Spectrum (Devon and Cornwall Autistic Community Trust)

High View

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

Summary of findings

Overall summary

About the service
High View is a residential care home providing personal care for up to five people with learning disabilities and or autism. At the time of our inspection two people were using the service.

The service is a detached three-story building with an enclosed rear garden. Currently one person lives on the lower floor with the other person living on the first floor. Shared communal areas and the office are also located on the ground floor. The service is located on the outskirts of Truro, Cornwall.

People's experience of using this service and what we found
Staffing levels in the service were unsafe and insufficient to meet people's support needs. The service was designed to provide people with support from five staff each day with an emergency minimum safe staffing level of three experienced staff. Prior to our arrival on the day of our inspection the service had been operated by two staff. They had recognised this was unsafe and would significantly impact on people's wellbeing. As a result they had made arrangements for an additional staff member to come in for a short period and had borrowed a staff member from an adjacent service to support one person to attend their educational placement.

Rotas and other records showed the provider had regularly staffed the service at emergency minimum staffing levels. On one occasion the rota had been written up for staffing below the emergency minimum with guidance to seek support on the day from the provider's on-call arrangements. Planning to staff the service regularly at emergency minimum levels meant any staff sickness or unexpected absence exposed people and staff to risk of harm. Staff told us, "It's not safe for us, let alone them" and "With two staff I would say it is definitely unsafe, if [People's names] are in a great mood they may be ok but it is definitely not safe."

Records showed staff were regularly working significantly in excess of the contracted hours in order to ensure people were as safe as possible. On the second day of our inspection one staff member was in the process of completing 60 hours continuously on duty in the service and another staff member told us, "I ended up doing 53 hours on site and I know others have done that too."

Prior to the inspection the provider had recognised the service was significantly understaffed and had allocated one additional staff member to support the service. This action was insufficient to address the staffing shortage.
As a result of our significant safety concerns in relation to staffing levels we made a safeguarding alert following the first day of our inspection. In addition, we sought assurances from the provider that immediate improvements would be made to staffing arrangements to ensure the service was staffed above emergency minimum levels. Assurances were provided, however unexpected staff absence meant that in the five days between the two site visits the service operated at emergency minimum levels during five out of ten shifts.

Records showed people did not get on well together and on some occasions it was clear one person's

actions were negatively impacting on the other person and causing them to become distressed. This sometimes led to them acting in ways which put themselves and others at risk. Low staffing levels meant it was difficult to avoid or manage these risks. Records showed people were unable to go out regularly as a result of the staffing arrangements. Staff told us, "We can't go out as [Person's name] needs three staff to go out and so it would leave no one with [the other person]" and "There should be enough staff to take people out and give them the best quality of life rather than struggling to keep them safe each day."

There had been a significant turn-over of staff at the service. Records showed people were regularly supported by staff who did not have the skills and experience necessary to meet their needs. Recently recruited staff said, "I am still new so I do not know [the person] that well so it is better if [they] have confident staff." While experienced staff told us, "I can't remember the last time we were left on three and I was comfortable with the three staff we were left with."

The provider's on call system and other procedures designed to ensure the service operated safely were ineffective. Necessary support had not been provided when the number of staff on duty had dropped below the emergency minimum level. Quality assurance systems had failed to identify shortfalls, and senior managers had failed to respond appropriately to address the staffing shortages in the service. On one occasion staff had directly reported critical staff shortages to the providers' chief executive. The chief executive had taken immediate action to address the specific situation however action had not been taken to address the wider staffing shortages in the service. Staff did not feel supported by the provider and told us, "Spectrum, I just feel we have no support or willingness to support us. No matter what we did we have had nothing back from them. We have been left to our own devices to manage" and "I know that [the provider] was aware, as there is a duty ring around for the day and we have been reporting that we are short staffed. It seems we were not a priority until you turned up."

Staff had been safely recruited and understood how to appropriately raise safety concerns outside the service. Medicines were managed appropriately, and systems were in place to protect people from financial abuse.

Staff understood the need to use PPE and were participating in regular COVID-19 testing. However, staffing levels meant it would not be possible to support people individually in the event of an outbreak of the infection.
People's needs had been assessed before they moved into the service and their care plans reflected their current support needs.

