Spectrum (Devon and Cornwall Autistic Community Trust)

Carrick

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

People's experience of using this service and what we found
The service was regularly short staffed and frequently operated at minimum safe staffing levels which impacted on people's freedoms. One staff member routinely worked in excess of 84 hours per week, contrary to documented risk assessments. This exposed people to a risk of harm and poor quality of life, and had resulted in the service being unsafely staffed on one occasion.

Safeguarding incidents had not always been shared with the local authority and the provider had not worked collaboratively with partners to ensure people's safety.

The provider's quality assurance systems were ineffective and action plans developed to address issues identified at our last inspection had failed to drive improvements in the service's performance.

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.

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:
Staffing levels were insufficient to enable people to go out when they wanted to. Some staff were working excessive hours which impacted on their performance and exposed people to increased risk of harm. People were not treated equally and their needs were not met.

Right care:
People did not consistently receive person centred care appropriate to their needs. People were excluded from routine decision making and available communication tools were not used.

Right culture:
There was a lack of effective oversight of the service. In combination with low staffing levels, long working hours had led to unplanned restrictions on people being used within the service. The acting manager had limited leadership experience and had received minimal support from the provider.

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 Requires Improvement. (Report published 14 September 2021) Breaches of the regulations were identified . The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found not enough improvements had been made and the provider was still in breach of a number of regulations.

Why we inspected
We received concerns in relation to staffing levels and staffing working hours from a whistle-blower. A decision was made for us to inspect and examine those risks and the overall performance of the service. We also undertook this inspection to assess that the service is applying the principles of right support, right care, right culture.

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

We have found evidence that the provider needs to make improvement. Please see the Safe, Effective, Caring, Responsive 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 Person centred care, Dignity and respect, Safe care and treatment, Safeguarding, Staffing and Governance at this inspection.

Please see the action we have told the provider to take at the end of this report.
Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
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 always 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**

Carrick

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 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 three inspectors over two days. Two inspectors were present in the service on each inspection day.

Service and service type
Carrick is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at incident reports, training data and quality assurance records. We spoke with the acting manager, nominated individual and two people's relatives.

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 requires improvement. At this inspection this key question has now deteriorated to Inadequate. 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 ensure there were enough staff available keep people safe. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we again found there were not enough staff available to meet people's support needs. This unnecessarily restricted people's freedoms and exposed them to risk of harm. This meant the service remains in breach of the regulation.

- The five people who lived at Carrick needed support from four staff during the day with a two-hour period when five members of staff were required. This was intended to enable one person who needed support from two members of staff to go out, to leave the service for a short period each day. The service's contingency plan had been amended since our last inspection. The emergency minimum safe staffing level had been reduced from "four experienced team members during the morning and three experienced team members in the evening from 5pm" to "three experienced members of staff".
- The rota showed there were four full time staff vacancies at Carrick during the week of our inspection. The manager told us, "We have 128 hours of vacancies". This meant it was difficult for the service to consistently have the right level of staff working.
- On the second day of the inspection the service was operating at emergency minimum safe staffing levels with the acting manager and two care staff on duty. The acting manager told us, "Yesterday we were on four in the day, we managed to get out in a staggered capacity. Was going to drop to two in evening so I stayed on and did the sleep in".
- Records for January showed the service had operated at emergency minimum staffing levels during 11 of 48 shifts. At these staffing levels people's freedoms were restricted as there were not enough staff to support people to leave the service. By regularly planning to operate at emergency minimum staffing levels the provider had exposed people both to risk of harm and unnecessary restrictions to their freedoms.
- On one occasion, on 23 January during the morning, the service had been unsafe as only the manager and one member of staff were on duty. This situation had developed because a staff member who was working excessive hours was unexpectedly unwell. This situation was unsafe and was not promptly resolved by the provider. No arrangements had been made to provide additional staffing support to ensure people's safety by the provider.

At the last inspection we identified that in response to staffing shortages the provider had begun using agency staff to ensure people's needs were met. Some agency staff were routinely completing 14 hour shifts

which was an inherent risk to people's safety. This inspection was in part planned to investigate reports received from a whistle blower that staff were working excessive hours, and this had led to one staff member falling asleep whilst on duty.

At this inspection, we again found that agency staff were working excessive numbers of hours. This exposed people to risk of harm.

