# Spectrum (Devon and Cornwall Autistic Community Trust)

# Rosewin

## Inspection report

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## Ratings

| Overall rating for this service | Requires Improvement |
|---|---|

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

# Summary of findings

## Overall summary

About the service
Rosewin is a residential care home providing personal care for one person with a learning disability. It is part of the Spectrum (Devon and Cornwall Autistic Community Trust) group, a provider with 15 other similar services across Cornwall.

Rosewin is located on a main road in a rural area west of Cambourne in Cornwall. The service is a detached two-story building with an enclosed garden area to the rear.

People's experience of using this service and what we found
At this inspection we again found that the service did not employ sufficient staff to meet the person's needs. Agency staff were being used to ensure the person's safety and these staff were working long hours with four agency staff due to work an average of 71 hours each in the week of our inspection. Although agency staff were happy with these arrangements there are inherent risks when staff work excessive hours in care settings.

The use of agency staff had increased the numbers of staff on duty each day. However, there had been a small number of short periods where the service had operated at or below minimum staffing levels in the first two weeks reviewed and one occasion where a staff member had been awake and on shift for 25 hours.

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

Based on our review of safe, responsive and well-led the service was not able to meet some of the underpinning principles of Right support, right care, right culture.

Right support:
• The environment and location of the service disempowered the person. They were unable to go for walks from the service because of the busy road and were unable to access the garden independently because of unmanaged environmental risks.

Right care:
• The location of the service in combination with the limited availability of staff able to drive had restricted the person's freedom and ability to access the community.

Right culture:
• The instability of the staff team and reliance on agency staff to ensure the person's safety had prevented

the development of a positive and supportive culture. The person's care plan recognised that staff changes and lack of consistency in approach were likely to impact on their wellbeing.

People received their medicines as prescribed. Staff and the registered manager understood about local safeguarding arrangements.

Risks in relation to the person's care needs and behaviours had been assessed and staff were provided with clear guidance on how to manage and mitigate these risks.

Risks in relation to the environment of the service had not been appropriately managed and timely repairs had not been completed prior to the inspection. Broken windows had been boarded up and a damaged radiator cover in the person's bedroom had not been promptly repaired and had exposed the person to risk of harm.

We are assured that risks in relation to the COVID pandemic had been managed appropriately.

The person was comfortable with the support staff and sought reassurance and support from them without hesitation. However, professionals were concerned the high staff turnover had impacted on the quality of communication support provided.

Staff told us they were well supported by the registered manager who provided effective leadership. However, the current registered manager had resigned prior to our inspection and there had been significant management turnover since our last inspection.

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

Rating at last inspection
The last rating for this service was Good (report published 10 January 2020).

Why we inspected
We received concerns in relation to the quality of support the service provided. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections 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. 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 safety, staffing, the premises and governance.

Please see the action we have told the provider to take at the end of this report.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## 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 entirely safe.

**Requires Improvement**

**Is the service responsive?**

The service was not entirely responsive.

**Requires Improvement**

**Is the service well-led?**

The service was not entirely well-led.

**Requires Improvement**

# Rosewin

**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.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Rosewin 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.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We met with the person who lives at Rosewin. We spoke with the registered manager and three members of staff.

We reviewed a range of records. This included rotas, care records, medication records and incident reports. We looked at two staff files in relation to recruitment.

After the inspection
We completed additional analysis of documents requested from the service during the site visit. In addition, we spoke with two relatives and two additional staff by telephone and gathered feedback from three professionals who worked with the service regularly.

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 this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● At our previous inspection in November 2019 the service was short staffed and staff were working long hours to achieve minimum safe staffing levels. Staff were concerned this was impacting on the person's wellbeing as they were seeing the same staff constantly. We made a recommendation in relation to these and other issues.

● At this inspection we again found the service did not employ enough permanent staff to meet the person's recognised needs. Rotas and staff allocations for the week of the inspection recorded staff vacancies for 158 daytime hours and 100 night hours. This equated to 6.5 full time staff members.

