Spectrum (Devon and Cornwall Autistic Community Trust)

St Erme

Inspection report

St Erme
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
St Erme Campus is a care home providing personal care for up to twenty people with autism. At the time of the inspection 13 people were living at the service.

Accommodation is on a campus style development and is based in three separate houses known as The Lodge, The House and St Michaels. There is also a small office building on the campus. Campuses' are group homes clustered together on the same site. They may share staff and some facilities. The service is part of Spectrum (Devon and Cornwall Autistic Community Trust) which has several services in Cornwall providing care and support for autistic people and/or people with a learning disability.

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

Right support:
The model of care and setting did not maximise people's choice, control and independence.
People did not have fulfilling and meaningful everyday lives. There were limited opportunities to leave the service and a lack of variation in available activities.
The environment and facilities did not promote independence and autonomy.

Right care:
There were not enough suitably skilled staff to meet people's needs and keep them safe.
Where people had identified goals and aspirations, they had not been supported to achieve these.

Right culture:
We identified a poor culture where there were low expectations for people and an acceptance of situations and quality of life which would not be acceptable for most people. People were not supported to live full and meaningful lives or develop their own routines.

At our last inspection we identified staffing shortages, the use of agency staff was introduced and this impacted positively on staffing numbers. However, staffing levels remain a concern and St Erme Campus is frequently working to 'contingency' levels which are set by the provider as the lowest number of staff required to keep people safe. The risk of running the service at, or near to, 'safe' levels was highlighted when

three agency staff, all working 14-hour shifts, (70 hrs each per week) tested positive for Covid-19. This left the service understaffed with limited further staffing resources to draw from. Contrary to legal requirements for people to self-isolate following positive tests Spectrum allowed staff who had tested positive for Covid-19 staff to continue working at the service in a 'bubble' arrangement with people using the service who had also tested positive.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Deprivation of Liberty (DoLS) conditions were not met. Despite frequent reminders from the Cornwall Council DoLS team the manager had not supplied DoLS reports to them in line with conditions for three people.

The provider had failed to ensure monitoring, governance and business continuity systems were established and operating effectively to ensure compliance with the regulations. There was a lack of supportive leadership in place. There were indicators of a closed culture developing.

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 and there were breaches of the regulations (published 17 August 2021). We imposed conditions on the registration for the service which required the provider to send us monthly reports.

At this inspection not enough improvement had been made and the provider was still in breach of regulations. The service remains rated inadequate. This means the service has been rated inadequate or requires improvement for four consecutive inspections.

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.

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

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, dignity and respect, safe care and treatment, safeguarding, staffing levels and deployment, and governance.

We took legal steps to remove the service from the providers registration. The service has now closed.

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.	**Inadequate**
Is the service effective? The service was not effective.	**Inadequate**
Is the service caring? The service was not always caring.	**Requires Improvement**
Is the service responsive? The service was not responsive.	**Inadequate**
Is the service well-led? The service was not well-led.	**Inadequate**

St Erme

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 carried out by four inspectors on two separate days. A third planned day was cancelled due to an outbreak of Covid-19 at the service. The remainder of the inspection was completed remotely.

Service and service type
St Erme Campus 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 is required to have a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of the inspection there was no registered manager in post.

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. We sought feedback from the local authority and professionals who work with the service. 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 with six people who used the service. We spoke with fifteen members of staff and the deputy operations manager.
We reviewed a range of records. This included people's care records, incident reports, daily logs and medication records. We looked at two staff files in relation to recruitment and staff supervision.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with four professionals who regularly visit the service. We spoke with seven relatives. We requested contact details for staff so we could speak to them privately but they declined to share their details with us.

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.

