Spectrum (Devon and Cornwall Autistic Community Trust)

Rose House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
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 or autistic people. At the time of our inspection one person was using the service. It is part of the Spectrum (Devon and Cornwall Autistic Community Trust) group, a provider with 15 other similar services across Cornwall. 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.

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

The service had not made sufficient improvement since the last inspection to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support: The service remained short staffed. This limited opportunities for the person to be supported to leave the service and meant it had not been possible for the person to engage with activities they were known to enjoy.
Right care: The person was subject to several restrictions to keep them safe. They were unable to access the service's outdoor spaces or the community without significant staff support.
Right culture: The morale of the staff team had improved, and the person was now being supported to regain some skills they had lost. Relatives recognised staff had developed positive and supportive relationships with the person.

At this inspection we found that although there had been improvements in staffing arrangements since our last inspection, there were still insufficient staff available to meet the person's support needs. This limited the person's freedoms and ability to engage with activities.

Low staffing levels in combination with unsuitability of the service's garden meant the person was unable to go outside without significant restrictions in place. This had prevented the person from engaging in some of the activities they enjoyed.

Fire risks had not been appropriately managed prior to this inspection. Firefighting equipment was serviced promptly once this issue had been identified during the first day of our inspection.

Some improvements had been made to the service's environment since our last inspection. However, additional works were still necessary. In addition, at this inspection we found the person's vehicle had not

been regularly cleaned, and that a staff bathroom was poorly maintained and lacked appropriate equipment for the disposal of hand washing waste.

Staff now understood how to manage specific risks in relation to the person's support needs and the manager recognised the importance of, where possible, reducing restrictions within the service.

Medicines were managed safely and staff understood their role in protecting people from abuse.

Staff had received appropriate training and support. They had developed the skills necessary to meet the person's needs and were gaining confidence in their abilities.
Staff had spent time getting to know the person and now had a good understanding of the person's individual needs and preferences. They spoke positively of the person they supported and relatives told us, "The staff have done well. [My relative] seems much more settled".

Information on the person's individual needs was fully documented. A shortened version of the person's care plan had been developed to help new staff quickly gain some understanding of their specific needs. Staff now understood the person's communication needs and were able to communicate effectively with the person. The manager was providing effective leadership to the staff team, whose morale had improved.

Relatives were complimentary of the manager and reported that the service communicated effectively with them. Visiting was actively encouraged and the person had been supported to maintain these relationships.

Although the provider's systems had driven some improvements in the performance of the service, more work was needed to achieve compliance with the regulations.
We were assured that safe infection control practices were being followed in the service.

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 Inadequate (published 22 September 2021). At this inspection some improvement had been made but the provider was still in breach of regulations. The service is now rated inadequate in Safe, Responsive and Well led.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. 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.
You can see what action we have asked the provider to take at the end of this full 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. At this inspection although improvements have been identified the service remains in breach breaches of the regulations relating to safety, staffing levels, opportunities to go outside, the environment of the service and governance. 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 until we return to visit as per our reinspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service 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 always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not entirely caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

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
The inspection was completed over two site visits. Each visit was completed by two inspectors. In total three inspectors participated in this inspection.

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 did not have a manager registered with the Care Quality Commission. A 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. 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
We met and spoke with the person living at Rose House. We spoke with four members of staff, the service's manager and the provider's Nominated Individual. We observed staff as they supported the person with their routines on both days of the inspection. This helped us to understand their experience of living at Rose House.

We reviewed a range of records. This included care records and medication records. We looked at 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 in place in the month prior to the inspection. We also spoke with two of the person's relatives to gather their feedback on the service's performance.

Requires Improvement

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 we only looked at part of this key question and so were unable to provide a rating. At the inspection prior to that on 8 July 2021, this key question was rated as inadequate. At this inspection this key question has improved to requires improvement. This meant the service was not entirely safe and there was limited assurance about safety.

Staffing and recruitment

At the last inspection the provider had failed to provide sufficient numbers of staff to ensure the person living at the service was safe. Prior to our last inspection the registered manager and entire staff team had resigned. A new staff team had been recruited but there had been insufficient time to enable an effective hand over of knowledge and skills to the new staff team. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found some improvements had been made but the service was still regularly short staffed. This unnecessarily restricted the person's freedoms and choices. As a result the service remains in breach of the regulations.