● The provider has been experiencing significant challenges in recruiting and retaining staff during the COVID-19 pandemic. Since our last inspection there had been an overall reduction in staff numbers at Carrick.
● As a result, the use of agency staff had continued. Staff rotas showed that agency staff were regularly allocated 14 hours shifts. Following safeguarding concerns at a number of services operated by Spectrum, they assured the local authority that agency staff members would be limited to a maximum of 70 hours per week .
● Records showed there had been an occasion when an agency staff member had fallen asleep in the early evening while supporting a person in their flat. This had been investigated by the manager and the staff members working hours limited to a maximum of 70 hour per week with one rest day.
● The rota showed this member of staff was again working above 84 hours per week. In the 31 days prior to the inspection, they had worked for 28 days. This comprised a minimum of 84 hours during the day, per week and additional sleep-in shifts. During the week beginning 26 December this staff member had worked 94 day hours and had completed 40 hours of sleep-in shifts.
● In response to the draft report, the provider supplied the commission with a risk assessment for this staff members working hours during the week beginning 26 December. This assessment recognised risks in relation to the staff member's Psychological wellbeing, ability to drive and ability to complete accurate records because of tiredness. This risk assessment did not recognise or identify any risks in relation to the quality of care provided by tired members of staff.
● When this staff member had been unwell on 23 January, the service had operated at below its emergency minimum staffing level and struggled to fill all shifts the following week. Working these excessive hours with limited opportunities for rest exposed both the staff member and the people they supported to significant risk of harm.

The provided has again failed to ensure sufficient numbers of experienced staff were available to meet people's recognised needs. This was an ongoing breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the first day of our inspection, we raised a safeguarding alert with the local safeguarding authority about the current staffing arrangements at Carrick.
● Staff were recruited safely. Necessary checks had been completed, before new staff started work, to ensure they were suitable for employment in the care sector.

Assessing risk, safety monitoring and management
● Risks in relation to scalding and hot water temperatures had not been appropriately managed. People were able to access the service's kitchen and bathrooms independently. Weekly water temperature checks were planned to manage these risks. However, these checks had not been completed since 23 December 2021. In addition, the service's boiler had broken down and been repaired in late January and no checks of the service's water temperatures had been completed following these works.
● Staff had identified a link between one person's support needs and their ability to go out. This was dependent on a specific vehicle. The provider had attempted to install a driver monitoring system on the

vehicle. This system had not worked correctly, and staff were instructed not to use the vehicle for a number of weeks until the system was operational.
●This resulted in restrictions to the person's freedoms which were identified as a contributing factor in incidents records in November and December 2021. The provider's failure to ensure the person was able to go out had exposed them to a risk of harm.

The providers failure to complete necessary water temperature checks and failure to manage risks associated with restricting people's freedoms, had unnecessarily exposed people to the risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care plans included information about events and incidents likely to cause people to become anxious or upset. This included details of possible triggers, descriptions of how they were likely to express their anxiety and guidance for staff on how they should respond to help people to manage their anxiety.
● At the last inspection changes in one person's support needs were adversely impacting on others. Following that inspection changes had been made to how this person was supported. At this inspection there had been a reduction in these incidents.
● Records showed physical restraint and other restrictions were used appropriately and for the minimum time necessary. Staff confirmed this was correct.
● Personal Emergency Evacuation Plans were available for everyone who lived at a Carrick. These documents provide staff and emergency personnel with guidance on the support people would need to evacuate the building.

Systems and processes to safeguard people from the risk of abuse

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

At this inspection we found this issue had not been resolved and that necessary safeguarding referrals had not been made following incidents that had occurred in the service. This meant the service remained in breach of the regulations.

● An agency staff member had been found asleep while on duty in the service. This incident had been internally investigated but no safeguarding alert had been made. There was no evidence available to demonstrate details had been shared with the recruitment agency.
● The provider's safeguarding procedures required that information about specific incidents of alleged abuse be shared with the provider's senior managers and reviewed before the commission or local authority were informed. This practice led to inherent delays and failures in the making of safeguarding alerts.
● We identified issues in relation to the management of people's financial affairs by the provider. We requested additional information from the provider to demonstrated people were appropriately protected from financial abuse. This information was not provided.