Staffing and recruitment

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

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

- The provider had taken action to try and address the low staff numbers. Agency staff had been recruited on a long-term basis and were working at the service alongside permanent and bank staff. However, this had not had the desired impact and there were occasions when the service was only staffed to contingency levels or below. Contingency levels are the number of staff, as defined by the provider, required to deliver a safe service and are intended only to be in place in extreme emergencies. The contingency level in The House was six members of staff during the day. On the second day of the inspection six staff were rota-ed on but one had phoned in sick leaving the service staffed below safe levels.
- We completed an analysis of rotas, staff signing in books and support grids for The House covering the 12 September 2021 to 2 October 2021. There were several occasions when there were only six members of staff on the rota. We identified some days when only five staff were on duty at certain times.
- A note in one person's records dated 15 October stated; 'Shared support 8 – 9.30. Only three staff until 9am.' Low staffing numbers impact on the quality of care provided and people's opportunities to live full and meaningful lives in the way they wish.
- Agency staff did not have all the necessary skills and training to deliver safe care. They did not have the appropriate training to enable them to administer medicines. This meant they could not support one person to go out as they sometimes required immediate access to 'as required' medicines (PRN). We identified night shifts when agency staff had worked without the support of permanent staff. This meant no-one was available to administer PRN quickly if it had been needed.
- Staff told us people living at St Erme Campus had complex needs and benefitted from being supported by staff who knew them well and had built up relationships with them. Because of the large proportion of agency staff working at the service people were often supported by staff who had not had the opportunity to develop their understanding of their needs and preferences. One member of staff commented; "We have the numbers, but they are just bodies." Another member of staff talked of leaving agency staff to only 'watch' people while they themselves were busy with medicines or records. We asked about the use of the word 'watch' and they confirmed this was all the agency staff were doing.
- The inspection was planned to include three visits to the service. Following the second visit we were

contacted by the provider to inform us there had been a Covid outbreak at the service and three agency staff had tested positive for Covid-19. All three worked 14 hour shifts five or six days a week. As the three houses were often working with the minimum number of staff required, the loss of staff working that normally worked extensive hours meant there was a risk people would not receive their support as planned.

Arrangements to address staffing shortages had not been effective. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment records showed appropriate checks were carried out before new staff started work at the service.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management

At the last inspection the provider had failed to ensure people received safe care. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Low staff numbers and high use of agency staff who did not have the necessary training or background knowledge of people's needs and preferences meant people were put at risk of harm.
● A member of staff took two people out for a walk during the inspection visit. Both people should have been supported individually, by one member of staff. The member of staff knew both people well and had assessed that the benefit of the exercise and fresh air outweighed the risks. This left four staff in The House, two members of staff were occupied supporting individuals in their flats leaving the other two members of staff supporting three people, one of whom could be unpredictable and found their emotions difficult to manage. Had an incident occurred there was no way of contacting the staff member that had gone out to ask them to return and assist. The failure to provide staff numbers above safe levels put people at the risk of harm.
● A member of staff commented; "I think with [name], the incidents have been increasing as the agency staff do not know them well, they will let them not follow routines. [Name] needs a routine daily and if it does not happen it is difficult for staff to do it again." An analysis of the incident reports showed there were frequent references to inconsistent approaches from staff being a behavioural trigger for the person. For example, in August there were four recorded incidents, three of them cited inconsistency as a contributory factor.
● Minutes of a managers meeting dated 16 September stated: 'We have had to agree the maximum is 70 hours per week, and the team member must have one full day off. Going forward with immediate effect the 70 hours rule applies.' However, it remained the case that some staff were working very long hours. For example, during the week beginning 26 September one agency staff worked 80 hours over seven continuous days and a second worked 73 hours over six continuous days. In the same week a member of permanent staff worked a waking night followed by a 14-hour day shift broken by a half an hour break followed by another waking night. There is an inherent risk associated with staff working long hours, particularly when supporting people who can be unpredictable, and require considered focused support. Although this issue had been recognised by senior management, agency staff continued to work excessive hours.

The failure to manage rotas effectively so staff could provide people with safe care at all times was a

continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Many aspects of people's lives were restricted by staff, including people's freedom to move around their home. One person was often frustrated by this as was demonstrated by a review of incident reports. Reports showed that on the 13, 14, 16 and twice on 20 September 2021 the person was asked to leave a room or specific area. On each occasion the person became distressed leading to incidents.

This contributed to the breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had received training in safeguarding and told us they knew how to raise a concern. Information on the process for raising a safeguarding alert was displayed in the service. Some of the information was out of date.
● Environmental risk assessments were in place. Staff and people took part in regular fire evacuation drills.

Preventing and controlling infection

At the last inspection the provider had failed to ensure systems to prevent the spread of infection were embedded. This contributed to a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● We were not assured that the provider was ensuring infection outbreaks could be effectively prevented or managed. On the day following the second inspection visit three agency workers and two people tested positive for Covid 19.