- The person had been assessed as requiring support from three members of staff at all times during the day and two members of staff at night. The emergency minimum staffing level was defined as two staff members during the day and one waking and one sleeping staff member at night. At emergency minimum staffing levels it was not possible to engage the person in activities within the service or enable them to go outside.
- Recruitment to adult social care posts had been challenging in the period since the last inspection and the provider had been unable to recruit sufficient additional staff to meet the person's support needs. The manager told us, "[We have been] unable to recruit any additional night staff so have had to accept one waking and one sleeping staff."
- In response to staffing challenges, in this and a number of other services operated by the provider, the use agency staff had been introduced. Two members of agency staff had been based in the service for most of the time since our last inspection. They knew the person well and understood their support needs.
- At this inspection we found there had been some improvements in staffing levels within the service. Records showed staffing levels had not dropped below emergency minimum staffing levels in the last month and staff told us, "It has always been two [staff] on shift, so it was never unsafe. Staffing has absolutely improved. I definitely feel more comfortable and [the person] is definitely more comfortable with us. We are starting to see sides of [the person] that we did not before. [Their] sense of humour".
- Relatives recognised there had been some improvement in staffing levels and consistency, since our last inspection. They told us, "The staff team is more consistent, there has only been one new agency staff recently".
- However, there had been a number of occasions in daytime hours, when the COVID pandemic had not

directly impacted on staff availability, that the service had operated at emergency minimum staffing levels since the last inspection.
● We completed an analysis of staffing levels achieved in the service in the month prior to the inspection. Of the 60 day shifts reviewed the service had operated at emergency minimum staffing levels for 18 shifts. Staff told us, "With two staff it is not an ideal situation, but the communication is pretty good and we adapt to it and keep [the person] safe" and "When we have three [staff] on you can get [the person] out and get them active. Those are the most rewarding days, [the person] really thrives on that". When operating at emergency minimum staffing levels, the person's freedoms and the staff team's ability to offer opportunities to go outside, were unacceptably restricted.
● The service was struggling to retain staff and was increasingly dependent on agency staff to meet the person's needs. The manager told us, "We have just lost two staff, we have recruited a member of agency staff to cover their hours." In the week prior to our inspection, agency staff have worked 137 day shift hours, Spectrum staff had completed 115 day hours and the registered manager had completed 61 day hours and 10 hour waking night shift. This demonstrated the service did not currently employ sufficient permanent staff to meet the person's support needs.
● One additional member of agency member of staff had recently been allocated to work at Rose House. On their fourth day in the service, this new agency staff member had been required to work with one other member of staff to support the person. At that time this member of agency staff was not sufficiently skilled to support the person, who it took time to get to know and build a trusting relationship with. This member of agency staff did not have the skills and knowledge required to support the person safely and in line with their preferences. This put the person and staff team at risk.

Sufficient numbers of appropriately skilled and competent staff had not been consistently deployed to meet the person's needs. This is a repeated breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● 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.

Assessing risk, safety monitoring and management
At the last inspection the provider had failed to ensure people received safe care as staff did not have the skills to meet the person's needs when upset or distressed. 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 we found improvement had been made in relation to risks associated with the person's supported needs. Additional failures in relation to the management of fire risk were identified at this inspection. This meant the service remained in breach of regulation 12.

● The person's care plan included detailed and informative guidance for staff on the management of risk both within the service and when accessing the community. This guidance was understood by staff who were gaining confidence in meeting the person's specific needs. Relatives told us, "I feel staff are getting a better understanding of [persons name's] behaviour and how to manage it and keep [our relative] safe." This meant the previous breach of this regulation had been addressed.
● However, fire risks had not been managed safely. Timely action had not been taken to address issues identified during a recent inspection by the fire service, a missing kitchen ceiling tile had not been replaced and the service's fire risk assessment had not been updated. In addition, on the first day of our inspection firefighting equipment had not been serviced and routine safety checks on the service's electrical circuit had not been completed.

The provider had failed to manage fire risk within the service. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager and staff team took prompt action, in response to feedback provided, and by the second day of the inspection the firefighting equipment had been serviced.

