibility for managing two people's finances. This had impacted on systems for supporting them to make withdrawals from the bank. As a result, the provider was having to lend these individuals money to enable them to participate in activities and make day to day purchases.

At our last two inspections people were not always protected from the risk of harm as necessary safeguarding alerts had not been made. This was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found safeguarding alerts had been appropriately made. This meant the service was no longer in breach of this regulation.

● A number of incidents had occurred between people living in the service since the last inspection. These

incidents had been appropriately referred to the local authority as safeguarding alerts.
● The new manager had a good understanding of safeguarding procedures and had sufficient confidence to make alerts to the local authority independently. Staff also understood their role in ensuring people were protected from abuse.

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 new manager had a good understanding of the MCA and recognised the importance of enabling people to make meaningful decisions and choices. People's capacity in relation to specific decisions had been assessed and where people lacked capacity in relation to specific decisions, these had been made in the person's best interests.
● The provider had identified that freedoms of some people who lacked capacity were restricted at Carrick to ensure their safety. Appropriate DoLS applications had been made to the local authority for the authorisation of potentially restrictive care plans. Where changes had been made to people's care plans during these assessment processes the provider had ensured the local authority was kept up to date.

Preventing and controlling infection
● We were assured that the provider was using PPE effectively and safely.
● 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 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.
● People were supported to maintain contact with friends and family. The home was following government guidance in respect of care home visiting. Relatives, people and staff confirmed that visits in and out of the home were supported.

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 Inadequate. At this inspection this key question has improved to requires improvement. This meant services were not always 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.

At the last inspection, the provider had failed to meet people's communication needs which restricted their ability to participate in decision making. This contributed to the breach of the requirements of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found no action had been taken to address this situation and additional training in communication techniques had not been provided to staff. The service remains in breach of the regulation.

● During our last two inspections, we identified that staff needed additional training and support to meet people's communication needs. The provider had previously recognised this training was required and stated it would be provided in 2021.
● At this inspection, Staff had again not received any additional training in the use of signs to facilitate communication. We noted no increase in the use of signs or other aids to meet the communication needs of people living in the main part of Carrick.

The provider had again failed to provide staff with the skills, they recognised as necessary to meet people's communication needs. This meant the service remained in breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In the annex, we observed that staff effectively used specific signs to meet one person's communication needs. Staff were able to explain the meaning of specific gestures the person used regularly. This increased the person's ability to exercise control over their life.

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

At the last inspection people were not being supported to engage with activities and live meaningful lives like ordinary members of society. This contributed to the breach of the requirements of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found people were now more regularly being supported to leave the service. The service is no longer in breach of this part of the regulation. However, further improvements in relation to staff practices are required.

● During this inspection, we again observed periods of minimal engagement by staff with the people they were supporting in the service's communal areas. People spent significant periods of the day in the service's lounge with limited support from staff to engage in meaningful activities.
● Staff did not always enable people to participate in decision making. When a film, one person was enjoying ended, staff spent time channel surfing without involving the people present in deciding what to watch next.

We recommend the provider seeks advice and guidance from reputable sources on the provision of effective person-centred care.

● At this inspection, the sensory box one person required access to was now available. The person was able to access sensory items when they wished and engaged with this equipment at points during both days of the inspection. Staff reported that the re-introduction of this equipment to the lounge had not impacted adversely on others.
● Daily care records showed people were now more often able to access the community. Everyone was now being offered opportunities to go out. Staff confirmed people had been able to go out more often and told us, "We are offering opportunities to go to the pub, woodland walk or out for a drive. [Person's name] is not interested in high end activities, we are trying to make it person centred", "The most important thing is we are getting our service users out" and "[Person's name] needs two staff now when going out, just in case for trip hazards. [They] have been for fish and chips. It is just a pleasure for [them] to go out in the car". Since the last inspection one person had been supported to join a local sports team, which they greatly enjoyed.
● Plans were beginning to be developed to support people to engage with a wider range of more interesting activities. The new manager told us of their intention to develop more a person-centred approach to activities, where people would be offered opportunities to develop new skills and re-engage with their known interest. A water sports lesson had been arranged for one person on the second day of our inspection, but this had to be postponed due to unsuitable conditions.
● Staff and the new manager had identified alterations were needed to the service environment to enable people whose needs were changing to continue to access the service's outdoor spaces independently. These issues had been raised with the provider's maintenance team and plans were being developed to improve access to and facilities in the garden.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● People's care plans provided staff with guidance on how to meet their individual needs. These lengthy documents were difficult for new or agency staff to access and understand quickly.

Improving care quality in response to complaints or concerns
● There were systems in place to enable any complaint received to be investigated and resolved.

