Community Homes of Intensive Care and Education Limited

Compton House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Compton House is a care home, without nursing, that provides care and support for up to 11 adults with autism and learning disabilities and other multiple needs. There is a main house which accommodates eight people and three self-contained annexes that accommodate a further three people. At the time of the inspection there were 11 people using the service.

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

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right Support
More needed to be done to ensure that people were consistently supported to have a fulfilling and meaningful everyday life and to pursue their interests. People's care was provided in a safe, clean, and overall, well maintained environment that met their physical needs. People were able to personalise their rooms and a sensory room was available, but this needed to be further developed to ensure this provided a stimulating and interactive environment. Staff enabled people to access health care services in their local community and people's medicines were managed in a way that ensured good health outcomes. The service planned for when people experienced periods of distress and this supported staff to respond safely, using a person centred approach. However, improvements were needed to ensure that staff learned from those occasions in a timely way.
When supporting people who might lack capacity to make decisions, the approach taken needed to be personalised and best interest decisions more inclusive.

Right Care
Risks to people had been assessed, but there were occasions when the guidance in place was not being followed. People's support plans did not always fully reflect their needs or contained conflicting information. Staff tried to ensure that people's wishes, needs and rights were at the heart of the support

provided. However, staff turnover was high and too many agency staff were supporting people which meant they did not always receive consistent care from staff who knew them well. More needed to be done to ensure people consistently had sufficient opportunities to take part in activities that enriched their lives. Staff understood how to protect people from poor care or abuse.

Right culture
Staff were provided with training which helped to ensure that they understood how people with a learning disability or autistic people saw their environment. More needed to be done to ensure that people were fully involved in shaping their support. Whilst the provider demonstrated a commitment to create a culture of improvement that provided good quality care to people, the success of this approach had been affected by changes in leadership at the service. The current manager was making improvements and was taking steps towards ensuring a culture where people's quality of life was being enhanced.

We have made a recommendation about the supervision of agency staff.

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

Rating at last inspection
The last rating for this service was good. (Published April 2019).

Why we inspected
We undertook this inspection to assess whether the service was applying the principles of Right support right care right culture.

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

The inspection was prompted in part due to concerns received about culture and staffing. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective 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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified a breach in relation to governance.

Follow up
We will request an action plan from 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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Compton 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.

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
Two inspectors, an assistant inspector, a member of the CQC medicines team and an Expert by Experience carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service did not have a manager registered with the Care Quality Commission. A registered manager is, along with the provider legally responsible for how the service is run and for the quality and safety of the care provided. A new manager had started at the service in November 2021 and had applied to the CQC to become registered.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since it was last inspected. The provider was not

asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We communicated with six people living at the service. They used a variety of ways to communicate their needs and choices. This included using verbal communication, Makaton, pictures, photos, symbols, objects and their body language.

We are improving how we hear people's experience and views on services, when they have limited verbal communication. We have trained some CQC team members to use a symbol-based communication tool. We checked that this was a suitable communication method and that people were happy to use it with us. We did this by reading their care and communication plans and speaking to staff or relatives and the person themselves. In this report, we used this communication tool to seek the views of six people about their experiences of living at Compton House. We also focussed on completing observations throughout the day. We also spoke with six people's relatives.

We spoke with 17 members of staff including the manager, assistant regional manager, deputy manager, assistant manager, seven support workers, two agency workers, a member of the bank team and the cook. We also spoke with two members of the provider's positive behaviour support team. We reviewed a range of records. This included four people's care records and multiple medicines records. We looked at three staff files in relation to recruitment and staff supervision and three agency workers files. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with four professionals who regularly visited the service.

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.
Assessing risk, safety monitoring and management

- Overall staff were generally well informed about the risks described in people's support plans; however, we did observe occasions where the guidance in place was not being followed. For example, one person's support plan identified that they were at risk of choking as they could eat too fast. The plan also said that they must always have a drink when they were eating. We observed this person eating their breakfast, whilst the staff member was encouraging this person to eat slowly and not place too much food in their mouth at once, the person had not been given a drink. Another person's support plan stated that they should not be left to eat alone due to risks associated with choking. We saw this person eating alone.
- The provider was installing a new kitchen in one person's flat. Although there had been previous concerns about the person's use of their kitchen, the provider showed a willingness to continuously reassess risk and to not be risk adverse, providing people with more independence and control. Where necessary, people had a risk assessment in relation to their safety whilst using the internet.
- Each shift was led by a person in charge who monitored that a range of safety related checks were taking place; this included the administration of all medicines, counting and checking people's monies and checking that key equipment such as epilepsy monitors were working.
- Monthly health and safety audits were completed, and checks made of the fire and water safety within the service either by staff or external contractors. Whilst most of the required food hygiene checks were being completed, staff were not using a temperature probe to ensure that meals were being served at a safe temperature. This is an area for improvement.
- People had a personal emergency evacuation plan (PEEP) to support their safety during a fire.