● The manager recognised that the person experienced significant restrictions to their freedoms. The manager was focused where possible, on reducing restrictions to improve the person's quality of life, while maintaining their safety.
● Incident records showed staff now understood how to meet the person's support needs when upset or anxious. When interventions had been necessary to ensure the person's safety these techniques had been used appropriately and for as short a period as possible.

Systems and processes to safeguard people from the risk of abuse
● Staff and the manager understood local safeguarding procedures and knew how to raise safeguarding alerts. Information about the local authorities safeguarding procedures was readily available to the staff team. Records showed necessary safeguarding alerts had been made.
● Staff and relatives recognised that the service was safer that it had been at the time of our last inspection. One staff member told us, "I believe it is a much happier and safer service than it was when I joined."

Using medicines safely
●The person's medicines were managed safely. There were appropriate systems in place to ensure the person received their medicines as prescribed.
● A new digital medicines administration record system had been introduced and was being used for the first time on the day of our inspection. Staff understood how this system worked and were using it effectively.
●Medicines that required stricter controls had been stored appropriately.

Preventing and controlling infection
● 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 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
● Incident had been appropriately documented by staff and investigated by the manager. Where significant incidents had occurred, staff had been debriefed in detail to try to understand why the incident had occurred and identify any areas of learning.
● Information and learning gathered was used to identify any patterns of behaviour and had been shared with the staff team to reduce the risk of similar events recurring.

Requires Improvement

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.

When this key question was last inspected in 2019 it was rated as Good. At this inspection this key question has deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Adapting service, design, decoration to meet people's needs
At the last inspection parts of the service were in disrepair, with damaged and dirty paintwork, and unsightly, unpainted wood coverings used to protect switches and electrics throughout the service. Prompt action had not been taken by the provider to address defects reported by the registered manager. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found some improvement had been made to the service's environment, but further works were required. The service remained in breach of the regulations.
● The front door remained boarded up but in a more aesthetically pleasing way. The manager told us they intended to use the covering more creatively in future. Staff said, "They have started to do little bits and pieces, they have painted in [the dining room]."
● However, limited improvements had been made to some aspects of the environment, particularly the first floor, which is where the person spent most of their time. The dining room, corridors and hallway were bare and unwelcoming. The person's wardrobe door had been recently damaged but not promptly repaired. Relatives had concerns about the service's environment and felt more could be done to make the service more homely. The manager reported that these works had not yet been completed as they had not developed a process which would not overly impact on the person's freedoms.
● On the first day of our inspection the interior of the person's vehicle was visibly dirty with food debris present around their seat. This issue was raised with staff but had not been addressed by the second day of our inspection.
● The downstairs staff toilet was poorly maintained, dirty, difficult to clean and did not have appropriate equipment for hand drying and disposal of waste.
● Signage directed at visitors and people making deliveries, gave a poor impression of the service. This was raised with the manager during the second inspection day, who agreed to resolve this issue promptly.

The provider had failed to ensure that the premises and equipment were clean, appropriately maintained and suitable for their intended use. This was an ongoing breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service's outdoor spaces did not meet the person needs. They were unable to access this area without support from staff as this area had not been appropriately adapted to the person's needs. This issue is discussed further in the responsive section of the report.

● Some cosmetic improvements had been made to the environment on the ground floor of the service since our last inspection. Walls had been repainted, including light switch covers, which had previously looked unsightly.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider had systems and processes in place to assess and identify people's needs before they moved into a service. Rose House currently supported one person and there were no plans for additional individuals to move into the service at the time of our inspection.

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 service's manager had a good understanding of the MCA and staff consistently sought the person's consent before providing support.
● Restrictions to the person's freedoms were regularly reviewed and the new staff team had worked collaboratively with the person to enable them to access additional areas inside the service.
● Where appropriate, relatives and commissioners were involved in best interest decision making processes.

● Conditions associated with the person's DoLS authorisation had been complied with.

Staff support: induction, training, skills and experience
● Staff told us their training was up to date and records showed staff training and skills had been regularly updated. A training matrix had been developed for the new staff team which identified when training required updating.
● The manager had previously been the providers training lead and had provided each staff member with tailored training on how to meet the person's specific needs while upset or anxious. Although this training had been provided informally there were plans in place to provide staff with further formal training in practical positive behavioural management techniques.
● Most staff had received supervision from the manager. There was a supervision schedule in place to ensure staff had regular opportunities to review practice, share learning and identify training and development opportunities. The manager had a clear focus on supporting and encouraging staff to development.
● In response to the COVID pandemic, new Spectrum staff completed a two-week online training programme before they began working. On arrival at Rose House new staff normally shadowed more experienced members of staff for a small number of days before they were permitted to provide support

independently. New agency staff received one day, introduction to Spectrum training, before being allocated to support individual services.