The providers failure to report safeguarding incidents and appropriately manage the risk of financial abuse was an ongoing breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Relatives were confident people ware safe at Carrick and staff told us, "People are very, very safe". Despite this positive comment we found evidence that people were not always supported safely.

Learning lessons when things go wrong
● The provider had failed to learn lessons when things went wrong. Risk assessments completed following incidents had not been followed. This meant action had not been taken to minimise the risk of similar events reoccurring.
● Accidents and incidents had been appropriately documented. Where injuries had occurred the records of these incidents had been reviewed by the provider. Some additional guidance or suggestions had been made on changes in approach that could be attempted.

Using medicines safely
● People received their medicines safely and as prescribed. Staff understood how to support people with their medicines and there were appropriate processes in place to ensure 'as required' medicines were used appropriately. They told us, "Two staff do medicines so there is a check".
●The service was preparing to transition to a digital Medicine administration record (MAR) system and necessary medicines audits had been completed regularly.
●Where written changes had been made to MAR entries, these had not been consistently countersigned to ensure information had been transcribed accurately. The introduction of the digital MAR system was expected to resolve this issue.
● Since our last inspection, systems had been developed to enable most people's medicines to be stored in their own rooms.

Preventing and controlling infection
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in Care Homes
People were supported to maintain contact with friends and family. The home was following government guidance in respect of care home visiting. Relatives, people and staff confirmed that visits in and out of the home were supported.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency.

● The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

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.

Staff support: induction, training, skills and experience

- New Spectrum staff completed a programme of induction training before joining the service. During the covid-19 Pandemic this training had been provided online and staff told us, "I had a week's online training when I started and a whole heap of e-learning to do".
- The service did not have effective systems in place to ensure all staff training was regularly updated. The training matrix showed all staff needed medicines training, seven staff required safeguarding training, seven staff required first aid training and five staff required food hygiene training. The acting manager had recognised these issues and had allocated online courses for staff to complete. However, this issue had not yet been resolved.
- The agency staff member had received one day's training from Spectrum before joining the service. This agency staff member had limited previous knowledge of learning disability care and there was no information available to demonstrate they had the skills necessary to meet people's support needs when they were upset or anxious.
- Staff had not received regular supervision. There was a supervision schedule in place, but records showed this support had not been given as planned. This meant staff had not had opportunities to review practice, share learning or identify training and development opportunities.

The provider had failed to ensure staff had the skills and knowledge necessary to meet people's care needs. This forms part of the ongoing breach of ongoing breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People were not supported to have choice and control in relation to their meals. Staff planned and prepared meals with limited or no input from people. Communication tools were available to enable people to participate in meal planning but were not used during either day of the inspection.
- The same lunch time meals were served to everyone. The delay in supporting one person to get up meant there was only a limited gap between their breakfast and lunch.

The provider had failed to promote people's dignity by supporting and enabling them to have control of their diet. This forms part of a breach of the requirements of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Staff restricted and controlled one person's access to drinks. When a hot drink was made for them, a timer

was set and the person was not allowed the drink until after an alarm sounded. The person then immediately collected and quickly consumed their drink. Details of this restrictive practice were not readily alliable at the time of the inspection. Following the inspection, the provider produced additional information which demonstrated this restrictive practice had been reported as part of a necessary DOLS application. In addition, guidance was sough from involved professionals, following the inspection, on how this restriction could be reduced."
● Some people were supported to participate in shopping and fresh ingredients were available within the service.

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

At the last inspection we found the kitchen units were damaged, recliner chairs shabby and in need of repair and that the outside of the building had been neglected. This meant people did not have a comfortable and homely environment.

At this inspection we found improvements had been made to the service's environment.

● Kitchen units had been repaired or replaced. Lounge carpets had been cleaned and damaged recliner chairs had been upgraded.
● Improvements had also been made to the outdoor environment of the service. The tyres had been removed and people were able to use the service's rear garden independently.
● The annex was well maintained and decorated in accordance with the person's interests.
● The boiler was broken on the first day of our inspection. Additional heat sources a had been provided and prompt repairs completed prior to our second inspection day.

