

# Spectrum (Devon and Cornwall Autistic Community Trust)

## Menna House

### Inspection report

Menna  
Grampound Road  
Truro  
Cornwall  
TR2 4HA

Tel: 01726883478

Website: [www.spectrumasd.org](http://www.spectrumasd.org)

Date of inspection visit:

16 January 2017

24 January 2017






Date of publication:

11 April 2017

### Ratings

#### Overall rating for this service

Requires Improvement 

Is the service safe?	<b>Requires Improvement</b> 
Is the service effective?	<b>Good</b> 
Is the service caring?	<b>Good</b> 
Is the service responsive?	<b>Requires Improvement</b> 
Is the service well-led?	<b>Requires Improvement</b> 

# Summary of findings

## Overall summary

We inspected Menna House on 16 and 24 January 2017, the inspection was unannounced. The service was last inspected in November 2014, we had no concerns at that time.

Menna House provides care and accommodation for up to five people who have autistic spectrum disorders. At the time of the inspection five people were living at the service. Menna House is part of the Spectrum group who run similar services throughout Cornwall.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager had been in post since October and was applying to CQC to be registered manager.

There were not sufficient staff on duty at all times to meet people's individual needs. Spectrum had identified 'contingency levels' which are the lowest levels at which the service can run safely. These are only supposed to be in place in emergencies such as flu epidemics or extreme weather conditions. We found the service was often running on contingency levels and sometimes below these levels. Due to staffing problems, people were not being supported to take part in individual activities which had been identified as meaningful to them. Although people were supported to go out on various trips this was usually as a group, as most required the support of two staff while accessing the community.

Recruitment practices helped ensure staff working at the home were fit and appropriate to work in the care sector. Staff received training when they first started work at Spectrum in various areas, including how to recognise and report abuse. Training was regularly refreshed to enable staff to keep up to date with any changes in recommended practices or legislation.

The service kept people's personal monies for them and records of all expenditures. The system for recording expenditure of money was not robust and we identified discrepancies in four people's records.

People were assessed in line with the Deprivation of Liberty Safeguards (DoLS) as set out in the Mental Capacity Act 2005 (MCA). DoLS provide legal protection for vulnerable people who are, or may become deprived of their liberty. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals when appropriate. Records showed applications for DoLS were being made appropriately and in line with the registration. This helped ensure people's rights were protected.

The building had been modified to help meet people's individual needs and two people had their own

private living room. Others shared living and dining areas and four of the five people shared a kitchen. Bedrooms and private living areas were comfortable and reflected people's personalities and preferences. Shared areas of the building had limited furnishings and decoration. The manager told us they would discuss this with the staff team to consider ways of making the environment more comfortable for people.

People's support plans included clear and detailed information about their health and social care needs. Care plan reviews were held regularly and the information up-dated accordingly. Staff described to us how they would support people in certain situations and this was in line with the information in care plans. Daily logs were in place to record what people had done during their day and information about their general health and well-being. We identified several gaps in these records.

Roles and responsibilities were well-defined and understood by the staff team. The manager was supported by a deputy manager who had a clear set of responsibilities. There was a key worker system in place. Key workers are members of staff with responsibility for the care planning for a named individual.

Regular audits were carried out to continually assess the standard and quality of the service provided. However, these had failed to identify the discrepancies in records concerning people's personal money.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not entirely safe. There were not sufficient numbers of staff on duty at all times.

Records of people's personal monies contained discrepancies.

Care plans contained clear guidance for staff on how to minimise any identified risks for people.

**Requires Improvement** ●

### Is the service effective?

The service was effective. Staffed received comprehensive and regular training.

The service acted in accordance with the legal requirements of the Mental Capacity Act and associated Deprivation of Liberty Safeguards.

People had access to other healthcare professionals as necessary.

**Good** ●

### Is the service caring?

The service was caring. Staff were kind and considerate in their interactions with people.

People's privacy and dignity were respected.

Staff knew and understood people's preferred communication styles

**Good** ●

### Is the service responsive?

The service was not entirely responsive. People were not supported to take part in pursuits which were meaningful to them and reflected their individual interests.

Daily logs were not consistently completed.

Care plans were detailed, and regularly reviewed.

