Spectrum (Devon and Cornwall Autistic Community Trust)

Trelawney House

Inspection report

Polladras
Breage
Helston
Cornwall
TR13 9NT

Tel: 01736763334
Website: www.spectrumasd.org

Date of inspection visit:
01 July 2019
02 July 2019

Date of publication:
13 August 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Trelawney House is a residential care home providing personal care for up to six people with learning disabilities. At the time of our inspection six people were using the service.

The service is a detached two-story building with enclosed gardens. It is located in a very rural area near Helston, Cornwall. This meant people were unable to access the local community without support from staff.

People's experience of using this service and what we found
Two people were frequently awake in the early hours of the morning and were often noisy. This could adversely impact on others living in the service. People's sleep was regularly disturbed and this had impacted on their wellbeing. These issues had been identified and reported to commissioners in February 2019 and various changes to people's routines and medications had been made to attempt to address this situation. These approaches had proved unsuccessful and the service had failed to resolve this situation. We made a safeguarding alert following the inspection as we were concerned about the impact these behaviours were having on other people living in the service.

On arrival on the first day of our inspection the service was short staffed and records showed this occurred regularly. This impacted on both people's ability to access the community and increased the risk of incidents occurring within the service. Staff comments included, "[Person's name] is two to one, most evenings you are lone working. You end up getting more injured" and "People get bored as they can't go out. It caused a vicious circle as behaviours escalate."

Medicines were managed safely, and necessary staff pre-employment checks had been completed. The service was clean and risks had been appropriately assessed.

New staff received appropriate induction training. However, training for established staff was not regularly updated to ensure they had the skills necessary to meet people's needs. The service was well maintained and people were supported to participate in the planning and preparation of meals.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff were caring and responded promptly to people's needs. People were valued as individuals and their choices were respected.

People's care plan's had not been regularly updated and did not accurately reflect their current care and

support needs.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support as low staffing levels meant people were unable to access the community when they wished.

Staff were able to communicate effectively with people using a variety of personalised techniques. Complaints received had been appropriately investigated.

The service used digital systems to record details of the care and support each day and any incident records. There was only one computer available to access this information on the day of our inspection and it was unreliable. This meant it was difficult for staff to input information into the system and for the manager to review completed records of incidents that had occurred.

The provider' quality assurance processes were ineffective and had failed to ensure compliance with the requirements of the regulations.

The service had experienced significant management changes since our last inspection. A new manager had been recently appointed and was in the process of applying to become the registered manager.

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

Rating at the last inspection
The last rating for this service was good. (Report published 15 August 2017)

Why we inspected
The inspection was prompted in part due to concerns received in relation to staffing levels and the quality of support people were receiving. A decision was made to inspect and examine those risks.

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

You can see what action we have asked the provider to take at the end of this full report.

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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Trelawney House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was completed by one inspector.

Service and service type
Trelawney House is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 our inspection there was a new manager in post who was in the process of applying to become registered.

Notice of inspection
This inspection was unannounced. However, on arrival on the first day of the inspection the service was experiencing significant challenges as a damaged water supply in an upstairs bedroom had led to flooding in the lounge. Mains electricity had been switched off to manage resulting risks and this incident had caused people living in the service some distress. As a result, the inspection was postponed until the following day.

What we did before inspection
We reviewed information we had received about the service since the last inspection and sought feedback on its current performance from the local authority. 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 this information to plan our inspection.

During the inspection
We met and spoke with five people who used the service about the quality of care and support the service provided. We also spoke with six members of care staff, the new manager and the provider's operations manager.

We reviewed a range of records. This included two people's care and medication records. We also looked at four staff files in relation to recruitment and supervision. A variety of records relating to the management of the service were reviewed, including policies, procedures, staff rotas and the service's training matrix.

After the inspection
Following the inspection, we spoke with a relative and the advocate for two people living in the service about the services performance. We also spoke with the provider's recruitment officer and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also requested additional information from the service's manager.

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 Good. At this inspection this key question has now deteriorated to requires improvement. 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.