● Agency staff were being used to cover gaps in the service's rota and, on the week of our inspection, there were five agency staff working regularly in the service.

● The use of agency staff had improved staffing levels in the service and staff told us, "We could do with more staff, agency staff are doing really well, [Person's name] has taken to them really well" and "The agency staff have been here since May".

● Records showed however, there had been a small number of occasions, in the four weeks prior to our inspection, where staff numbers had dropped below minimum safe staffing levels for short periods and one instance where a staff member had worked a 25 hour waking shift. These incidents were concentrated in the early part of the period reviewed and in the two weeks prior to our inspection the service had been consistently staffed.

● During the week of our inspection, we again found that staff were working long hours in the service. Four agency staff were due to work a total of 284 hours during this week, giving an average of 71 hours each. Approximately half of the staffing hours were being provided by agency staff and a permanent staff member told us, "There are about six of us staff in total and six agency staff as well." Although agency staff were happy to work these extended shifts there are inherent risks associated with staff regularly working long hours.

● Relatives and professionals felt the lack of a consistent, permanent staff team had impacted on the person's well-being. Relatives told us, "There has been a lot of staff turnover. It does impact on [Person's name] as [they] get to know people, then suddenly they are gone." While professionals' comments included, "The current staffing situation at Rosewin is dire. The need to have trusted and enduring relationships is critical in supporting people with complex communication needs. This is not valued and has not been possible for Spectrum to maintain."

The provider's failure to ensure there were enough skilled, competent and experienced staff available to meet the person's needs was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

● The provider was experiencing significant challenges in recruiting and retaining suitably qualified and skilled staff at a number of services during 2021. The registered manager told us, "Recruitment at the moment is very difficult. I cannot even say they are trickling in."

● Staff were recruited safely. Necessary pre-employment checks were completed to ensure prospective staff were suitable for employment in the care sector.

Assessing risk, safety monitoring and management

● The radiator, in the person's bedroom, had been fitted with a cover to manage known risks. This cover had become damaged which represented a significant risk to the person. The registered manager had reported this damage to maintenance staff a month prior to our inspection but no action had been taken to address this situation.

● Inspectors were concerned by this unmanaged risk and sought assurance from the registered manager it would be resolved. The damaged radiator cover was again reported during the inspection and necessary repairs were completed later that day to ensure the person's safety.

The provider's failure to take prompt action to address the reported damage had unnecessarily exposed the person to risk of harm and was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care records provided staff with clear guidance on how to support the person if they became anxious or upset both within the service and while accessing the community. All permanent staff had received training in positive behaviour management techniques and agency staff told us, "When I came they gave me a basic training but I have asked to do a refresher on restraint and it is booked for the week after next."

● Records showed that where restraint had been necessary to ensure the person's safety this had only been used as a last resort and for the minimum time necessary. Staff told us, "It is the very, very last measure, we always try to low key at first, try giving space, try distraction measures. It is our last port of call. As long as you keep talking to [the person] is normally absolutely fine".

● Necessary checks of the building utilities had been completed and fire fighting equipment had been regularly tested and serviced.

● A Personal Emergency Evacuation Plan had been developed detailing the support the person would require in the event of a fire or other emergency evacuation.

Using medicines safely

● There were appropriate and safe systems in place for the management of medicines.

Systems and processes to safeguard people from the risk of abuse

● The registered manager and staff team understood local safeguarding arrangements and how to escalate safety concerns if this became necessary.

● The person was relaxed and comfortable with their support staff who responded promptly and appropriately to changes in the person needs during our inspection. Staff spoke positively and compassionately of the person they supported. Their comments included , "[Person's name] is lovely, I can't fault [them], I just love working with [Them]" and "I know we have [person's name] best interest at heart." A relative told us, "The staff that are with [my relative] really do care for [them]."