The outcomes for people did not reflect the principles and values of Right Support, Right Care, Right Culture. People were regularly unable to take trips out or live like ordinary members of the community. The organisation exhibited many of the risk factors associated with closed cultures including ; people's level of dependence on staff for basic needs, the inability of people to access the community without appropriate support, the high turn-over of staff, and the lack of effective oversight. In addition, the provider had failed to respond appropriately to address safety concerns reported by staff.

During feedback at the end of our inspection senior managers recognised their systems for monitoring staffing arrangements were ineffective. They told us prior to the inspection they had been unaware of the severity of the situation at High View and believed it had developed in the last month. Records gathered showed that the service had been short staffed for each of the five weeks prior to the inspection.
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 03 February 2020)

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 bring forward this inspection to examine those risks. As a result, we undertook a focused inspection to review the key questions of safe, effective, responsive and well-led only.

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

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. 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 staffing, safe care and treatment, person centred care and governance at this inspection.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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.

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.

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.

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 responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

High View

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by two inspectors.

Service and service type
High View 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 no registered manager in the service. A new manager had been appointed to lead the service three weeks prior to our 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 and sought feedback on its current performance from the local authority. The provider did not complete the required Provider Information Return. This is information providers are required to send us with key information about the

service, what it does well and improvements they plan to make. We took this into account in making our judgements in this report.

During the inspection
We met briefly with both people who used the service. We also spoke with five members of care staff, the service's new manager and the provider's regional manager.

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

After the inspection
Following the inspection, we spoke with one person's relatives and a further eight staff by telephone. We also sought feedback from involved professionals on the service's current performance and received three replies. We also reviewed the information we had requested from the service during the inspection.

Inadequate

Is the service safe?

Our findings

Staffing and recruitment

● There were not enough staff available to meet people's recognised support needs. The service was commissioned to have four staff on duty for seven hours each day, five staff for seven hours each day and three waking night staff to meet people's needs. This level of support was commissioned to enable both people to leave the service with appropriate support when they wished.

● On the first morning of our inspection the service had been severely short staffed prior to our arrival, when only two members of staff had been on duty. Staff had recognised this was unsafe, would significantly impact on people's wellbeing and prevent one person from attending college. A member of staff told us, "I started at 08:00, on arrival this morning it was just [one other staff member] and we rang [a third staff member] to say we were on two, can you come in. Then I rang [a nearby service] to say we are on three we need a fourth to take [person's name] to college."

● The provider's business continuity plan stated, 'In extreme emergency situations' the minimum staffing level for High View was three experienced staff during the day and two waking and one sleeping staff at night. In these situations, staff were not to give people tasks to complete within the service or support them to leave the building. Staff told us, "Most days [we] are on three, lucky to have four or five. Left on three mostly. We might get a new person sent over from another unit but it's not much help."

● Rotas for the month prior to our inspection showed that the service was regularly aiming to get to 'emergency minimum' levels of staffing. On one occasion the rota was written up at unsafe staffing levels with guidance for staff to seek support from the provider's on-call manager during the shift. Rotas designed to only achieve the minimum staffing levels meant people's opportunities were restricted and unnecessarily exposed them to risk of harm.

● The rotas showed that the service had been significantly short staffed for the five weeks prior to our inspection. The rota for the week beginning Sunday 28 March identified 100 hours of day staff vacancies (including a manager vacancy) per week and a full-time night staff vacancy. The rota for the week beginning the 2 May also highlighted 100 hours of day staff vacancies and two full time waking night vacancies. Staff said, "With two staff I would say it is definitely unsafe, if [people's names] are in a great mood they may be ok but it is definitely not safe", "There are just not enough staff for the rota" and "We are short staffed, it has been like that pretty much since I got here."

● As a result of these issues the existing staff team were routinely having to work significantly more hours than contracted. This was impacting on staff morale, their well-being and the quality of support provided. We found some staff had worked extremely long periods to help cover shifts. On the second day of our inspection one staff member had started work on Saturday at lunchtime, was still on shift on Monday at 15:00 and had been authorised to complete an additional sleep-in that evening. This meant this staff member had been permitted to be on shift for over 60 consecutive hours. Staff comments in relation to over long shifts included, "One day three staff called in sick, so I came in and did 14 hours and a sleep in and then another 14 hours and then another sleep-in. I ended up doing 53 hours on site and I know others have done that too", "Everyone is doing a lot of overtime and that does bring morale down" and "It's been horrendous recently, the hours we have to work. Not enough staff. A joke really. I nearly left after the first week!"