Systems and processes to safeguard people from the risk of abuse

- Staff understood their roles and responsibilities in relation to ensuring people's safety. They were confident specific safety concerns reported to the new manager would be addressed and knew how to report safeguarding concerns outside the service.
- People, their relatives and representatives told us that two people had very irregular sleep patterns and often got up in the early hours of the morning. They could sometimes become noisy and disturb the rest of the house. Records confirmed this, and staff told us, "Four times a week. [Person's name] is up early in the morning", "It has happened quite a lot that everyone is woken up at night. The noise really does affect all of them" and "It is very noisy at night, so people get up tired and teasy and it is just a vicious circle from there."
- Various changes to people's routines, medicines and care practices had been made in attempts to minimise the impact on people's sleep but these measures had proved unsuccessful.
- Staff also disclosed to inspectors that one person was exhibiting self-injurious behaviours when their sleep was disturbed. These behaviours had not been fully documented within the person's care records. As a result of disclosures by staff and people using the service a safeguarding alert was made following the inspection.
- An analysis completed by the provider in February 2019 had identified that people's behaviour at night was adversely impacting on others. The service had shared these concerns with commissioners and requested additional support. Managers reported further support had not been agreed and as a result the service they had raised their safety concerns via the safeguarding process.
- However, the actions taken by the service and the systems currently in place had not prevented people's behaviour at night from impacting on others. The service had failed to resolve this situation.

Assessing risk, safety monitoring and management

- Significant changes in some people's support needs when they became upset or anxious had occurred. These changes in people's needs were not reflected in their current care plans. For example, one person's care plan advised staff that restraint techniques should not been used within the service. However, we found records of restraint techniques being used within the service and staff told us, "[Person's name] has become more physical with staff. There has been some restraint in the last couple of weeks." Although staff were trained in how to use restraint techniques appropriately the failure to review and update care plans in relation to the use of restraint meant people were not receiving safe care.
- The environment was well maintained and firefighting equipment had been regularly serviced.
- The level of support each person would require in an emergency evacuation had been identified and

recorded. These plans did not entirely reflect all known risks within the service and the new manager agreed they would be reviewed and updated.

Learning lessons when things go wrong

● A digital care planning system had been introduced to the service. Staff were supposed to use this system to record details of the care they provided and any incidents or accidents that occurred. However, on the day of our inspection there was only one computer available for use. Additional tablet computers had been provided but were not used because of reliability issues and poor WiFi coverage within the service. Staff told us, "The computer is rubbish. It is very annoying when you have to complete incident records as it keeps crashing" and "There is one computer and a tablet for the service. It is not ideal, could do with at least two computers really." During the inspection staff disclosed details of incidents that had occurred but had not been recorded.

● The new manager recognised that the digital care planning system was difficult for staff to use because of reliability and connectivity issues. In addition, they reported it was difficult for them to review information on the system and this was observed during the inspection.

Care and treatment was not being provided in a safe way. All reasonably practical measures had not been taken to prevent people's behaviour from impacting on others, care plans did not accurately reflect people's current support needs when they became upset or anxious and accidents and incident had not been accurately recorded. This mean the provider was in breach of the requirements of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The service's recruitment practices were safe and necessary disclosure and barring service checks had been completed. However, references had not always been requested from prospective staff members' previous employers in the care sector. This was discussed with the provider's recruitment officer after the inspection who will ensure these references are required in future. references from previous employers in the care sector were requested in future.

● Relatives and representatives told us, "Sometimes they are very short staffed" and "I think staffing is probably the biggest issue."

● On arrival on the first day of our inspection the service was short staffed, and staff told us, "We are one below contingency today." Prior to our arrival a request had been made to the provider's on call manager for additional staff support and this was subsequently arranged.

● Records showed that on some occasions staffing levels had been below contingency levels. At these staffing levels people's access to the community and planned activities was significantly restricted as there were not enough staff available to safely support people outside the service. In addition, rotas showed people were regularly not receiving planned levels of support. This exposed both people and staff to unnecessary risk. Staff told us, "[Person's name] has two to one for a reason but [they are] not always getting it" and "[Person's name] is two to one, most evenings you are lone working. You end up getting more injured."

● We reviewed staff rotas and allocations and found that the service was regularly short staffed. Staff comments included, "We have been short staffed for about six months, it has got better but not much better", "Mondays, Wednesdays and weekends we are usually short staffed" and "Once or twice a week we get fairly good staffing days."

● A recruitment campaign was underway to address staffing issues and five new staff had been appointed since April. However, in the same period four staff had resigned from the service.

The failure to provide enough staff to safely meet people's needs was a breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Prior to our inspection the provider had identified that staffing levels were not sufficient to meet people's support needs. These issues had been raised with commissioners but not yet resolved.

Using medicines safely

● There were suitable arrangements for ordering, receiving, storing and disposal of medicines, including medicines requiring extra security.
● Medicines were administered safely, and Medicine Administration Records had been appropriately completed.
● Medicines audits were completed and where any errors occurred appropriate action was taken to prevent similar incidents reoccurring.

Preventing and controlling infection

● The service was clean and there were appropriate procedures in place to manage infection control risks.
● Staff encouraged and supported people to participate in cleaning and domestic tasks within the service.

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.