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.
● Staff did not support people appropriately to make day to day decision and choices. Low staffing level unnecessarily restricted people's ability to leave the service when they wished. These failings are detailed in the caring section of this report.
● The acting manager had some understanding of the MCA and records showed assessment of people's capacity to make some decisions had been documented. However, these records included limited evidence of attempts to involve the person, their advocate or family members in decisions.
● The provider had recognised there were restriction in place to ensure people's safety which prevented

people from leaving the service if they wished. Necessary applications had been made to the local authority for authorisation under the deprivation of liberty safeguards.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Carrick was currently full. However, there were appropriate systems and processes available to assess people's specific needs before they moved in.
● People did not receive person centred care and unplanned restrictive practices were observed during this inspection.

Staff working with other agencies to provide consistent, effective, timely care and access healthcare services and support; Supporting people to live healthier lives
● As detailed in the responsive section of this report people were not consistently supported to exercise. One person liked to cycle and had their own bicycle, despite a recent period of fine weather the person had not been supported to use it.
● People were supported to access health and care services as necessary. Records showed people had recently accessed dental and physiotherapy service with support from the staff team.
● Information about people's specific support and communication need in the event of a hospital admission had been recorded and was available for use if required.
● People were appropriately supported to manage their oral health needs.

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

- Low staffing levels and the excessive working hours of some members of staff had impacted on the quality of support people received. People were not treated equally and people whose actions were unlikely to impact on others, received minimal engagement from staff.
- Staff told us, and records showed one person's access to particular outdoor spaces had been restricted. There was no information available in the person's records detailing why this restriction was necessary or appropriate.
- Routines in the service were often created for the benefit of staff rather than people. As at the last inspection, staff delayed supporting one person to get up in the morning. This person required more support than the other individuals living in the service. By restricting this person's freedoms, the limited number of staff available were better able to meet other people's needs in the early morning. One staff member told us, "This is the usual time for [Person's name] to get up, tend to get the others up first because [Person's name] needs more time and attention."

Respecting and promoting people's privacy, dignity and independence

- Staff did not treat people as individuals or support their independence. People living in the main part of the service were routinely referred to as a group and were not treated as individuals.
- People were not supported or encouraged to complete tasks independently or gain new skills. Staff routinely completed tasks for people rather that supporting people to do things for themselves. Staff told us people were unable to prepare the own breakfast as they would be unable to judge appropriate quantities to use. Support was not provided to help people gain the necessary skills and instead meals were normally prepared by staff. One person attempted to participate in preparing a drink and was told by staff, "You go and sit down, and I'll bring it to you."

The Provider had failed to support people to participate in decision making, be as independent as possible or to gain or develop new skills. This forms part of a breach of the requirements of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- People were not consistently supported to maintain their dignity and appearance. On the first day of our inspection one person was unkempt with greasy, unwashed hair and dirty clothing.
- Confidential personal information was not stored appropriately when not in use. In addition, a notice board in the service's lounge and visible from outside and to all people, included information about

incidents that had occurred within the service.

Supporting people to express their views and be involved in making decisions about their care
● Staff regularly spoke together in front of people without involving them in conversations. Two staff discussed and planned the lunchtime meal together. People were present during this discussion but were not supported to participate in either planning or the preparation of the meal.
● People's care records included limited evidence to demonstrate people had been effectively supported to make decisions or express their views in relation to how support was provided.

The provider had failed to ensure people were consistently treated with dignity and respect. This forms part of a breach of the requirements of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A survey of relatives had been completed had been completed in 2021 to gather feedback on the service's performance from people's relatives and supporters. The feedback provided was complimentary.

Inadequate

Is the service responsive?

Our findings

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

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

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 this inspection staff engaged less with people than during our previous inspections of Carrick. Staff were observed speaking over people, not engaging them in decision making or encouraging participation in leisure activities.

● Staff spent significant periods passively observing people in the services' communal spaces rather than supporting them proactively to engage in meaningful activities. When offered opportunities to engage with domestic tasks people were motivated and keen to engage. However, these activities were of limited duration and people spent most of the day passively watching TV.

● Another person's care plan indicated they required access to a sensory box which was to be stored near their chair in the lounge. This box was not present during the inspection and the person was observed interacting with a photograph regularly throughout the inspection. When asked, staff confirmed there was no sensory box in the lounge, but he had some sensory 'toys' in his bedroom. These were not provided during either day of the inspection.