Supporting people to eat and drink enough to maintain a balanced diet

● The person was supported to maintain a healthy and balanced diet. The new staff team had worked with the person to develop their skills in the kitchen which the person was now able to use with staff support.

● The person was regularly offered drinks, involved in menu planning and they decided what to have for each meal.

Supporting people to live healthier lives,

● Although staff had started to build trust with the person and were more confident supporting them to go out than previously there were still limited opportunities for the person to take exercise and live a healthy and active life. This issue is discussed in detail in the responsive section of this report.

● There were appropriate systems in place to support the person with their oral care needs.

Staff working with other agencies to provide consistent, effective, timely care and access healthcare services and support

● The person was supported to access health and care services as required. Information about the person's specific support needs had been prepared for sharing with professionals as necessary. This guidance aimed to enable external professionals to provide support consistently.

● Timely referrals for health care professional input had been made and guidance provided acted upon.

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.

The last time we inspected this key question it was rated as Good. At this inspection this key question has deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- As detailed in the safe and responsive sections of this report, low staffing levels in combination with the service's outdoor environment limited the person's freedoms and ability to go outside.
- The provider had failed to promptly resolve issues, previously identified, in relation to the environment of the service. Improvements were needed to the first floor and it had been recognised the necessary works were likely to impact on the person's wellbeing and freedoms while underway. However, no plans had been developed to resolve this situation.
- Staff had not always been respectful of the person. No action had been taken to clean the person's vehicle between inspections and care records included occasions where staff had used inappropriate and unsuitable language in relation to the person's support needs.
- Staff spoke about the person fondly and with respect. They had spent time getting to know them and understanding what worked best when providing support. Staff comments included, "[The person] has come on really well. It is lovely", "I believe [the person] is happier than [they] were" and "I think [the person] is doing much better, I still feel I am getting to know [the person] in many ways. We have had moments where [the person] has tried to push the boundaries and slowly as a team we're becoming wise to [their] behaviours and patterns and what makes [them] tick".
- During the inspection, we observed staff working effectively with the person. They now understood the person's sense of humour and used appropriate approaches to encourage and support them. Staff recognised the person had their own routines which was important to them and provided gently and appropriate encouragement that had positive outcomes.
- Within the building the person was able to choose how they spent their time and request specific activities which were provided. They approached staff for support and reassurance without hesitation and staff responded promptly and appropriately to the person's request.

- Relatives recognised the new staff team were developing supportive and effective relationships with the person. Their comments included, "The staff have done well. [My relative] seems much more settled" and "I feel since [the last inspection there has been a] large improvement. [My relative] has taken a while to bond with new team."

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

- A poster in the dining room outlined the person's goals and wishes. The information was in simple text and pictures and photographs were also used. However, we found limited evidence that support had been provided to help the person achieve these identified goals.

● Staff supported and encouraged the person to express their views and respected their decisions and choices.

Respecting and promoting people's privacy, dignity and independence

● Staff acted to ensure the person's privacy, dignity and independence was respected while they kept the person safe. Where staff were required to supervise the person while completing specific tasks, the need for this supervision was regularly reviewed to ensure it was still necessary and proportionate.
● Since our last inspection staff had started to support the person to use the kitchen more frequently. The manager told us this was going well and the person enjoyed baking during the first day of our inspection.

Inadequate

Is the service responsive?

Our findings

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

At our inspection in July 2021 this key question was rated as inadequate. At this inspection this key question has remained inadequate. This meant services were not planned or delivered in ways that met people's needs.

Support to follow interests and to take part in activities that are socially and culturally relevant to them
At our last inspection we found low staffing levels and high staff turnover had meant the person was not being supported to leave the service to participate in activities. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At this inspection we again found the person had not regularly been supported to engage in meaningful activities outside.