● Following the first day of our inspection the service's new manager and provider's regional manager told

us that they recognised there were insufficient staff employed to meet the needs of the people the service supported. They accepted that the service had operated below minimum safe staffing levels. Their comments included, "There are no two ways about it we need those extra bodies here" and "I do know of one occasion where we were below [minimum safe staffing levels], it was an on the day sickness."

● Prior to the inspection the provider had tasked a full-time deputy manager from another registered service to join the staff team at High View. This additional support was insufficient to address the staffing shortages. The actions taken by the provider in response to this situation are discussed further in the well led section of the report.

● As a result of the significant risks identified in relation to the provider's failure to adequately staff the service we made a safeguarding alert following the first day of our inspection. In addition, we sought assurances from the provider that they would take immediate action to ensure the service was staffed at above minimum staffing levels. Assurances were subsequently provided that for the five days following the first day of our inspection all, but one morning shift, would be staffed at above minimum staffing levels.

● On the second day of our inspection we reviewed the staff levels achieved since our first inspection day. We found, contrary to the assurances given, that unexpected staff sickness had resulted in the service operating at minimum staffing levels on five occasions.

The provider had failed to ensure there were enough staff available to safely meet people's support needs. This unnecessarily exposed people to significant risk of harm and limited their opportunities. This was a breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● Incident and daily care records demonstrated that the people living in the service did not get on well together. These records included details of only one positive interaction but numerous examples of negative interactions and occasions when people had avoided spending time together

● Some of the incident reports indicated the actions of one person were having a negative impact on the other, causing them to become distressed. In these situations, they sometimes acted in a way which put themselves at risk of physical harm. The low staffing levels meant it was difficult to avoid or manage these risks as people were unable to spend time apart.

● Staff recognised that it was very difficult to manage these situations when the service was short staffed as they were unable to support people to go out. They told us, "We do complete incident forms, some of the incidents that we know are caused by noise impact from [One person] we do put down in the suggestions 'have more staff so we can separate them easier'. It is a tricky one, to know what to do", "They don't get on at all" and, "It is very frustrating as if there are four of us on we can offer [Person's name] a trip out of the house so they can have time apart but obviously on three (staff) we can't do that and that is a problem. So the situation just escalates."

● Incident records showed that restrictive practices were not being regularly used in the service. Staff understood when to use these techniques to ensure people's safety and told us they were only used as a last resort. However, our review of staffing rotas and training records found occasions when the service was operated on minimum staffing levels, where none of the staff on duty had completed practical training in the safe use of restrictive practices. This exposed people and their support staff to risk of harm through the potential use of inappropriate techniques. Staff told us, "I watched some videos [on Positive Behaviour Management], the quality is great, but I think you need to do it physically. I have not had to do any restraint" and "On Friday it was [three staff members names], we are the least experienced. It went ok but it could have gone so wrong."

● One person's care plan identified that delays to planned trips out of the care home, could lead to them becoming anxious which might result in them acting in a way which put themselves or staff at risk. The care

plan stated that an "emergency pack" containing sweets and a drink should be available to help staff support the person in the event of unexpected delays while traveling. Staff were unaware of this 'emergency pack' and it was not available in the person's vehicle.

The failure to adequately manage risks meant care and treatment was not provided in a safe way. This forms part of the breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Personal Emergency Evacuation Plans had been developed for each person detailing the support they would require in the event of a fire or other emergency. Firefighting equipment had been regularly serviced and other necessary safety checks of the service's environment had been completed.

Learning lessons when things go wrong

● The provider used digital data analysis systems to review incidents records and identify patterns and trends in people's behaviour. These systems relied on the effectiveness of coding information completed by care staff while completing incident records, to identify and report possible trigger behaviours. It was unclear what specific training staff had received in this data entry process or what audits had been completed to ensure all behaviours had been correctly identified and recorded.

● Despite the several reports identifying incidents arising at times of low staffing numbers and as a result of the incompatibility of the two people living at High View, no action had been taken to address these issues.

● Incident reports had been completed and made available to the new manager and provider's leadership via the service's digital care planning system.

Systems and processes to safeguard people from the risk of abuse

● Staff had a good understanding of safeguarding procedures and told us they had previously reported concerns to senior managers about an individual staff member's practice. These concerns had been investigated and resolved. Details on how to report safety concerns to the local authority were available to staff.

● Staff had recognised the adverse impact of current staffing arrangements on people's wellbeing. They had appropriately reported whistleblowing concerns to the provider and the Commission.