● As detailed in the safe section of the report, staff recognised that boredom, lack of activities and restrictions to people's freedoms because of low staffing levels had contributed to incidents occurring in the service; however very little action had been taken to improve people's experiences since our last inspection.

● There was a significant inequality at the service in relation to people's opportunities to use the community and do things they enjoyed.

● Three of the five people who lived at Carrick were regularly supported go out. Records showed they had been supported to do a range of activities in the community including exercise, shopping and entertainment. Staff told us, "Here, people go out every day", "We almost always get [person's name] out. [Two other people's names] go out most days" and "[Two people's names] tend to say no but we try to get them out when we can".

● Staff prioritised supporting these three individuals to leave the service as they recognised boredom and lack of community access could lead to them acting in ways that put themselves and other at risk of harm. The remaining two people were not regularly supported to leave the service because they did not show the same high levels of anxiety when unable to go out. One of these people's care plans recorded that they liked to, "Complete the weekly shop (with familiar team members), playing dominos and pairing games with team members, spending time watching science fiction and going to the local pub and shop". Their care records showed they had only left the service once, had been offered one other opportunity to leave the service and had been offered six opportunities to play dominos in January 2022.

● The acting manager reported that these two people shared staff and this meant it was more difficult to support these individuals go out. In addition, the acting manager reported one person often refused support

to leave the service. However, commissioning documents of the person who had only left the service once showed this person was meant to receive six hours of one to one care each day, including three hours of support to enable them to access the community. Their care plan stated, "[Person's name] shares his care with another service user, therefore has approximately 6 hours 1:1 staffing ratio". The services' rota did not provide for this need and the staff team were unaware the person was supposed to receive one to one support each day.

● The provider had identified in October 2021 that activities schedules in place at Carrick and used to plan what activities people would be offered each day were not person centred. This issue had not yet been resolved and we found limited evidence of people being supported to engage with meaningful activities during this inspection.

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 staff had not received training in Makaton training to meet one person's communication needs. The action plan produced following that inspection identified that this issue would be resolved by December 2021.

● At this inspection, no additional Makaton training had been provided to staff to enable them to communicate more effectively with people.

● Information about people's communication needs and preferences was available to staff within people's care plans. We observed one person repeatedly using a small number of phrases regularly during the inspection. There was limited information about what these phrases meant or how to interpret this specific behaviour in the person's care plan. Staff tended to discourage this behaviour using a specific phrase to which the person consistently responded. However, this staff practice was contrary to the guidance in the person's care plan.

The provider had failed to meet people's communication needs, enable people to effectively participate in making decisions and had failed to support people to live meaningful lives like ordinary members of society. about how their needs were met. This contributed to the breach of the requirements of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One person liked the colour red and this colour had been used to develop a document to support them to take on responsibility for specific tasks within the service.

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

● There were care plans in place for each person which provided guidance for staff to meet people needs. However, we observed staff did not consistently support people in accordance with their planned care.

Improving care quality in response to complaints or concerns

● The provider had a system in place designed to ensure all complaints were recorded and investigated.

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 Requires improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection we found there had been a lack of oversight in the service and that low staffing levels and long working hours had impacted on the quality of care people received. This was a breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the service's performance had deteriorated further. Low staffing levels and excessive working hours remained significant challenges which the provider had failed to resolve. In addition, recognised failures in relation to the quality and accuracy of records had not been resolved. This meant the service remains in breach of the regulations.

- There was no registered manager at Carrick. The provider had appointed an acting manager with limited previous leadership experience to lead the service following the previous registered manager resignation.
- The manager at Carrick was supposed to be supernumerary but low staffing levels meant they were routinely having to provide care and support. Rotas showed that of the 19 shifts the manager had worked in January they had been supernumerary on only four occasions. This lack of dedicated management time meant there were limited opportunities for the manager to focus on their leadership responsibilities and improving the service.
- The provider's structure was for each service manager to be supported by a regional manager responsible for overseeing up to eight services. The provider's structure was for each service manager to be supported by a regional manager responsible for overseeing up to eight services. However, there was currently only one regional manager available to support all of the services operated by the provider. This situation meant there was limited time available for the regional manager to provide support and guidance to the acting manager at Carrick. During the second day of the inspection the acting manager told us, "[The regional manager] has been good as gold but has responsibility for a lot of services. [They are] coming in tomorrow."
- The acting manager received minimal support from the provider during the inspection process. Information shared with the Nominated Individual about the safeguarding alert made by the commission following the first inspection day was not passed on to the acting manager.
- There were significant staff vacancies at Carrick and agency staff were being used to cover gaps in the service's rota. As detailed in the safe section of this report, the provider had scheduled agency staff to routinely work extremely long hours contrary to documented risk assessments. Working excessive hours without necessary rest periods meant staff were tired and increased the risk of staff sickness impacting of staffing levels. Lack of effective oversight of the service had failed to ensure limits on staff working hours,