- The person's care plan identified that they had previously lived an active lifestyle and enjoyed exploring new environments.
- Although staff now had a better understanding of the person's support needs when outside they still did not have complete confidence in their abilities to meet those needs. One staff member told us, "Going out can be challenging." As detailed in the safe section of this report the service was not adequately staffed and this also limited opportunities for the person to choose to go outside.
- Since the last inspection the times the person had gone outside or left the service, had not increased significantly. In both October and November, the person had only been supported to leave the service on four occasions each month. Most trips out had been for shopping or to attend medical appointments. The person had not been supported to exercise or engage with their other interests.

At our last inspection we found the service's garden and outdoor area were not sufficiently secure to enable the person to go outside independently. The provider had not acted as a strong advocate to ensure this issue, originally recognised in 2018, was resolved.

At this inspection we again found no action had been taken to address this situation.

- The service's outdoor spaces did not meet the person's needs and they were thus unable to use it safely without significant staff support.
- The unsuitability of the outdoor area meant the person was currently unable to use the garden for activities they enjoyed. They had only been supported to use the garden on three occasions in October 2021. Relative's confirmed that the restrictions in place to keep the person safe in the garden, impacted adversely on the person's wellbeing and freedoms.
- A multi-disciplinary meeting had been planned to discuss issues associated with the service's outdoor space. However, no meaningful action had been taken to resolve this issue since the last inspection. This meant the person continued to be significantly restricted whenever they went outside.

The provider had not ensured the person received appropriate support to go outdoors and use the local community. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

● Following the inspection, we received information from the service that showed the person had been successfully supported to re-engage with some hobbies and outdoor activities in the community.
● Staff supported the person to follow their interests and complete domestic tasks within the service. The person was particularly interested in computer gaming. The manager and staff team had developed their knowledge of this subject to enable them to meaningfully engage with the person about their interest.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
●The person's care plan was personalised, detailed and informative. It provided staff with guidance to enable them to meet the person's support needs. The person's care plan was a very lengthy document which was difficult to navigate and took significant investment of time from new staff members to fully understand.
● As the care plan was so large an abridged version, containing key information, had been developed. This document made it easier for staff, new to the service, to quickly gain a basic understanding of the person's support needs.
● Staff had worked with the person to identify their current interests and this had led to the development of specific goals that had been agreed with the person and their relatives. Three goals had been developed but there was limited evidence to show what progress had been made towards achieving these goals.
● Accurate daily care records had been maintained of the support staff provided and the activities the person had completed. Staff told us, "I try to make the records detailed without being too long, so we can help understand what was going on each day."
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 our last inspection we found that the new staff team did not fully understand the person's communication needs. At this inspection we found this situation had improved and staff now had a good understanding of the person's specific communication needs.
● The manager and current staff team were now able to communicate effectively with the person. They had developed an understanding of the person's specific needs and preferences. Staff understood how to interpret specific gestures and phrases the person used regularly.
● The person's care plan included detailed guidance on the use of specific techniques to facilitate communication, and staff used these techniques successfully during the inspection.
● Additional tools had been used appropriately to support the person to understand complex information.

Supporting people to develop and maintain relationships to avoid social isolation
● Staff supported and encouraged the person to maintain relationships that were important to them. Regular communication was maintained with relatives via video conferencing technologies and visiting was actively encouraged. One relative visited every week and arrangements had been made to improve relatives' comfort while awaiting COVID test results prior to entering the service.

Improving care quality in response to complaints or concerns
● There were procedures in place to ensure any complaints received were investigated and addressed.

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people and understanding quality performance, risks and regulatory requirements.

At our last inspection we found the provider had not taken sufficient action to ensure the person received a high-quality service. Risks associated with the resignation of the previous registered manager and staff team had not been appropriately managed which had significantly impacted on the person's wellbeing. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found that, although some improvements had been made, the provider's systems had failed to ensure that compliance with the regulations was achieved. This meant the service remained in breach of the requirements of regulation 17.

● At this inspection we found the staffing situation had stabilised and staff recruited to replace the previous staff team had now developed a good understanding of the person needs. However, the service remained short staffed and as detailed in the safe and responsive sections of this report low staffing levels and the quality of the environment at the service, continued to restrict the person's freedoms and not meet the person's needs.
● The provider operated an on-call manager system that was designed to ensure services did not regularly operate at emergency minimum staffing levels. This system had not operated effectively because concerns about low staffing levels had only been raised when there was a risk of Rose House operating at below emergency minimum safe staffing levels.