●There were systems in place to protect people from the risk of financial abuse, Where the service held money for people receipts were kept for all purchases and records balanced.

Using medicines safely

● Medicines were managed safely. Staff understood how to support people with their medication and records had been accurately completed. There were appropriate protocols in place in relation to the use of 'as required' medicines.

● Medicines had been ordered, received, stored and where necessary disposed of safely.

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 somewhat assured that the provider was taking action to prevent outbreaks of infection. However, current staffing arrangements were insufficient to enable people to be supported individually if this became necessary.

● 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.

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 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

● Staff did not always have the necessary skills and experience to support people safely and in line with their needs and preferences. The service had experienced significant staff turnover. Recruitment records showed more than half of the current staff team had been recruited since our last inspection in January 2020.

● Peoples' care plans identified they would benefit from a stable and consistent staff support. Staff recognised that the lack of staff consistency had impacted on people's wellbeing. They told us, "I think there are a lot of new faces, and in [person's name] care plan it says [They are] not a fan of new faces", "[Persons' name] does not like strange faces and now [they are] often having incidents due to being cared for by strangers" and "[Person A] does not like new faces and it takes time to build trust, even [Person B] is not completely confident around me as [they] do not know me that well."

● There had been occasions when there had been no experienced staff on duty and the service regularly operated on minimum staffing levels that included inexperienced staff. Staff said, "It has been a thing where it put real pressure on the experienced staff where the other on duty are in-experienced. It is not regular that it is three experienced staff, normally it is two or even one plus new staff" and "I can't remember the last time we were left on three and I was comfortable with the three staff we were left with".

The failure to ensure staff had the skills and experience necessary to safely meet people support needs. This failure forms part of a breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff recruited during the COVID-19 pandemic had completed a one-week online induction training package and a number of additional e-learning courses before they began working in the service. One recently recruited staff member told us, "I had a Zoom induction for a week, a day of autism, Positive Behaviour Management principles, safeguarding training and 'what to expect'. Then I have done nine e-learning course's"

● Recently recruited staff told us they did not have the knowledge and experience necessary to meet people's needs and were grateful for the guidance provided by experienced members of the team. Their comments included, "I have felt a bit uncomfortable, but I do have confidence in the staff who have been here over a year as they know what to do", "I am still new so I do not know [the person] that well so it is better if [they] have confident staff" and "Today we have two staff who know people well and two staff who

are helping out."

● Staff reported they had received supervision from the interim manager and that team meetings had occurred. Their comments included "We had a team meeting two weeks ago a bit of a handover from [the interim manager to the new manager]. We had one about three weeks prior to that as well."

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.

● We were concerned that stakeholders involved in best interest decision meetings were not given all the relevant information to help them form conclusions. People's ability to make specific decisions had been assessed. Where people lacked capacity in relation to specific decisions the service had involved people's relatives and professionals in the best interest decision making process. During a recent best interest meeting in relation to where a person should live the provider had failed to disclose details of the current staffing situation in the service. This issue is discussed further in the Well led section of this report.
● The provider had correctly identified that some people who lacked capacity to make decisions about where they lived were the subject of restrictive care plans. They had appropriately sought authorisation for these arrangements from the local authority in accordance with Deprivation of Liberty Safeguards (DoLS). A DoLS authorisation had been recently granted for one person and the provider was developing new recording systems to enable compliance with the conditions of this authorisation.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs had been assessed by the provider before they moved into the service. These assessments had aimed to identify and understand people's specific needs and had involved people, their relatives, previous care providers and commissioners.
● Managers told us there were no current plans for additional people to move into the service. They said assessing any possible impacts of admissions on people currently living in the service would be an important part of any future assessment processes. However, the managers action plan for April identified that additional furniture was required, "to make spare rooms marketable", which would indicate that future admissions to the service would be considered.

Supporting people to eat and drink enough to maintain a balanced diet
● People chose what to eat and were supported to participate in meal planning and preparation.
● Staff understood people's dietary needs and encouraged healthy eating. Fresh fruit and vegetables were readily available.

Adapting service, design, decoration to meet people's needs
● The service was well maintained and adapted to people's individual support needs.

Supporting people to live healthier lives, access healthcare services and support

- People were supported to access healthcare services when necessary and plans were in place to ensure people's support needs would be met in the event of a hospital admission.