**Requires Improvement** ●

### Is the service well-led?

The service was not entirely well-led. Quality assurance checks had failed to identify discrepancies in financial records.

There was a clearly defined management structure in place which was understood by the staff team.

The manager was developing systems to improve communication with families.

**Requires Improvement** 

# Menna House

## **Detailed findings**

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 January and 24 January 2017 and was unannounced. The inspection was carried out by one inspector.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed previous inspection reports and other information we held about the home including any notifications. A notification is information about important events which the service is required to send us by law.

Due to people's health care needs they were not able to express their views of living at the service. We spoke with the manager, a divisional manager and eight care workers. Following the inspection visit we contacted two relatives and three external healthcare professionals to hear their views of the service.

We looked at detailed care records for two individuals, staff training records, staff rotas, three staff files and other records relating to the running of the service.

# Is the service safe?

## Our findings

When we arrived at the service at 9:00 am on the first day of the inspection there were four members of staff on duty. The minimum staffing levels for that time of the day was six care workers. Staff told us the contingency staffing level was four. Contingency levels are those identified by Spectrum as the emergency minimum staffing levels at which the service can run safely. These are only intended to be used in extreme circumstances such as flu epidemics and extreme weather conditions. The identified minimum staffing levels fluctuated during the day. The rotas showed that between 8:00 am and 9:00 am and 7:00 pm and 10:00 pm there should have been five care workers on duty. During the rest of the day, i.e. between 9:00 am and 7:00 pm there should have been either six or seven members of staff on duty depending on the time and day of the week. During the night time the rotas showed there should have been two waking night care workers and one sleep-in. We looked at rotas for the first two weeks of January. On eleven occasions between 8:00 am and 9:00 am staffing levels had been at the contingency level or below. During the rest of the day staffing had been at the contingency level on a further 17 occasions out of 56. Overall, out of 70 day time shifts there had been 53 occasions when the minimum staffing levels had not been met. At no time during the two weeks had the minimum staffing level of seven been met between the hours of 12:00 and 5:00.

On the second day of the inspection which took place one week later, we looked at the rotas for the preceding week. Again we found staffing levels had dropped to the contingency level or below on several occasions. For example on Saturday 21st January there had been three staff on duty between 6:00 pm and 10:00 pm. On Sunday 22nd January there had been three staff on duty between 7:00 pm and 10:00 pm. Staff told us it was not unusual for them to work at contingency levels. Comments included; "It's all I've known since I've been here" and "On-call can't help. You ring and they say, "Oh well, there's no staff, it's the same everywhere."" An entry in the staff communication book read; "Three staff here in the evening is not enough to keep the staff and service users safe. ....Felt really unsafe here with someone off baseline all evening. Left one staff member to care for four service users on their own as it took two staff to support [the person who was 'off baseline']"

This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On six of the fourteen nights we looked at there had been no sleep-in support at the service. We discussed this with the manager who told us there was limited funding for this support. They told us they were researching the possibility of using technology to help monitor people during the night and reduce or eliminate the need for the third member of staff.

There were vacancies for two full time and one part time care worker at the service. Spectrum had recently recruited some new staff who were going through the induction process at the time of the inspection. One of these was expected to take up a post at Menna House.

Recruitment processes were robust; all appropriate pre-employment checks were completed before new

employees began work. For example, Disclosure and Barring checks were completed and references were followed up. This meant people were protected from the risk of being supported by staff who did not have the appropriate skills or knowledge.

The service held money for people to enable them to make purchases for personal items and to pay for appointments such as the hairdresser and chiropodist. We looked at the records and checked the monies held for people. Only one person's records tallied with the amount of money being held. For most people the discrepancy was very minor. For one person we were unable to establish how much money they should have as the records were unclear and difficult to read. Two of the records we looked at had been marked at some stage to indicate the running total was incorrect. However no action had been taken to establish why this had happened or make any amendments. We found the systems in place to protect people's monies were not robust.

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

People living at Menna House had limited verbal communication and were unable to talk to us about their experience of living at the service. People spent time with staff and the positive interactions we observed indicated they felt safe and comfortable in their home. We saw people relaxing in their rooms and shared areas and heard staff speak to them with compassion and in a friendly and open manner. During both days people came into the office and displayed a curiosity and interest in what was happening. It was clear they were used to being able to access the office and were comfortable doing so. Relatives told us they believed their family members were safe.