Staffing and recruitment

- The planned staffing levels were based upon the amount of one to one, two to one and shared care hours that each person had been assessed as needing by their commissioners.
- Like many care homes, the service was experiencing significant recruitment and retention challenges. There had been a large turnover in managers and staff, for example, 38 staff had left the service within the last 12 months and there remained 19 vacancies for support workers. The service had also been without an activity coordinator for some time, although one had just been appointed.
- We reviewed the rotas for the week of the inspection and the two previous weeks. These were hard to interpret, but along with the daily allocation sheets, mostly provided assurances that planned staffing levels had been met, albeit with high numbers of agency staff each day. For example, it was not uncommon for 50% of the shift to be agency staff during the day and at night we noted a number of occasions where all three staff on duty were agency staff. When this was the case a permanent member of staff slept in in case to provide additional support. The provider assured us that these agency staff were suitably trained in the use of physical interventions.

● One agency worker had worked for 21 nights consecutively without a night off and another for 13 long day shifts without having a day off. When we discussed this with the manager, they were not aware that staff had been working this type of shift pattern. We were concerned that these were very long periods to work in a demanding setting where people could need intensive interaction and that this could impact on the quality of the care they were able to provide to people.
● Some of the relatives we spoke with expressed concerns about the high use of agency staff and the turnover of staff. Comments included, "[Person doesn't like working with agency people", "When new people come in, its difficult for [Person] to settle, they need to understand him."
● Most staff felt that the staffing levels were usually adequate and helped to ensure safety. For example, one staff member said, "Whilst I have worked here we have always had enough staff and we have procedures in place to make sure this is always the case, such as having on call members in case of sickness and checking the rota 3 days ahead to make amendments if needed".
● There was no clear system in place to monitor that people's two to one hours were being provided. This meant the management team could not be assured about how these hours were being used to give people individualised support to access the community, for example.
● There were two shared 'house' vehicles which meant transport was available to support trips into the community, although some relatives and staff raised a concern that planned visits could not always go ahead due to the lack of drivers. For example, one relative said, "They try to facilitate, get a driver from another home, or sometimes say, sorry no driver".
● Staff also told us, and our observations would support, that the current skill mix of permanent to agency staff did at times impact upon the quality of care people received. We have spoken about this more in the well led section of this report.
● The provider was working hard to try and address the recruitment crisis within the service. They had made block bookings with agencies to try and secure regular agency and introduced a number of initiatives to attract new staff including improved terms and conditions and career pathways. They had recently managed to recruit a number of new staff who were also willing to be trained as drivers.
● To mitigate the staffing challenges, the provider had made an active decision not to admit any new service users.
● Recruitment processes promoted safety, although some of the agency profiles did not include sufficient information. For example, whilst they provided a date that a DBS check had been completed, it did not record the outcome of this. The profiles did not provide assurances that the agency workers had a full range of training, for example, safeguarding training. The assistant area director was taking action to address this with the agency.

Using medicines safely
● People were supported by staff who were trained and followed systems and processes to prescribe, administer and store medicines safely.
● The service monitored how people's behaviour was being controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles.
● People could take their medicines in private when appropriate and safe.
● Where medicines were administered along with food, staff took care to ensure that the person knew they were also being offered medicine
● Staff ensured each person's medicines were regularly reviewed by health practitioners to monitor the effects on their health and wellbeing.
● Protocols for the use of 'when required' or 'PRN' medicines were available to support the use of these medicines.

● When the PRN medicines were prescribed to help manage distressed behaviours, the protocols in place were informed by the person's positive behaviour support plan and also recommended monitoring the person after the medicines had been administered, although did not describe how the monitoring should be undertaken and this is an area where improvements could be made.
● We found some inconsistencies in how information about people's medicines was recorded across different medicines related records which we were concerned could cause some confusion for staff.
● Staff made sure people received information about medicines in a way they could understand, and this helped to support people to make their own decisions about medicines wherever possible.
● Staff assessed whether it was safe for people to administer their own medicines. However, even where self-administration was not felt to be safe, we found that people could be encouraged more to take part in other medicines tasks that might promote their independence, and this is an area where the approach of staff could be developed further.