This contributed to the breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● 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 promoting safety through the layout and hygiene practices of the premises.

● 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

At the last inspection the provider had failed to learn from untoward incidents. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● There had been no actions following the last inspection to make improvements in the service.
● Incident reports for the four weeks preceding the inspection showed there had been a total of 22 incidents involving one individual during this period. Ten of these had taken place before 8.30 am and one of the records dated 12 October 2021 noted a need to review their support needs at this time. We requested a copy of the most recent night-time protocol which was dated 25 June 2020. Although a need to review the protocol had been identified this had not been completed and no action taken to mitigate the risk of incidents reoccurring. This meant the person was likely to continue to become distressed at this time of the day.
● Incident reports did not consistently contain enough detailed information to enable managers and staff to learn from the event. One report stated '[Name] had been obsessing over the usual things during the morning.' The lack of information about what the person was focusing on would make it difficult to learn from the event. Furthermore it indicated a dismissive attitude to the persons anxieties.

The failure to learn from experiences and untoward events was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Agency staff had not received training to enable them to administer medicines. The deputy operations manager told us the organisation was planning to provide training to all staff in the future.
● People received their medicines as prescribed. At The Lodge staff were trialling an electronic medicine recording system. They told us this was 'brilliant' and minimised the risk of errors.
● Care plans recorded what medicines people were taking and why. Most people had their medicines kept in their personal rooms, so they were able to be supported with them in privacy.
● One person was being supported to be more independent when taking prescribed medicines.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Before the inspection we were contacted by a representative of the local Council DoLS team who informed us the manager had failed to provide evidence in respect of four people to demonstrate they were supporting them in line with conditions associated with deprivation of liberty authorisations. This was despite regular reminders. They told us; "It feels like the only person doing any work on these conditions is me."
● Following the inspection, the area manager told us they had addressed the issue and all the documentation had been submitted. We checked this with the DoLS assessor who told us this was not the case and they were still waiting for the appropriate evidence.
● The DoLS authorisation for another person from outside of the county had expired and no renewal had been submitted by the service.

The provider had failed to ensure it was acting lawfully when people were deprived of their liberty. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● A training matrix for The Lodge showed only one of the 13 staff had completed Makaton training. Only two

members of staff had up to date positive behaviour management training. Six members of staff were overdue refresher training in medication. We were told this information was out of date and so we asked for the most recent matrix to be sent to us. This evidence was never presented.
● Staff did not have regular opportunities to reflect on their practice and air any concerns or make suggestions. They told us they had not received supervision for some time. One commented; "I had one supervision with [manager] when he started. It lasted about five minutes." We requested a copy of the supervision matrix to check how often staff were receiving supervision, but it was not provided.

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

● New staff and agency staff completed an induction before they started working at the service. Agency staff told us this included training in Positive Behaviour Management.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not consistently supported to eat a healthy diet in line with their personal choices.
● The manager was on leave and had not made arrangements for staff to collect money for grocery shopping. As a result there was limited food available in The House on the first day of the inspection. There was very little fresh fruit or vegetables available. We saw only two large sacks of potatoes, a box of browning bananas and some courgettes and windfall apples.
● There was some food in a freezer, but this was of limited variety. There was a heavy build-up of ice and frost in the freezer. This can result in freezer burn which can affect the integrity of the food.

This contributed to a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's likes and preferences were recorded, and any needs associated with their health in terms of what they ate and drank was monitored.
● Some people were at risk of losing or gaining too much weight. Their weights were regularly recorded and information in care plans guided staff on what the safe limits were.

Staff working with other agencies to provide consistent, effective, timely care
● Communication between the service and other agencies did not consistently enable other professionals to support people in line with their needs.
● An external professional told us; 'At my last visit I asked specifically if there were any issues I should know about and was told no and when I spoke to [family member], they informed me there was a Safeguarding ongoing. I did feel this had been deliberately omitted from the conversation' and 'It feels that the staff are defensive, and it has been difficult for me to talk to direct support staff as I am always met and spoken to by a manager.'

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

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

At our last comprehensive inspection we made a recommendation that action was taken to improve the environment.