Staff had received training to help them identify possible signs of abuse and knew what action they should take. Flyers and posters in the office displayed details of the local authority safeguarding teams and the action to take when abuse was suspected. The manager told us they discussed safeguarding issues at staff meetings and supervisions to help ensure staff were aware of their responsibilities.

Care plans contained detailed information to guide staff as to the actions to take to help minimise any identified risks to people. The information was contained within the relevant section of the plan. Some people sometimes found it difficult to express themselves and cope with emotions. This could result in them behaving in a way which staff might find difficult to manage. Care plans described what situations might lead to a person becoming anxious and what action staff could take to prevent this. There were clear guidelines around the procedures to follow to support people appropriately and enable them to regain control of their feelings. This helped staff to avoid situations which might result in people hurting themselves or others. During our discussions with staff it was clear their understanding of how to support people when they were distressed corresponded with the support plan.

People's medicines were stored securely in a locked cabinet. Medicines that required stricter controls by law were stored appropriately. The amount of medicines held in stock tallied with the amount recorded on medicine administration records (MAR). Following several medicine errors, two staff were required to sign the MARs to minimise the risk of further errors. This was not being consistently completed as, due to the staffing problems, there were not always two members of suitably qualified staff on duty to complete this. Not all creams, ointments and liquid medicines had been dated on opening. This meant staff might not be aware when the medicines could become ineffective or at risk of contamination. We discussed this with the manager who told us they would remind staff of the need to do this.

One person had displayed difficulties taking medicines in tablet forms. Arrangements had been made for



them to be prescribed medicines as liquid. This demonstrated staff were able to respond to people's individual needs appropriately. Information was available for staff about people who required, as needed (PRN) medicines. The information set out under what circumstances this medicine should be administered and the protocols to be followed including getting approval from an on-call manager. These safeguards helped ensure staff took a consistent approach when deciding whether to administer PRN.

## Is the service effective?

### Our findings

There were systems in place to help ensure all staff had the right skills, competencies and behaviours to support people well. New staff completed a full induction programme which included training identified as necessary for the service as well as familiarisation with organisational policies and procedures. The induction training also included Positive Behaviour Management (PBM) and Values and Behaviours. This meant staff had access to information and training to give them the confidence to carry out their roles effectively and meet people's specific needs. The induction was in line with the Care Certificate which replaced the Common Induction Standards in April 2015. It is designed to help ensure care staff that are new to working in care have initial training that gives them an understanding of good working practice within the care sector. Staff told us the induction was "thorough." One commented; "It was really good, they give you a lot of information and I learnt a lot about autism."

New staff were not required to shadow more experienced staff before they started working alone and were included on the rota. We discussed this with the manager who told us new staff did not work alone at first but alongside more experienced staff. They aimed to meet with new staff in the first month to discuss their confidence and competencies. A relative told us they often saw new staff at the service but that they were usually with a more experienced member of staff. However, staff told us that, due to the problems with staffing numbers, it was not always possible for new staff to work alongside experienced staff. One commented; "You get new staff learning from other new staff."

Training identified as necessary for the service was updated regularly. Staff also had training specific to people's needs such as autism awareness. A relative commented; "The staff appear competent and we hear about their training opportunities within the organisation."

Due to changes in the management of the service, supervision had lapsed. However, the new manager had started to address this and two thirds of the staff team had received supervision in the last three months. Others were scheduled to take place in the next few weeks.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Everyone living at Menna House was either subject to a DoLS authorisation or an application had been

made to that effect. The applications and other related records showed the correct procedures had been followed. Mental capacity assessments and best interest meetings had taken place and were recorded as required. Where DoLS authorisations were in place any attached conditions were being adhered to. People were supported by Independent Mental Capacity Advocates (IMCA) when important decisions about their care and support were made. This helped ensure people's rights were protected.

Staff had received training in the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards (DoLS). These areas were covered during the induction process and updated with regular on-line training. Managers received additional training in the MCA to help enable them to carry out their legal responsibilities effectively.