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 Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection we found the provider had failed to address and resolve issues previously identified in relation to the management of the service, low staffing levels, excessive working hours and the accuracy of record keeping. This was a breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we again found there was no registered manager in post, that agency staff continued to be permitted to work excessive working hours and quality assurance systems remained ineffective. This meant the provider remained in breach of the regulation.

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

- There was no registered manager at Carrick. The acting manager who had been responsible for the service at the time of our last inspection had left shortly after that inspection. This had meant the service had lacked effective leadership in the period between these inspections.
- A registered manager from another location, operated by the provider, had agreed to take on responsibility for managing Carrick. The new manager told us, "I offered to come across here, do a review and be interim manager, I started officially last Monday."
- The new manager at Carrick intended to be based in the service three days per week and was available to give guidance and support by telephone while working in their other service.
- Staff were complimentary of the new manager and gave positive feedback based on their initial interactions with the new manager. Staff comments included, "[The new manager] is brilliant", "Pretty good at the moment, it is nice having a manager here" and "I have been really impressed with the manager, she is really nice and is a good manager. I know they are looking for a full-time manager and I hope we get someone like that." Due to the temporary arrangement we were not assured the provider had ensured there was stable leadership at the service and positive approaches would be embedded and sustained.
- The new manager recognised significant improvements were needed to enable the service to meet people's needs. They had requested and had been provided support from both the provider's facilities management and positive behaviour support teams since they took on responsibility for Carrick. During the inspection, we noted this support was beginning to impact positively on the service's performance, but we could not assess whether this would be embedded and sustained. Staff were receiving practical guidance on how to meet people's support needs and maintenance issues were now being addressed. Further improvements were planned to declutter and upgrade the service's outdoor spaces.
- The provider had also appointed three staff to other leadership roles within the service. A positive

behaviour support lead and two senior carer posts had been filled. However, there was limited evidence available to demonstrate these staff had been provided with additional training or support to enable them to fulfil these new roles.
● The provider continued to operate a digital recording system. This system did not enable staff or the manager to view daily care records in chronological order. Although it remained difficult to quickly identify missing care records, we found there had been an improvement in the quality and accuracy of the information recorded.

The provider' had failed to ensure there was a registered manager in post. This failure contributed to the breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care
● The provider did not demonstrate they had implemented a learning culture at the service. The provider had continued to allow agency staff to work excessive hours as they had been unable to recruit additional permanent members of staff. These working practices continued to expose people and staff to risk of harm as detailed in the safe section of this report.
● The provider's quality assurance systems remained ineffective and a number of repeat breaches of the regulation have been identified during this inspection. No additional audits of the service's performance had been completed by the provider since the February 2022 inspection. Although meetings had been held at provider level about the issues identified during that inspection, no details of these meetings or any actions identified as necessary to improve the service's performance were available in the service.
● Relatives were concerned that the provider was continuing to struggle to meet people's needs. There comments included, "I do not feel very comfortable with the place at the moment, I do not feel it is reaching the standard it should" and "I hope Spectrum can stabilise itself."
● Staff had not been given prompt and appropriate support from the provider's behaviour team in response to the significant increase in one person's behaviours that was harming themselves and others prior to this inspection. Incident records had been read and reviewed by the behavioural team and the significant increase in frequency recognised. However, limited additional practical support or guidance had been provided.

The provider had failed to appropriately manage agency staff working hours and to ensure compliance with the requirements of the regulations. This contributed to the breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the last inspection, staff had been unable to access support and guidance form managers when incidents had occurred outside of office hours. At this inspection records showed this situation had improved and staff had been able to access support from the providers on-call managers when required.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The culture of the service remains of concern. There had been a lack of effective oversight by the provider since the last inspection and limited management support prior to the most recent new manager's arrival in the week prior to this inspection. The provider had recognised that additional senior managers were required to support its services. A recruitment campaign was underway for additional regional managers to meet this need.
● The service was entirely dependent on a small number of agency staff, working excessive hours to enable

people's needs to be met. This combined with the lack of consistent and effective leadership in the service since the last inspection meant there was a significate risk of a closed culture developing which could significantly adversely impact on people's well-being. The provider had not identified or addressed these risks.

● We again found people's equality characteristics were not fully considered and support the provider had recognised as necessary, to enable staff to meet people's communication needs had not been provided.

The provider had failed to manage the risk of a closed culture developing at the service. This contributed to the breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● The service had worked with appropriate professionals to ensure people's health needs were met.

● Staff had identified possible opportunities for people to engage in voluntary work placements. The staff team were working collaboratively with a prospective employer to develop a placement tailored to one person's specific interests.

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 a good understanding of their responsibilities under the duty of candour and intended to ensure people's relatives were kept up to date.

● The new manager was open and honest throughout the inspection process. They recognised significant changes were required to meet people's need and had begun taking action to improve the service's performance.