● There were appropriate systems in place to support the person to manage their finances.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● 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 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

● Accidents and incidents were recorded, reviewed and investigated. Information was shared with the providers behaviour support team and involved professionals so any pattern or trends could be identified. However, when analysis had identified specific issues and risks timely action had not always been taken. For example, risk had been identified in relation to how the person was supported to access the service's outdoor areas. A solution had been identified, however, issues in relation to how necessary changes to the environment would be funded had delayed action being taken. This had resulted in additional restrictions to the person's freedoms.

Requires Improvement

# Is the service responsive?

## Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to requires improvement. This meant people's needs were not always met through good organisation and delivery.

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

- The person's care plan was detailed, informative and highly individualised. It provided staff with clear guidance on how to meet the person's support needs. Staff told us, "There is a lot of information to take in but everything in [the care plan] is things we do. I think it is pretty accurate. Everything in there is what we do day to day to meet [the Person's] needs. It is very accurate."
- Care records had been accurately maintained and regularly reviewed by the registered manager.
- Relatives had been involved in the development and review of the person's care plan.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The person's communication needs and preferences had been recognised and recorded. Communication care plans had been developed and staff had been provided with detailed guidance on how to share information with the person and support them to make decision and choices.
- Professionals told us they had previously provided specific training for new staff on the person's individual needs. They noted this training had not been recently requested despite the significant turnover of staff.

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

- The service was located on a busy road that it was unsafe for the person to walk along. This meant transport and a driver were necessary for the person to engage with any activities out of the service.
- At the time of our inspection only one staff member and the registered manager were able to drive the service's vehicle and therefore the person was only able to access the community when one of these two staff were on duty. These staff had regularly completed additional shifts to enable the person to leave and records showed the person had been regularly supported on short trips away from the service to complete recycling tasks, go shopping and visits local beauty spots. However, there was limited evidence of the person having extended trips away from the service to access significant periods of exercise and activity. Relatives told us, "One of the key factors is not enough drivers so [Person's name] is not always able to go out every day. [Person's name] needs to be out and to be active".

The high levels of staff turnover and significant use of agency staff meant the person was regularly

supported by staff with limited understating of their specific needs. In addition, the lack of staff with driving skills had restricted the person's ability to access the community. This contributed to the breach of regulation 18 detailed more fully in the safe section of this report.

The provider's failure to ensure there were enough skilled, competent and experienced staff available to meet the person's needs was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At our last inspection, we found an indoor beach had been constructed in the conservatory as the person was known to enjoy spending time on the beach and digging in sand.
● At this inspection, the indoor beach had been removed as a result of a change in the person's behaviours. This space was now being used for storage and a small area of sand had been provided outside. The person was unable to access the service's outdoor spaces independently due to recognised but unmanaged risks in this environment.
● Professionals were concerned the service was not currently meeting the person's needs as the environment and location of the service had become unsuitable. They reported that the person had limited access to personal items or things to engage with independently and during our inspection we found that the person was unable to access items without support from staff. Professionals told us, "The house is too big. It is located on a corner on a very fast road which is a hazard to cross. [The person] cannot walk anywhere from the house due to its location", "Staff are not currently engaging [the person] in a full range of activities both at Rosewin and in the community. The approach is one of containment" and "I do not feel the staff have a good understanding of the importance of promoting purposeful engagement. The focus seems to be more about managing behaviours by implementing restrictions".

● On the day of our inspection the person spent most of their time in the service's lounge area watching television and seeking support and comfort from staff. This was provided with compassion and the person was clearly comfortable with and reassured by the staff team.
● The service supported the person to maintain relationships that were important to them. During the pandemic the person had been supported to maintain contact with their relatives and to visit regularly when this was permitted. Staff recognised that lockdown restrictions had impacted on the person's confidence in the community and told us, "We get out as much as we can. I think COVID had a massive impact on [Person's name], we were getting out a lot but I think his confidence has been hit a little".
● The service provided regular updates to the person's relatives detailing activities they had engaged with and recent achievements.

Improving care quality in response to complaints or concerns
● There were systems in place to ensure any complaints received were documented and investigated. Changes had been made in response to complaints received to prevent similar situations reoccurring.