Care plans recorded individual preferences and dislikes in respect of food and drink. People ate varied and healthy diets. People were supported to be involved in menu planning for the week and photographs and pictures of meals were available to support people to make choices about what they ate. The manager told us they were planning to start asking people what they wanted to eat on a daily basis as this would be more meaningful for people.

People were supported to access other health care professionals as necessary, for example GP's, opticians and dentists. Care documentation contained information about past appointments and any action taken as a result. A relative told us their family member was supported to have regular health checks.

The building was arranged to meet people's needs. One person had a self-contained flat-let as they found sharing with others stressful. Another person had their own living area as they liked to spend time alone relaxing and watching television. The remaining three people had their own bedrooms and shared a lounge and dining area. A room had been used to create a sensory area which one person particularly enjoyed although it was used by others as well. There was a large garden area and the perimeters were secured to allow people to access it independently and safely. People's private spaces were furnished and decorated to reflect their own tastes and were comfortable and welcoming. A relative told us "He has got a lovely bedroom, very well suited to him." Furnishings and decorations were limited in the shared areas of the house. An external healthcare professional commented; "I feel there could be more done to make the house feel more homely." We discussed this with the manager who told us they would discuss any ideas for improving the environment with the staff team.

# Is the service caring?

## Our findings

People were treated kindly and respectfully by the staff team. We observed people smiling and engaging with staff. We spent time in the office and constantly heard staff chatting to people in a cheerful and upbeat manner. A relative told us; "They're very fond of [my relative]."

People had either very limited verbal skills or did not use words to communicate at all. However, staff directed conversation at people and included them in discussions about plans for the day. At one point on the first day of the inspection three people went for a bus ride and to have lunch out. A fourth person had planned to accompany them but changed their mind at the last minute. Staff tried to gently persuade them to go out but respected their decision to stay behind and altered the plans to accommodate the person's preferences.

Staff needed to share information with us about how people might behave to enable us to act accordingly and know how best to respond to any actions. They did this respectfully and displayed an understanding of people's needs and a concern for their well-being.

Care plans contained information about what was important to people as well as what was important for them. There was as much emphasis on people's social and emotional needs as there was on their health needs. This demonstrated a person centred approach to documenting people's care and support needs. One member of staff told us they had found the care plans very useful when they first started working at the service.

Care plans also recorded detailed information about people's communication styles. This included comprehensive descriptions of facial expressions people might use at particular times; for example; "Pushing my bottom lip out with my tongue [to indicate anxiety]." There was information regarding what might indicate when someone was distressed and how to support them and avoid any triggers. Objects of reference were used to help people to make day to day choices; for example offering people boxes of cereal to choose from. The manager told us how one person responded particularly well to intensive interaction approaches. Intensive Interaction is a practical approach to interacting with people with learning disabilities who do not find it easy communicating or being social. Staff were able to use the theories underlying this approach to engage meaningfully and in an enjoyable and fun way. A member of staff commented; "Learning how to communicate with people takes time, continuity and patience. They all have different ways of communicating."

People were supported in a way which meant their privacy and dignity was protected. Staff respected people's personal spaces and asked before entering or showing us their rooms. One person disliked being crowded and this was respected. When the manager took us to meet this person they, and the staff supporting the person, spoke in low tones to avoid causing them anxiety. This demonstrated an understanding of the person's needs and regard for their preferences.

Care plans included personal histories and information about people's backgrounds. This meant staff were

able to gain an understanding of past events which may have contributed to who people were today. When talking about people's individual needs the manager and divisional manager were able to put this in the context of their backgrounds and experiences.

## Is the service responsive?

### Our findings

Daily logs recorded when people had been supported to access the community. This was usually group bus trips to go shopping at a nearby supermarket. Some people had been supported to take local walks. Activity rotas and care plans showed people had various interests and hobbies including swimming and horse riding. The activity rotas recorded that people were also to go on 'link trips' on a monthly basis. These are trips out further afield than the immediate locality to locations such as the cinema, theme parks or other tourist attractions. These individualised trips were not taking place and staff told us link trips had not occurred for a few months. One person had high energy levels and benefitted from daily walks. Under the section; "What's important for [person's name]" it read; "Going on walks to burn his energy." There were ten occasions during the fourteen days we looked at when they had not been supported to go on a local walk. On six days there was no record of them going at all. Staff told us this could have a negative impact on the person's mood. A relative said; "I'd like [person's name] to be stimulated a bit more but I don't know if they've got the staff." Although people's interests and preferences had been identified, low staffing levels had resulted in a lack of meaningful activities designed to meet individual needs.