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.

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

- Staffing levels in the service meant it was not possible for people to live like ordinary members of the community or to live their best lives.
- The provider had failed to staff the service at the levels commissioned and necessary to enable people to go out when they wished. Staff told us, "If we are low [on staff], [Person's name] cannot go out and [their] activities suffer" and "I have had to do split shifts to be able to get [person's name] back from college. [The Person] has been late for college due to staff shortages. Sometimes when there are only two staff on at High View we cannot collect [The person] from college. The other day College rang to say [Person's name] needed to be collected as in a crisis and there was no one to go to get [them]."
- Staff recognised that low staffing levels restricted people's ability to go out when they wished. They told us, "We can't go out as [Person's name] needs three staff to go out and so it would leave no one with [the other person]", "There should be enough staff to take people out and give them the best quality of life rather than struggling to keep them safe each day", "[Person's name] has not been able to see [their] family because we did not have enough staff to take [them] so dad had to come here" and "[Person's name] has not been out for a walk [for the last six days], went out for lunch yesterday, but before that [They] had an incident on the last two trips out. That is pretty much down to lack of staffing." This person's daily care records showed that prior to the trip out six days before the inspection visit, they had not left the service for nine days.

The providers failure to ensure enough staff were available to enable people to access the community prevented people from living like other members of society and breached their human rights. These failures meant the service was in breach of the requirements of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 guidance for staff on their specific communication needs and preferences. One person used MAKATON to communicate. The service's training matrix identified that eight staff required training in this communication technique. This training had been requested but not arranged by the time of our inspection. This meant people were unable to communicate effectively with their support staff.

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 of the people the service supported. These lengthy documents provided staff with sufficient information to enable them to understand peoples' needs and preferences.

● Relatives and professionals had been involved in the development and review of people's care plans to ensure these documents reflected people's support needs.

Improving care quality in response to complaints or concerns

● There were systems in place to record any compliments and complaints received by the service. Staff told us complaints they had raised in relation to issues other than staffing levels had been investigated and resolved.

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 good. 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

- The provider is required to ensure there is a manager registered with the Care Quality Commission who is in day to day control of the service. At the time of our inspection there was no registered manager in post. The previous registered manager had left the service in January 2021. The provider had initially transferred a manager from another registered service to provide interim support to the staff team at high view. Three weeks prior to the inspection a new manager for High View had been appointed. They had not yet applied for registration with the commission.
- The roles and responsibility of the manager were well defined and understood by staff. However, since the new manager had been appointed, they had spent their time on the staffing rota to provide hands on care, as a result of staffing shortages. This meant the new manager had no time allocated to focus on their leadership responsibilities.
- Arrangements to cover unplanned staff absences were ineffective. The provider operated a two stage on call system which was designed to ensure a manager was always available to immediately attend and support a service in response to unexpected staff absences. The provider also stated that a more senior manager should also be available, at all times to source additional staffing resources as necessary, and provide guidance when required.
- Staff in the service were supposed to seek support from on-call managers whenever the service operated at minimum safe staffing levels. However, practices of rostering to minimum safe staffing levels, in combination with staff experiences of a lack of support from the on-call system, when operated at minimum staffing levels, meant staff only attempted to access support when staffing levels became unsafe. Staff told us, "Duty is supposed to support us when we have not enough staff, they are supposed to come but they don't. Some come, some don't. We have to get staff from other homes to help when desperate", "When we have been less than three staff we ring on call, that gets some results", but another said, "It is no support at all. We expressed our concerns and they promise to sort it out and it has been too long now. We were down to two staff after six o'clock the other day, we called on-call and [They] came for two hours but would not stay for the four hours so called the waking night in early to cover. We are always short."
- Following feedback, the provider investigated staff reports that on-call managers had not provided necessary support when the service was seriously understaffed. They found these events had occurred when the on-call managers had been scheduled on a staffing rota at another care home, at the same time as being on-call to support other services. This meant when services were seriously understaffed the on-call system was unable to provide prompt and appropriate support.
- Staff were complimentary of both the interim and recently appointed managers. They told us, "[The interim manager] was here from mid-January until three weeks ago, [They] were fantastic I can't sing [their]

praises enough" and "The new manager is doing a phenomenal job".