Learning lessons when things go wrong
● Staff raised concerns and reported incidents and also completed 'behaviour observation charts' (BOCs) to help identify what might have caused a person to become distressed and what approaches were used by staff in response.
● The BOCs we viewed had been signed by both the manager and behaviour practitioner, but there was no evidence that there had been a thorough and contemporaneous evaluation of the information to ensure that staff had responded appropriately. For example, had they only used physical interventions as a last resort. This approach meant that there had, for example, been a missed opportunity to reflect in timely way with staff on how they might have responded differently to prevent two incidents escalating, and in one of these cases possibly prevented the need for PRN medicines to be administered.
● We discussed this with the provider who is to make changes to the charts to ensure that moving forward this evaluation is required and evident.
● Debriefs were used to reflect on the wellbeing of staff members following incidents or accidents. One staff member told us, "When I have been working with challenging behaviours, I have always had a variation of debrief afterwards".
● There was less evidence that debriefs were offered to people using the service or their peers and this is an approach which could be developed further.
● A biannual review of the number of distressed behaviours, physical interventions and the use of 'As required' or PRN medicines was undertaken to look for themes or trends that might require further exploration. For example, the most recent review had identified that there had been an increase in the use of PRN medicines and so plans were being made to explore the reasons for this with staff and put in place other proactive measures.

Systems and processes to safeguard people from the risk of abuse
● Overall, there was evidence that the management team worked well with other agencies to safeguard people from abuse. However, we did find that two incidents of unexplained bruising from October 2021 had not been adequately investigated to identify the possible causes so that remedial actions might be taken if necessary.
● Staff had had training on how to recognise and report abuse, knew where to access relevant policies and were confident that their current manager would act on any concerns raised. For example, one staff member said, "I remember having brought up a safeguarding to my current manager and she dealt with the matter almost instantly to a high standard".
● Overall, people felt safe living at Compton House. One person said, "Yes I feel safe". Two other people were also able to tell us through the use of our symbol based communication tool, that they were happy about their safety. However, one person told us they were unsure about the ways in which other people could at

times express their emotions. They told us this could sometimes make them "Feel a bit anxious". Whilst two other people were not able to elaborate why, they also indicated, using the communication tool, that they did not feel positive about the other people with whom they lived.
● Whilst relatives were, overall confident that their family member was safe, some also raised concerns about the mix of people living within the home. One relative was concerned that the needs of other people using the service could impact on the safety of their family member. We discussed this with the provider; they were confident that the current mix of people living together was safe but acknowledged that the service did not suit everyone who lived there. Work was underway to address this.

Preventing and controlling infection
● Overall, staff followed effective infection, prevention and control measures to keep people safe.
● Appropriate arrangements were in place to clean people's rooms and the shared spaces and records showed that these were being consistently completed as planned.
● Relatives told us cleanliness within the home had improved. Their comments included, "The whole feel has improved… efforts are being made", "I do now, it wasn't [clean] last year" and "Completely, I wish my own house was as clean".
● The provider had arranged for the installation of an odour control system to ensure that odours were effectively controlled and did not impact on people's quality of life.
● Staff were observed to follow guidance on the use of personal protective equipment such as masks.
● During a recent outbreak of Covid-19, suitable measures had been put in place to help prevent this spreading. For example, the use of shared spaces, including the garden, was carefully planned to help achieve, wherever possible, social distancing. One relative told us, "They did so well, outbreak recently".

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

Visiting in care homes

● Relatives were able to visit people at the service as per the government guidance. Whilst booking in advance was not necessary, relatives were asked to call first, just to make sure there was no infectious outbreaks and to ensure their family member was going to be in. All visitors were required to complete a Lateral Flow Test prior to their visit and show a negative result.

Care homes (Vaccinations as Condition of Deployment).
The Government has now changed the legal requirement for vaccination in care homes, but at the time of the inspection the service was mostly able to show that it was meeting the requirements in place at the time to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19. However, one member of the inspection team was not asked to demonstrate their vaccination status.

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.