Continuous learning and improving care
● The provider's regional manager had visited the service and completed audits of performance since our last inspection. These audits recognised some improvements had been made and that further improvements were necessary.
● A joint action plan had been developed with the local authority in response to issues identified prior to our last inspection. This plan highlighted that issues in relation to the environment of the service and fire safety, remained outstanding. As detailed in the safe and effective sections of this report, at this inspection these concerns were ongoing, and in addition breaches of regulations in relation to fire safety and the suitability and maintenance of the premises and equipment were identified.

The provider's systems had failed to ensure the service met the person's needs and had failed to drive necessary improvements to the service's performance. This means the service remains in breach of regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were systems in place to ensure leaning was identified and changes made to improve the quality of support the person received. Where significant incidents or accidents had occurred, these had been discussed with the provider's behavioural team to identify possible causes and establish if any changes in approach could be made to prevent similar events from reoccurring. Staff had been involved in these discussions and their input valued and acted upon.

Managers and staff being clear about their roles,
● The manager had a clear understanding of their role and responsibilities. They were providing effective leadership and support to the staff team. Staff meetings had been held and information about any changes in the person's support needs had been shared appropriately. Staff told us, "I think [the manager] has done a good job getting the staff in and building a team" and "I feel [the manager] is very approachable and I find [they] are doing really well".
● Relatives were complimentary of the manager and recognised the quality of support provided by the service was improving. There comments included, "[The manager] has done well, had no handover. [My relative] is starting to get more of a bond with the staff team" and "I have a good relationship with [the manager], he is always available. "
● The manager recognised and valued the benefits of them completing support shifts and regularly worked additional shifts as a member of care staff in order to gain a better understanding of the person's specific needs. Staff said, "The manager is supportive and hands on with the job and that has boosted confidence in his leadership". However, the low staffing levels meant the manager was needed to provide care and this had limited the time they had available to focus exclusively on their management responsibilities.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
At our last inspection staff morale was low and most staff gave negative feedback about the support they and the service had received from the provider's senior staff. At this inspection, we found that although staff morale had improved the provider remained remote from the staff team.
● Staff now felt well supported by their manager and were gaining confidence in meeting the person's specific needs. However, staff continued to feel relatively isolated and reported that they had received limited support from the provider. Staff comments in relation to the provider included, "I don't really know, I have never really met many [people from Spectrum]. I feel a little bit lost as I don't know who to go to [in the wider organisation]" and "I don't really have an opinion of Spectrum".
● The manager had been well supported by the provider's senior staff and records showed senior managers had visited the service since our last inspection. The manager told us, "Morale has improved, which I feel [the person] has picked up on".
● Relatives were in regular communication with the provider's nominated individual and felt confident they could raise any concerns directly with them if necessary.

Working in partnership with others
● The manager was keen to work collaboratively with partners to ensure the person's needs were recognised and appropriate support provided. At the time of the inspection, the manager was actively working with care commissioners to ensure appropriate systems and support were in place to advocate for the person and ensure their views were represented.

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 manager understood their responsibilities under the duty of candour and had informed the person's relatives of all significant incidents that had occurred within the service. Relatives told us the manager responded promptly to any request for information and said, "Communication is good".

● Information about how the person had spent their time was shared regularly with relatives via a weekly newsletter. A relative told us, "[They] send weekly contact sheets, so we can see what [person's name] has been doing" and "The Keyworkers are good at keeping us informed". Staff said, "I think we are engaging with the family each week and they are well informed of what has been going on".

● The manager took an open and honest approach to the inspection process, shared information when requested and recognised further improvements were necessary within the service to enable the person to live their best life.

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 received appropriate support to go outdoors and to access the local community. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We continued our enforcement action to impose conditions.

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 manage fire risk within the service. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We continued our enforcement action to impose conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure that the premises and equipment were clean, appropriately maintained and suitable for their intended use. This was an ongoing breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We continued our enforcement action to impose conditions.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems had failed to ensure the service met the person's needs and had failed to drive necessary improvements to the service's performance. This meant the service remains in breach of regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We continued our enforcement action to impose conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient numbers of appropriately skilled and competent staff to meet the person's needs. This is a repeated breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We continued our enforcement action to impose conditions.