● At this inspection we found there were still areas of the service which were in need of updating. Stairways and corridors were not homely or well-kept and felt impersonal. In The House wall heaters were rusting and heavily marked. The carpeting in The Lodge was stained and walls were scuffed. We were told there were plans to redecorate and replace the flooring, but these were areas that had already been noted as in need of improvement during an inspection in March 2020.

The failure to take timely action to address the recommendation contributed to a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's rooms were generally pleasant and arranged to suit their needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Although the deputy operations manager told us there were plans to develop the service in line with the principles of Right Support Right Care Right Culture no action had been taken.
● Care plans contained comprehensive details about people's needs and choices. However, low staffing, the high number of staff working who had limited knowledge of people's needs, and a culture of accepting the status quo and low expectations for people, meant care was not always delivered in line with guidance.

Supporting people to live healthier lives, access healthcare services and support
● Records showed people were supported to access health care professionals when necessary. For example, staff identified one person had a problem with their feet. This was highlighted to the GP and subsequently a referral was made to a podiatrist.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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; Respecting and promoting people's privacy, dignity and independence

● There was a culture of doing for people rather than doing with. This was partly due to a lack of facilities available to support the development of independent living skills. Staffing levels also impacted on staff opportunities to deliver personalised care to meet the needs of each individual. People were often supported in small groups of two or three or by staff who were also occupied completing paperwork. Trips out, even just on walks round the campus grounds, had to be staggered to ensure staff were deployed safely.
● An incident report recorded an event when staff were completing paperwork in the evening while supervising a person. In order to do this task they had switched on an overhead light which the person objected to. This had resulted in the person becoming frustrated and angry.
● One person enjoyed 'people watching' and looking at birds. He had a small fenced off garden area which he could access from his flat. There was no garden furniture or anywhere to sit. Minutes of a person-centred planning meeting held on 12 May 2021 recorded that spending time in their garden was important to them. The lay out and size of the garden did not meet the person's needs.

Supporting people to express their views and be involved in making decisions about their care
● Communication care plans described how to support people to make decisions. For example, using particular phrases or objects of reference. However, due to low staffing levels, choice making was rarely supported.
● Staff sometimes completed ABC forms. These can be used to analyse people's experiences, what worked well and what could be done differently. However, these were not always in place.

Systems to support people to make choices about how they lived their lives, develop their independence and capture their views and experiences were not well established. This contributed to the breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were not supported to develop and maintain their independence. Some people had basic cooking facilities in their accommodation which did not promote their independence. There was limited worktop space to enable people to be safely involved in food preparation.
● A relative told us their family member had less autonomy since moving to St Erme Campus due to the

layout of their accommodation.
● People's allocated rooms were not always treated with respect. One persons' kitchen was being used by staff to leave their bags in while they were working. In the same kitchen, bowel movement records were attached to the side of the fridge.

This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were comfortable with staff and relaxed in their company. Relatives told us staff were kind and knew their family member well.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

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 the provider had failed to ensure people's care was designed in a way which met their preferences and needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● We identified a poor culture where there were low expectations for people and an acceptance of situations and quality of life which would not be acceptable for most people. This was not in line with guidance contained in Right Support Right Care Right Culture.
● On day one of the inspection we noted one person (A) spent long periods of time pacing round a small concreted and fenced area outside his flat. There was no sensory stimulation available in the area. An agency member of staff was watching him from the kitchen. We did not observe them interacting with the person. An inspector went to see the person in their flat. Later that day, we saw the person was allowed to access a larger area of the garden which was grassed and more pleasant. However, there remained little evidence of staff interacting with the person.
● On the second day of the inspection the person (A) was once again in the grassed area, being supervised by an agency worker. The inspector approached person A and engaged with them for a short time which they responded positively to. This indicated the person was keen to interact with others, even if they were not well known to them.
● The lack of drive to interact with the person or offer them any meaningful engagement or sensory stimulation evidenced a culture of low expectations for people and an acceptance of a poor quality of life.
● When an inspector was visiting a second person (B) in their flat, person A noticed the staff member supporting person B and came to the glass French doors, smiling and shaking the door handles, attempting to engage with staff. We asked if this did not disturb B. The staff member told us they didn't mind it and if they did, he would deal with it. This was both disruptive to Person B and indicated again that Person A was keen to interact with staff.
● People's opportunities to go out and take part in hobbies and interests outside of the campus were few and lacked variety. A member of staff commented; "We tend to just go for a walk through the local lanes, we are not doing the activities they like to do."
● One person's care plan stated they liked to 'go to parties and see other people' and '[name] does like to

leave the house and do activities, so would be affected if he was not to do so.' We checked the daily log records for the person between 12 September 2021 and 10 October 2021, a period of 29 days. During this period, they had been out eight times. Three times for a drive, three times for a drive and a walk, and twice for a walk around the village. They had declined to go out on two occasions. On two occasions the daily logs stated there had not been enough staff to enable the person to go out.