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

- More needed to be done to ensure that people were being involved in choosing and planning their meals and that they were being supported to maintain a healthy and varied diet. For example, records showed that one person had had pasta for each of their meals on one day including breakfast. On 12 out of 14 days, this person had pasta for their meal at least twice. Chips were also regularly served, again sometimes multiple times a day.
- There was no evidence that staff were encouraging the person to try alternatives despite their support plan identifying that they needed to be encouraged to eat a varied and healthy diet.
- We saw similar concerns in relation to another two people whose records we reviewed. Records showed that one person ate nothing at all on one day, but there was no evidence that this had been identified as a concern or that staff had offered the person alternatives or snacks instead.
- Some relatives also expressed concerns about people not being involved in planning or choosing their meals. For example, one said, "[Person] moans about keep having pasta…. He doesn't know what he's having to eat until he gets it" and another said, "He gets meals presented to him from the main kitchen".
- The service employed a chef who prepared the meals Monday to Friday and planned menus were in place, but the meals served did not reflect the planned menus.
- There was a suitable dining room where people were supported to eat with support as required and mealtimes were flexible. Overall, the mealtime experiences observed appeared to be largely positive for people and each person indicated via the symbol based communication tool that they were happy with the food.
- People were able to approach staff and use symbols or pictures to indicate that they would like a request snacks or drinks, and these were provided.
- Place mats were being introduced which had a range of picture symbols on them which could be used to by people to indicate if they wanted a drink, or a particular sauce with their meal.

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

- Each person had a support plan which included an assessment of their physical, medical, communication and sensory needs. Pen pictures provided a helpful summary of the persons key needs, likes and dislikes and preferred daily routines.
- However, we found that support plans were not always accurate, contained conflicting information or referred to historic events without it being clear what relevance these still had to people's current support.
- Overall staff felt the care plans were adequate. Some staff felt they could be improved by making them more reflective of people's current needs and including more detail about the "Little things people enjoyed"

and the approaches that could prevent a person becoming distressed or emotional.
● The provider employed their own behaviour support team, one of whom spent three days each week at Compton House. The team worked alongside the manager and support staff to develop a collaborative and problem solving approach to people's support. For example, the team had developed a range of social stories that staff could use to help people understand and respond to new social situations or to help prevent behaviours which had a negative impact on others.
● The team had also been actively involved in supporting staff to achieve positive changes in how one person's sensory needs were managed. This had had a positive impact on the person's quality of life.
● Each person had a positive behaviour support plan. Positive behaviour support (PBS) is a person centred framework for providing long-term support to autistic people or those with a learning disability.
● The plans included strategies to help people stay calm and provided guidance about the early warning signs which might indicate the person was becoming distressed or emotional.
● In line with best practice, the plans included recovery strategies which helped to guide staff on how to reassure and support the person following an incident.
● Overall staff were well informed about people's PBS plans and told us how they recognised changes in people's demeanours and how they responded to these. One staff member told us, "I am very confident as over time I have got to learn and get to know the service users so I am very aware of triggers and ways to deescalate the situation in the manner that will suit his or her needs properly".
● A social care professional commented positively on the ability of staff to manage people's distressed behaviours saying, "The care staff appeared to know when behaviours would be exhibited, and the care plans were clearly indicating risk associated with the behaviours and how these are dealt with should they happen".
● We found that some elements of the plans could be improved, for examples, some contained outdated information or lacked information about how approaches such as intensive interaction could be used. Some of those viewed contained potentially misleading information about the physical interventions staff could use to respond when people had become emotionally distressed. We also found that the bi-monthly meetings used to review the effectiveness of the positive behaviour support strategies needed to be used more effectively in order to achieve this purpose.
● Some relatives felt that the support provided had improved people's quality of life. For example, one relative said, "[Person] loves being there, he's gone further with them than with me". Another relative told us their family member was "Like a different boy now…. He's the happiest I've seen him for years".
● We heard about examples where staff were supporting people to take steps towards achieving greater independence and learn new skills, however, we also found that overall, clearer pathways and strategies to support people to attain future goals and aspirations were needed.
● Whilst care plans contained goals, it was not clear whether these had been developed with people nor how staff should tailor support to ensure they were to be achieved.
● We saw missed opportunities to provide a flexible approach to teaching people new skills, for example, there was a rota for taking part in cooking activities in the kitchen, however, we saw that when a person wanted to do cooking on a different day this was not facilitated. Following meals, most people were not encouraged to complete tasks such as returning their plate to the kitchen or completing washing up.
● Service user meetings were held, but we could not see how the outcome of these, or the key worker meetings were being used to inform person centred, proactive support that led to increased independence or development of new skills. This is an area where improvements are needed.