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

● The service and the provider exhibited many of the risk factors and warning signs associated with closed cultures. These include but are not limited to; people's level of dependence on staff for basic needs, staff perception that one person was abusive towards another, the restrictive practices in place and inability of people to access the community without appropriate support, the high turn-over of staff, and the lack of effective oversight both by the provider and wider health system as professionals ability to visit had been restricted during the COVID-19 Pandemic.

● Staff reported that they had repeatedly raised concerns about the safety of staffing levels at High View with their managers, regional managers, provider's HR department and during one emergency situation, when the service was seriously understaffed and on-call arrangements had failed, directly with the provider's chief executive. The chief executive had ensured the immediate staffing crisis on that shift had been addressed. However, they had failed to address the wider staffing shortages within the service. Staff said, "Spectrum, I just feel we have no support or willingness to support us. No matter what we did we have had nothing back from them. We have been left to our own devices to manage", "It has been an issue for a long time and we have raised it many, many times with managers but nothing seems to get better. They say there are more staff coming. I don't know what happens but they do not end up here" and "I think it is further up the line where we do not feel supported , we have told them about the lack of staffing and get a positive response by the manager who takes the issue to HR but it does not get sorted".

● The provider had recognised, prior to our initial site visit, that the service was understaffed. In response an additional deputy manager had been allocated to support the staff team. This was insufficient to address the scale of the staffing shortfall which exceeded 100 hours per week. The provider had failed to make appropriate arrangements to provide people with the level of support they required. Agency staff had not been used and the provider had not attempted to access the local authorities staffing resources to ensure people's needs were met.

● During feedback the provider's senior managers recognised their systems for monitoring staffing arrangements were ineffective. They reported they were unaware of the severity of the current staffing shortage at High View and said they believed this situation had developed in the last month. Staff in contrast consistently reported the service had been significantly short staffed since the previous registered manager's departure in January 2021. Their comments included, "I would say [staffing] has been bad for the last six months definitely, perhaps longer" and "It's been like this for three months". This demonstrates that the providers' systems for overseeing the service had failed.

● An audit of the service's performance had been completed by a regional manager on the 9 April 2021. This audit had identified three vacancies at the service and recorded that this information had been shared with the provider's recruitment team. This information was inaccurate as the rota for that week included vacancies for a full-time manager, 60 hours of care staff and two full time waking night staff.

● Each day, one of the provider's senior managers had contacted staff in the service to monitor staffing arrangements and planned activities, as part of the provider's response to the COVID-19 pandemic. Notes of these conversations were not available during the inspection process, but the provider had failed to recognise the service was routinely operating on minimum safe staffing levels. Staff told us, "I know that [the provider] was aware, as there is a duty ring around for the day and we have been reporting that we are short staffed. It seems we were not a priority until you turned up" and "When I go home at night! I won't be stopping its dangerous. I am scared something is going to happen and we will be blamed, not the management. I am pleased someone is listening to us, please try to do something.".

The provider had failed to take necessary action to ensure people received the support they needed to stay safe. On-call arrangements had been ineffective and quality assurance systems had failed to recognise the impacts of the staffing situation on people. Senior managers had failed to respond appropriately to concerns raised by staff. This meant the service is in breach 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

● Good communication links were maintained between the service and peoples' relatives. Where specific incident and accidents had occurred, information had been shared promptly and appropriately with relatives.

● During the inspection the staff team and new manager were open and honest with the inspector. They recognised the impact of staffing arrangements on people's wellbeing and were keen that these issues should be promptly addressed. At feedback and during subsequent safeguarding meetings the providers senior managers recognised that the service was understaffed and worked collaboratively with professionals to ensure future incidents of dangerously low staffing were avoided.

● However, the providers' senior managers had failed to raise staffing levels as an area of risk during a multi-disciplinary team meeting held on 16 April 2021. At this meeting a decision was made that it was in one person's best interest to continue living at High View. This meeting was held remotely because of COVID-19 restrictions. However, the rota showed this person did not received their commissioned levels of support during the day of the meeting and the service had operated on minimum staffing levels in the evening. Professionals involved in this meeting report they had no knowledge of staffing issues at High View prior to the Commission's inspection.

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

● The service endeavoured to engage regularly with people's relative and involve them in decision making about how support was provided.

● Staff had a good understanding of Equality and diversity issues and made sure people were protected from discrimination.

Working in partnership with others

●The service's new manager and staff team worked collaboratively with involved health professionals to ensure people's needs were met. Professionals reported the provider was not always fully co-operative and that it was sometimes difficult for them to access necessary information.