● The care plan also stated; 'introduce new sound experiences to [name], such as instruments and different types of music CD.' We asked the area manager if this was happening and they responded; 'A member of staff who uses percussion instruments has been supporting [name] with exploring sounds.' There was no evidence of this taking place over the 29 days we looked at.

● Following the inspection the area manager told us this had not happened as the member of staff had been away from work. There had been no attempt to encourage other staff to support the person in this area. The lack of drive to offer the person a range of opportunities meant they were not experiencing a full and meaningful life.

● Not all staff were able to drive, further limiting opportunities to go out other than on local walks. A member of staff told us; "I have been struggling recently, you want to make it fulfilling and make it positive for people but the staffing means it is not possible, you have to run around to do the meds. It takes half an hour to do the meds so you get agency to watch them while you are doing the meds."

● Established permanent staff told us agency staff had not always had the chance to get to know people well before supporting them independently and therefore were unable to engage effectively with them. Comments included; "Usually when you start you shadow experienced staff to get to know what people need but the agency staff did end up alone with [name] quite quickly" and "When agency are with [name] they tend to just sit in the kitchen."

● In The House we saw examples of records titled 'A day in the life of [name].' Staff told us they had been asked to complete these for seven days although they were unsure why. The deputy head of operations told us they were collating information to evidence how the service was working in line with Right Support Right Care Right Culture. The records were not always fully completed. The ones we did see showed people were largely spending their time with very little to occupy/stimulate them or engaged in mundane tasks. For example, one person's day was recorded with an entry made every hour between 8.00 and 21.00 except for one. The entries were; Activity. Morning routine/self-care. Breakfast. Cleaning rota. Drink/relax. Lunch. Local walk. Relax. Relaxed up in lounge. Dinner and meds. Relaxed upstairs. Watched TV main lounge. Bedtime routine. Teeth and bed. It was unclear how these records supported the principles of Right Support Right Care Right Culture. They described an uneventful and dull routine.

● A member of staff told us one person was asleep and said; "They tend to sleep when they are bored." This person had erratic sleep patterns which could have been made worse if they were napping during the day.

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

● There was a lack of purposeness to people's days. Staff told us they were unable to plan effectively due to low numbers of staff and some staff not being able to drive. This meant staff had to take opportunities to go for walks and drives with people as they arose. People were not involved in planning their day.

● People were not supported to live their lives according to their preferred routines. Records for two people showed they often got up early and staff would prompt them back to bed. For example; 'Came downstairs at 7.25 and was prompted that it was still a little early and to go back upstairs again' and 'waking up in the morning at 07:00. [Name] has been out of his flat a couple of times requesting laundry. I said to [name] that it was too early for laundry and to not shout as others were still asleep.'

● Peoples recorded goals and aspirations were similar in nature. For example, of the four people in The Lodge, three of them had goals in relation to finding new walks. There was no evidence of life goal setting or encouraging the development of new skills.

● Daily records for one person showed they were often incontinent during the night. There was no continence care plan in place to guide staff on how to support the person in this area. This showed an acceptance of the issue with no drive to improve matters and help the person have more comfortable nights.

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.
● Some people's care plans referred to the use of Makaton, a simple signing system, to support communication. It was recorded that one person had a goal to learn new Makaton signs and stated; 'team members should have a basic understanding of Makaton signs.' Most staff had not completed training in this area and we did not see it being used during the inspection.