Staff support: induction, training, skills and experience
● Overall, we found that people were supported by staff who had received relevant training to equip them for their role.
● Staff received an induction that included learning about policies and procedures, people's needs and

shadowing experienced staff. One staff member told us, "I had a very welcoming introduction to the house, I was well introduced to both staff and service users which made me feel happy and excited to start" and another said, "Yes I had a very clear and direct induction which made me feel confident when I started".
● The provider required staff to undertake training in areas such as emergency first aid, epilepsy, equality and diversity, safeguarding, infection control and medicines management. Completion rates for training were adequate, being mostly at, or above, the provider's target of 80%.
● Most staff had also undertaken training in autism and mental health awareness and communication. One staff member told us, "We are encouraged and supported by the choice care staff to carry out as much further education/training as we can. I personally have completed my sensory processing disorder awareness and have started my diploma on autism in adults. We also have an in house Makaton trainer which supports staff in developing these skills".
● Staff were required to be trained in a behaviour support programme and until they had completed this training, they were not permitted to undertake physical interventions.
● Training and modelling was also provided by the providers behavioural support team in approaches such as 'providing just the right level of support' and 'proactive positive risk taking'.
● Staff received support in the form of supervision. Whilst this had not been taking place at the frequency aimed for by the provider, staff all told us they felt well supported by the current manager and senior team. Their comments included, "We have continuous supervision and the supervisors are very supportive", "Yes my managers make sure we are getting our supervisions done regularly, I feel these are very supportive as we can bring up any concerns we may have".
● Agency staff were not provided with supervisions by the Compton House management team but by the supplying agency who we were told would update the Compton manager if there were any performance concerns.

We recommend that the provider consider implementing a programme of supervision for the longer term agency staff to provide opportunities to discuss people's support and any development or training needs relevant to the service and people's needs.

Adapting service, design, decoration to meet people's needs
● The building design fitted into the local residential area and there was nothing outside to show it was a care home.
● Overall, the environment was well maintained. A new kitchen had recently been installed which was attractive and well equipped. There were also plans for three bathrooms to be refurbished.
● People were included in decisions relating to the interior design of their home and of their room.
● Other than the kitchen and laundry, which were kept locked, people were able to move freely around the shared spaces which included a dining room and two lounges.
● People could be supported to access the gardens which were extensive. There were swings, a trampoline, seating and an area for growing vegetables.
● Most people had personalised their rooms and these were comfortable and homely. For example, one person's room was decorated with a football theme and another person who enjoyed sensory stimulation had lots of different sensory items available in their room.
● People were able to spend time privately, in their rooms as they wished, but following a recent safeguarding incident, doors to people's rooms were kept locked when they were not in there. Some people had a key to their room or were able to access their room independently by using a pin code. Others did need to seek the assistance of staff to unlock the door first.
● Walls had been decorated with murals and reflective surfaces to enhance the environment.
● These improvements were commented on by staff one of whom said, "I also believe the home is getting more and more homely with the new decor we are getting around the home making it feel more welcoming

and giving a home environment which I have seen make an impact on the service users".
● Overall relatives were generally positive about the environment. Their comments included, "There is a nice outside space, roomy lounges, they are not on top of each other. Very rural with trees" and "Yes, very very good…It's his home and he loves it'.
● There were areas where further improvements could be made.
● There were no curtains on some of the windows including the lounges and some bedrooms. We were told that these were pulled down by people. The manager told us that new Velcro curtains, that could be easily rehung, had been ordered. A washable stair covering was also on order to replace the worn stair carpet.
● Autistic people experience the world very differently to others and so consideration needs to be given to developing an autistic friendly environment based on people's individual sensory needs. Whilst there was a sensory room at Compton House, this was a work in progress and more needed to be done to ensure this was adapted and furnished in line with good practice. The manager was continuing to research how to further enhance this area through the addition of equipment aimed at meeting people's sensory needs and differences.
● Some repairs had not been completed in a timely manner, for example, two fire doors had been waiting repair for over 28 days. We raised this with the assistant area director who escalated the repairs and was later able to assure us that the repairs were now booked to take place the following week.