Requires Improvement

# Is the service well-led?

## Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement: This meant the service's management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The environment of the service and its location disempowered the person living at Rosewin. The busy un-pavemented road meant the person could not safely access the local area without transportation. These difficulties with the location and nature of the building are described more fully within the Responsive section of the report.
- The provider had identified increasing risks in the service's gardens following changes in the person's behaviours. In response, they had proposed the installation of significant additional fencing to enable the person to have continued access to outdoor spaces. These works had not been completed by the time of our inspection and as a result the person's freedoms had been further restricted as they were unable to go outside independently.
- A number of windows at the rear of the property were broken and had been replaced by chipboard. This restricted natural light in some areas of the property and gave the service an unkempt and uncared for appearance.
- Pictures of the person enjoying outdoor activities were displayed in some areas of the service. However, these pictures were out of date and were of the person as a child not the young adult they had become.

The provider's failure to properly maintain the service and ensure it was suitable for the person needs was a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The service was designed to be led by a registered manager who was supernumerary to the staff team. However, the high levels of staff vacancies meant the current registered manager was regularly providing care as opposed to focusing on their leadership responsibilities. On the morning of our inspection the registered manager was providing care and staff told us, "There are normally four of us, sometimes [the registered manager] is supernumerary."
- Staff were complimentary of the current registered manager and told us, "I cannot fault the manager, the support she gives us is amazing, she is really good. Anything, suggestion wise, we tell her and she tries to get it sorted" and "[The registered manager] has been very, very good, very supportive and has put a lot of faith and trust in me. They have given me a lot of good guidance."

● There had been a lack of consistent, stable leadership for the service. Relatives and professionals told us there had been three changes of manager in the last year. The current registered manager had resigned and was working out their notice period at the time of this inspection. Relatives said, "To lose another manager is utterly devastating".
● Audits had been completed by the registered manager and provider's regional manager. These audits focused on the quality of administration and had not recognised significant change in the person's needs and behaviours. Action plans had been developed detailing how identified issues should be resolved and setting time scales for these works.
● The provider had failed to take prompt action to repair the damaged radiator cover. This device was necessary to manage known risks within the persons bedroom. The damage had been initially reported to maintenance staff a month prior to our inspection. The necessary repairs were not completed until this issue was raised as a specific safety concern during the inspection. In relation to the current availability of maintenance personnel staff told us, "I think there is only one maintenance person for all 20 houses so it is difficult for them to get round".

Continuous learning and improving care; Working in partnership with others
● Prior to our inspection professionals involved in the person's care had become concerned that the placement was at risk of breaking down and was failing to meet the person's needs. As a result, additional support had been given to the service. Professionals were now working alongside the staff team to provide training and guidance on how to meet the person's specific needs. In addition, the provider's behavioural support team was also regularly visiting the service to provide additional support and advice to staff.
● The provider had not been proactive in identifying, or reporting to professionals, changes in the person's needs. This had increased risks within the service and had meant professional support had not been accessed appropriately. Professional's comments included, "Spectrum's senior management have contributed to the situation by minimising any problems in the support being offered to the [Person]" and, "The [Providers] specialist behavioural team are not proactive in analysing incident reports. They seem to collect enormous amounts of data but never actually do anything about it other than impose restrictions".

The provider's failure to take timely action to mitigate identified risks and effectively monitor the quality of support the person received was a breach of the requirements of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider and registered manager understood their responsibilities under the duty of candour. Relatives had been kept informed of changes in the person's behaviours and details of significant incidents that had occurred were shared appropriately.

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 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had failed to take prompt action to address the reported damage to the radiator cover in the person's bedroom. This had unnecessarily exposed the person to risk of harm and was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>The provider had failed to properly maintain the service and ensure it was suitable for the person's needs. This was a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to take timely action to mitigate identified risks and effectively monitor the quality of support the person received. This was a breach of the requirements of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or | Regulation 18 HSCA RA Regulations 2014 Staffing |

personal care

The provider had failed to ensure there were enough skilled, competent and experienced staff available to meet the person's needs. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.