The failure to ensure people received care and support in line with their needs and preferences was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● Relatives had mixed views as to how their complaints or concerns were responded to. Some told us they found it difficult to get a response if they raised any queries. Others were more positive and said they found management approachable.
● Records showed one person had requested not to be supported by a certain member of staff. We discussed this with a senior member of staff who told us the person often objected to working with individual staff members but would later change their mind. They told us the possibility of removing staff from the rota had been discussed. However, there was no record of this conversation. One incident report recorded the person had asked to speak to the manager about this. The staff member had written; 'I [staff] informed [name] I did not wish to take them [to see the manager].' Records then state the manager had been informed the person wished to speak to them but there was no record this had happened. Rotas show the member of staff had continued to work with the person. This indicated the persons anxieties were not addressed or further investigated.

The failure to design care or treatment with a view to meeting the person's preferences contributed to the breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

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

At the 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.

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

At the last inspection we identified the provider did not have effective oversight of the service and had failed to ensure people experienced good outcomes. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● There was no registered manager in post at the time of the inspection and no application had been submitted although the manager had been in post for several months.

Continuous learning and improving care

● This will be the fourth consecutive inspection that the service has been rated less than good and the second consecutive time it has been rated as inadequate. The provider has failed to make the necessary improvements to bring the service in line with current guidance and accepted good working practice.

● Monthly manager reports were completed. However these had failed to identify and address the areas for improvement identified at this inspection.

Working in partnership with others

● As part of the inspection process we requested various documents be sent to us. Not all of these have been provided. On 20 October we requested a total of 16 documents to review. Only four were provided.

● The service had been placed into 'red' by the provider organisation. This meant weekly meetings were held to discuss plans to improve the service. On the inspection visit of 12 October 2012 we requested copies of 'red meeting' minutes in order to help inform our judgements on the service. On 15, 20 and 25 October we again requested these via email along with various other documents. They were not provided.

● We were told a training matrix seen during the inspection visit, was out of date. This meant managers were unable to quickly identify if there were gaps in staff training. We requested an up to date version of the matrix. This was not provided.

● Some of the documentation and emails we saw indicated the provider was not working with the Commission in an open way. For example, we saw minutes of a managers meeting dated 16 September 2021 and an email from an area manager to a senior care worker that related to providing us with copies of

medicine audits. These indicated the provider was not being wholly transparent.

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

● We asked if there were any plans in place to develop the service in line with Right Support Right Care Right Culture. We were told about changes to the management of the site. This did not address how people's experiences could be improved.

● Staff told us there was a lack of oversight. On the day of the inspection a member of staff at The House told us; "We are a bit short of managers at the moment." Both the manager and a senior were on leave. The deputy manager had left the service at the beginning of the month. Staff at The Lodge also felt they were unsupported. The deputy had been working at a different service and one member of staff commented, "We have been without a manager for three months." This was despite there being a manager in post. This indicated the staff had felt unsupported.

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● One person had been bitten by another during a fire evacuation. The person's relative, (also their Relevant Persons Representative), had not been informed of the incident by the service and was not aware until they were told by an external professional.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Relatives were divided about their views of the service and how information was shared with them. One relative told us; "They [senior management] are not that good at telling us [information about their family member], we have to find out." Another said; "I usually find out [if things have gone wrong] in a roundabout way."

● Other relatives were positive about the service and told us they felt they were kept informed of any developments. Comments included; "Always in touch with senior management. We have always been happy with how things were going" and "Staff phone every Sunday evening and I get the information I need."

● Spectrum had worked with the local authority quality assurance team to develop a quality audit tool.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not treated with dignity and respect at all times. The provider had failed to support the autonomy and independence of service users. 1. 2.(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had not acted in accordance with the Duty of Candour.

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 People did not receive appropriate person-centred care that was based on and met their individual needs and reflected their preferences. 1(a)(b)(c)

The enforcement action we took:

We issued a Notice of Proposal to cancel the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. The provider did not take all reasonable steps to mitigate identified risks. 1. 2.(a)(b)(h)

The enforcement action we took:

We issued a Notice of Proposal to cancel the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems to ensure service users who were deprived of their liberty were not operated effectively to ensure this was carried out in line with legislation. 2. 5.

The enforcement action we took:

We issued an NoP to cancel the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective governance to assess, monitor and drive improvement in the quality and safety of services provided including

	the quality of experiences for service users. 1. 2. (a)(e)(f)

The enforcement action we took:

We issued a Notice of Proposal to cancel the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed. 1.

The enforcement action we took:

We issued a Notice of Proposal to cancel the location.