This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Daily logs were completed throughout the day for each individual. These recorded any changes in people's needs as well as information regarding appointments, activities and people's emotional well-being. In addition there was a communication book to record more general information which needed to be shared amongst the team. The daily logs had not been consistently completed and we identified several gaps in the records. For example, one person's daily logs for the period January 1st to 15th had no entries for the 5th. Entries for the 1st, 6th, 11th and 13th were only partially filled in.

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

People's care plans were detailed and informative, outlining their background, preferences, communication and support needs. There were sections including various aspects of people's care including behavioural needs, beliefs and values and daily living and finances. The care plans were regularly reviewed and information was reliable and up to date. One page profiles used photographs and limited text to outline what was important to and for people. Where certain routines were important to people these were broken down and clearly described, so staff were able to support people to complete the routine in the way they wanted. The descriptions included information about what people were able to do for themselves and how much support they needed. For example; "Will require hand on hand support to dry themselves but can do a small amount with verbal prompts and gestures." This meant staff had access to information to enable them to support people to develop and maintain their independence.

There was a satisfactory complaints procedure in place which gave the details of relevant contacts and outlined the time scale within which people should have their complaint responded to. No complaints were

on-going at the time of the inspection. Relatives told us they would be confident to raise any concerns they had with the service. One told us; "We would always raise anything we were concerned about and would anticipate that it would be dealt with appropriately."

## Is the service well-led?

### Our findings

Quarterly audits based on the Care Quality Commissions key lines of enquiry (KLOE) were carried out by the provider. Any highlighted issues or areas requiring improvement would result in an action plan with a clearly defined time frame. The registered manager had responsibility for producing a monthly report. However, the audits had failed to identify discrepancies in the records of people's personal monies.

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

The manager had been in post since October 2016 and was in the process of applying to be a registered manager with CQC. They had previously worked as a deputy manager at another Spectrum service. Staff and relatives told us there had been several changes of manager over the past two years. They were positive about the new manager and one member of staff told us; "Things have improved since she came in." A relative commented; "I hope we keep her." An external healthcare professional described the manager as; "competent and enthusiastic, and so far has been open to ideas and suggestions."

Roles and responsibilities were well-defined and understood by the staff team. The manager was supported by a deputy manager who had a clear set of responsibilities. There was a key worker system in place. Key workers are members of staff with responsibility for the care planning for a named individual. There was also a Developmental Support Worker (DSW) based at Menna House. DSW's work closely with Spectrum's behavioural support team. This means they are able to implement any changes to people's care plans identified as necessary by the behavioural support team and communicate the changes to the staff team. The manager told us they were well supported by the divisional manager who was working with them whilst they developed their knowledge of the service. Monthly manager meetings enabled them to keep up to date with any developments in the care sector and changes to working practices.

Staff told us morale was low, mainly due to staffing issues. Although they felt the new manager was a positive move they lacked confidence that they would be able to address the problems effectively and quickly. Relatives were also concerned that improvements may not be sustained. One commented; "A lot of staff go. You hear they are short staffed and then they get a lot of new staff." We discussed this with the manager who told us they were holding regular staff meetings to try and reassure staff about plans for recruiting new staff. They were involved in a locally based recruitment drive, linking up with job centres to attempt to attract new employees who lived locally. They told us that being involved in recruitment at this level would enable them to identify staff who were likely to be suited to the role and specific demands of the service.

Quality assurance surveys were circulated to families annually. The last one had been circulated in August 2016 and the responses had been positive. A monthly newsletter was circulated to families. This was intended to keep relatives up to date with any news about the service generally and their own family member. The manager told us they hoped this would encourage open communication with families.



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 9 HSCA RA Regulations 2014 Person-centred care  People's care and treatment did not consistently meet their needs or reflect their preferences. Regulation 9(1)(b)(c)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  Systems or processes were not sufficient to enable the registered person to assess, monitor and improve the quality and safety of the services provided. Regulation 17(2)(a)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing  There were not sufficient numbers of suitably qualified and experienced staff deployed. Regulation 18(1)