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 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 staff received a package of formal training before they began working in the service and recently appointed staff told us, "the training was good" and "I did two weeks induction training at head office."
- All new staff completed several shadow shifts in the service to get to know people and gain an understanding of their individual needs before they were permitted to provide support independently.
- The training of established staff had not been regularly refreshed to ensure they had the skills necessary to meet people's current support needs. Staff told us, "The training is good, I am behind on several things but [the new manager] has done a new schedule" and "I've got my training coming up, I know I have been booked on it." The new manger had identified that training for more than half of the staff team required updating.
- Staff had not received regular supervision prior to the inspection. The new manager was introducing new procedures to ensure supervision was provided regularly in future and staff told us, "I had supervision last week" and "I had supervision about three weeks ago".

The failure to provide training updates and regular staff supervision forms part of the breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed before they moved into the service to ensure their needs and expectations could be met.
- Care plans were then developed by combining information gathered during the assessments process, with details from previous care providers and staff feedback on the person's individual needs.

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

- People were supported to participate in the planning, preparation of and shopping for meals. There were a variety of fresh ingredients available and each person had their own cupboard space in which to store food and snacks.
- People were encouraged to make healthy dietary choices and meals served looked tasty and nutritious.

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

- The service was well maintained and decorated in a homely style. The enclosed gardens included two

summer houses where people could spend time when they wished.
●People's bedrooms had been individually decorated in accordance with their preferences and were highly personalised.

Supporting people to live healthier lives, access healthcare services and support
●People were supported to access healthcare services when required. Where concerns were identified in relation to people's health or wellbeing appropriate and timely referrals for professional support had been made.

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.
● Assessment of people's capacity to make specific decisions had been completed.
● Where people lacked capacity appropriate best interest decisions had been made with the involvement of relatives and health professionals.
● Some people who lacked capacity had restrictive care plans and necessary applications to the local authority had been made for their authorisation under the Deprivation of Liberty Safeguards.
● Staff offered assistance and sought people's permission before providing support.

Good

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 Good. At this inspection this key question has remained good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- People got on well with their support staff and told us, "I like the staff here" and "The staff are cool." While relatives and representatives' comments included, "Staff really do have the care of people in mind" and "The staff support people brilliantly."
- Staff responded promptly to people's needs and provided reassurance and care with compassion and patience. Staff spoke warmly of the people they supported and took pride in their individual achievements. Staff comments included, "[The people here] are all incredible. They all have big hearts" and "[Person name] did most of the paintings on the walls"
- Staff were dedicated and committed to the people they supported. They were concerned by the impact staff shortages and changes in people's support needs were having on the wellbeing of the people they cared for.
- The new manager and staff had a good understanding of equality issues and peoples' diversity was valued and respected.

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

- People were involved in making decisions about their care and relatives told us, "Staff try to offer choices wherever possible."
- Staff said, "There is a good system to support [person's name] to make choices and decisions" and we saw people's decisions in relation to activities and how support was provided were respected.

Respecting and promoting people's privacy, dignity and independence

- Staff respected people's privacy and ensured their dignity was protected. Where people required help this was provided discreetly.
- Some people choose to lock their rooms when they went out. Staff respected these decisions and sought people's permission before entering their room. Care records were stored appropriately when not in use.
- People were supported to do as much as possible for themselves and to complete a variety of domestic tasks and chores within the service.

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 now deteriorated to requires improvement. This meant people's needs were not always met.

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

● People's care plans were not up to date and did not always accurately reflect their current support needs. The new manager had recognised this issue and had begun to address and resolve these failings. Staff told us, "The care plans are in need of updating, this is underway", "The care plans are being updated, they are probably not as up to date as they should be" and "Care plans are slowly getting there. They are being updated but when you are short staffed it is very difficult to do key worker stuff as you are always called out on the floor."
● Relatives were being appropriately involved in care plan review processes and told us, "The care plan is being updated but has not been sent to me yet."
● One-page care plan summary documents were available to enable new staff quickly gain an understanding of people's individual needs.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People's care plans included detailed information and guidance for staff on their individual communication preferences and styles.
●Relatives told us, "[The staff] have a good knowledge of [persons name's] communication needs" and staff were able to communicate effectively with people using a variety of individualised approaches as described within their care plans.

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
● People were supported to engage with a variety of activities, tasks and chores within the service. A selection of board and video games were available in the communal lounge and there was a dedicated craft room on the first floor. Some people were supported to regularly attended day care centres and voluntary work placements.
● Staff reported that low staffing levels impacted on people's ability to engage with activities outside the service. Staff comments included, "You feel bad when you are off for the weekend because you know the guys are not getting out", "[Person's name] has been missing going dancing as we don't have enough staff" and "People get bored as they can't go out. It caused a vicious circle as behaviours escalate."