introduced following an incident where a staff member fell asleep on duty, were complied with.
● Accurate records were again not maintained of the care and support people received. In the records, of all three people we reviewed, numerous examples of missing care records were identified.
● Audits and previous inspections had identified that care records were not accurately maintained at Carrick. The provider's governance systems had again failed to address and resolve this known issue. An online record keeping system was used to document the support each person received. However, this system did not enable the acting manager or staff team to view information in chronological order. This made it difficult to identify and rectify missing entries in people's records.

Continuous learning and improving care
● The provider's systems did not effectively support the staff team at Carrick. Limited input had been received from senior management since the acting manager's appointed. In addition, the provider's on call system had not operated consistently to support staff when the acting manager was not on duty in the service.
● Incident records showed in December 2021, staff had attempted to seek guidance from the on-call manager during an incident where restraint and seclusion had been appropriately used to ensure people's safety. This incident record stated, "A team member called "on-call" six times, but unfortunately only got "it was not possible to connect your call" so could not even leave a message." The provider's policy was that use of PRN medicine required authorisation from the on-call manager. This meant the person was unable to access medicines prescribed to help them manage their anxiety.
●This incident had been reviewed by the provider's behavioural team, but no feedback was given, or action taken to identify why the on-call manager was unavailable or improve systems so this did not happen again. This demonstrated the provider was incapable of recognising and addressing failure in their systems.
●Following the previous inspection in July 2021 the provider developed an action plan which they shared with the commission. It detailed the action they intended to take to address and resolve the breaches regarding safeguarding, governance and staffing. As demonstrated by the findings of this report the action plan had failed to drive the necessary improvements in the service's performance.

The provider did not have appropriate systems in place to ensure compliance with the requirements of the regulations. This was a repeated breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The acting manager had received supervision from their regional manager and was being supported to complete additional leadership training. Staff were complimentary of the acting manager and told us, "The manager is brilliant, really nice".

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
● There was a closed culture in the service. The lack of effective management and oversight of the service had enabled unplanned restrictions to people liberties to develop. This in combination with low staffing levels, long working hours and with people's significant reliance on staff to meet their basic needs, meant people were exposed people to risk of harm and a low quality of life.
● Low staffing levels meant the service was unable to provide person centred care. As detailed in this report, the support provided during this inspection did not meet people's individual needs. People's freedoms were restricted, and limited support provided to help people gain skills, maintain their independence or develop new interests.
● People's equality characteristics were not fully considered and appropriate support was not provided to

enable people to participate in decision making.

Working in partnership with others
● The provider had not worked collaboratively with the local authority to ensure people's safety. Information requested as part of ongoing safeguarding processes had not been provided promptly.

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 acting manager understood of their responsibilities under the Duty of Candour.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to report safeguarding incidents and appropriately manage the risk of financial abuse.

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 failed to meet people's communication needs, enable people to effectively participate in making decisions and had failed to support people to live meaningful lives like ordinary members of society.

The enforcement action we took:

We imposed conditions against the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure people were consistently treated with dignity and respect.

The enforcement action we took:

We imposed conditions against the providers registration.

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 complete necessary water temperature checks and manage risks associated with restricting people's freedoms. This had unnecessarily exposed people to the risk of harm.

The enforcement action we took:

We imposed conditions against the providers registration.

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 appropriate systems in place to ensure compliance with the requirements of the regulations.

The enforcement action we took:

We imposed conditions against the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provided has again failed to ensure sufficient numbers of appropriately knowledgeable and skilled staff were available to meet people's recognised needs.

The enforcement action we took:

We imposed conditions against the providers registration.