● Visitors were actively encouraged, and people were supported to maintain relationships that were important to them. Relatives said, "They are very accommodating of family visits. We can cook meals together." During our inspection one person made a basket with support from staff and their visiting relative.

Improving care quality in response to complaints or concerns

● There were systems in place to ensure any complaints received were investigated.

End of life care and support

● The service was not supporting anyone with end of life care needs at the time of our inspection. There were systems and procedures in place to enable people's wishes and preferences in relation to end of life care to be recorded.

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 management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care, understanding quality performance, risks and regulatory requirements

- The provider had failed to effectively monitor the service to ensure the quality of care was appropriate. There was limited evidence of recent assessments of the service's performance by the provider. The last assessment had been completed in September 2018. It had not identified the issues which led to the breaches of regulations detailed in the safe and effective sections of this report.
- People's care plan's had not been regularly updated and did not accurately reflect their current support needs. Staff feedback and daily care records showed that information within care plans did not reflect the support people currently required when they became upset of anxious. These issues had been identified by the new manager but not resolved prior to our inspection.
- People were placed at risk of inappropriate care because the service was short staffed. The provider recognised that commissioned levels of support did not fully meet people's needs but had failed to ensure these staffing levels were achieved.
- Systems to ensure people's records were accurate and up to date were not effective enough. Issues with WiFi coverage and access to computers had impacted negatively on the quality of information recorded in daily care records and incident reports. This was because staff often had to repeatedly input this information into the system because of reliability issues. In addition, it was difficult for the new manager to analyse these completed records in the service because of the unreliability of links to the providers network.

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

- People's individual needs were not always managed well. Staff attempted to provide person centred care, but this was not always possible as staffing levels often restricted people's opportunities to access the community when they wished.
- Systems to address identified issues around people's care had failed to lead to improvements. Problems with the compatibility of people living at Trelawney House had been identified and the impact was known and understood by staff and the provider. However, the actions to address these issues had been unsuccessful which had negatively impacted on people's lived experience.

The systems and processes to assess, monitor and drive improvement in the services performance had failed to be effective. This meant the service is a breach of Regulation 17 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

● There was limited evidence that feedback from people and their relatives had been sought. Residents meetings had not occurred regularly and only one person had been supported to complete a quality assurance questionnaire. The new manager was aware of this issue and told us they intend to ensure people's feedback was sought regularly in future.

● Staff and the new manager had a good understanding of equality issues. They valued people as individuals and staff took pride in their achievements.

Managers and staff being clear about their roles

● The service operated a key worker system where individual staff members were responsible for reviewing and updating people's care plans and ensuring that their needs were met. Key workers were supposed to be allocated time to focus on these responsibilities but this had not always been possible because of staffing issues.

● The services manager's role was well defined and understood by staff. However, the manager was expected to complete a significant number of care shifts each week and had been regularly working as a member of care staff because of the staffing shortages described in the safe section of this report. This restricted the time available for them to focus on their leadership responsibilities.

● There had been a number of leadership changes since our last inspection. The previously registered manager had left the service in 2018 and a replacement had been appointed but had not become registered. Issues had been identified with the service's performance late in 2018 and additional leadership support had been offered by the provider. In April 2019 the new manager had been appointed and was now in the process of applying to the commission to become registered.

● People and their relatives were complimentary of the new manager and told us, "[The new manager] is cool, it has been more relaxed" and "The new manager is very proactive with a good vision for the team."

● Staff were confident the new manager was making a positive difference to the service's performance and told us, "I think [the new manager] is good. She has people's interests at heart", "[The new manager] is making changes for the better. It is a slow process but it will get there eventually" and "I have a good feeling about [the new manager]. It is still really early days."

● The provider had systems in place to support the new manager who told us, "I am getting support from [the operations manager] and from the behavioural team" and "It is 100% going to get better."

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 staff team, new manager and provider's operations manager understood their responsibilities under the duty of candour and were open and honest throughout the inspection process. They recognised and accepted that the service was not currently meeting people's individual support needs.

● Relatives and representative told us they had been kept informed of incident that had occurred within the service.

Working in partnership with others

●The provider had appropriately raised concerns with commissioners and professionals in relation to the impact of people's behaviours on others living in the service. Where these concerns had not been addressed or additional support provided the service had a raised these issues appropriately with the local authorities

safeguarding team.

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 All reasonably practical measures had not been taken to prevent people's behaviour from impacting on others, People care plan's care plans did not accurately the support they needed while anxious and incidents had not been accurately recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers quality assurance systems had failed to ensure compliance with the requirements of the regulations. People's care plans did not reflect their current support needs and incidents records had not been accurately maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of suitably skilled and supported staff available to meet people's needs.