Supporting people to live healthier lives, access healthcare services and support
● The service promoted good health and wellbeing outcomes for people, including supporting people to have an annual health check with their local GP.
● As staff had identified that they were not getting a responsive service that made reasonable adjustments for the individual needs of people using the service, a change of surgery was negotiated and was working well for people.
● People had hospital and health assessments which helped staff to monitor people's healthcare needs and provided guidance for healthcare staff on how to support the person in the way they needed.
● People had been supported to have flu vaccinations and access well person screening services. Dental check-ups were facilitated, and oral care plans were in place.
● Relatives felt that staff were prompt to take action if their family member was unwell and gave examples such as taking people to the minor injuries unit or liaising with the GP when one person had a urine infection.

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 and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Staff told us how they tried to empower people to make decisions about their care and support. For example, one staff member told us, "It is our job to encourage and support the wellbeing of our services users at all times, so we have practices in place to try, such as a different face, different place and even a different time. For example, if a service user doesn't like having meds straight after waking up we would talk to their GP about shifts in the administrative window and they would change the prescription if necessary, we all know how important it is to work with our service users and never against them".
● Where people lacked capacity, they had access to independent mental capacity advocates to help ensure that their views were heard, and their interests represented.
● However, there were areas where improvements were needed.
● When people needed to make an important decision, and there was doubt about their capacity to do so, staff had assessed and documented mental capacity assessments, but these needed to be more individualised.
● Best interests' decisions had not been taken in an inclusive way. Those seen had not, for example, involved the person's family or advocates and only recorded the views of staff.
● Staff had made applications for a Deprivation of Liberty Safeguards authorisation (DoLS) where needed.

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 require 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.

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

- We were not assured that the governance processes were fully effective or consistently helped to ensure that people were safe and always received good quality care and support.
- An internal review in November 2021 had identified a number of areas where improvements were needed, some of which reflected our findings at this inspection. We could not therefore be assured that sufficient action had been taken by the provider to deliver improvements.
- People had been receiving repetitive diets and there was no evidence that different or healthy alternatives were being offered. This had not been addressed through quality assurance systems.
- There was no clear system in place to monitor the number of support hours received by each person to ensure this was in keeping with their commissioned hours and supported their quality of life. This had been a recommendation of an external report following concerns being raised in from November 2021.
- Safety related maintenance issues were not always taking place promptly.
- The inspection found concerns about how effectively safety related incidents were scrutinised to help ensure that these had been responded to appropriately and remedial measures taken in response. Whilst the manager and assistant regional manager understood the importance of being honest with people when things, went wrong, we found that following a recent significant incident, the provider had not taken sufficient action to offer an apology to relevant people and share a full account of learning in line with the requirements of the duty of candour.
- Whilst people's records were well organised and did contain a range of helpful and personalised information, we also found a number of areas where people's records contained out of date or conflicting information. The quality of daily records was variable but most of those viewed lacked purpose and needed a stronger focus on how the support being provided was helping people meet individual goals and improve their quality of life.
- Improvements were needed to ensure that clear records were maintained of the checks that monitored people's safety or wellbeing following the use of physical interventions or the use of PRN medicines.
- Mental capacity assessments needed to be more individualised and best interests' decisions more inclusive.
- In the absence of a registered manager, the provider had not stepped up its scrutiny and oversight of the service to address and prevent quality and safety related issues.

The systems in place to assess and monitor and improve the service were not effective. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The manager had been in post for four months when we inspected. Overall, they had the skills and knowledge needed to perform their role, had a good understanding of people's needs and worked alongside staff regularly which helped to ensure people's safety.
● The manager had a plan in place to deliver improvements some of which reflected those found during the inspection. The provider had also recently reviewed its quality assurance processes to make these more robust.
● Our discussions did highlight that the manager needed to familiarise themselves with the principles of key statutory guidance such as the Commissions "Right Support, Right Care, Right Culture" which describes our expectations for how providers and leaders can best support autistic people and those with a learning disability.
● Whilst the inspection highlighted a number of areas where improvements were needed, staff were positive about the managers impact on the service so far. One staff member said, "[Manager] is amazing, she has done a lot for this house" and another said, "[Manager] has been able to flip the house entirely back onto its feet, you can see the morale in the staff rising again, people are getting more engaged and she has provided lots of new activities for the guys to do which has had a positive impact on both service users and staff, it is great to get the feeling to want to go back to Compton even after a long shift". A third staff member said, "I have been amazed at the work ethic our manager who has been doing to help put Compton back to its feet, any issues or concerns that get brought up she gets on it as quick as possible…. She makes herself available to everyone even when we all know she is busy she never brushes off anyone who needs to talk to her which is something that the house needs".
● Relatives also expressed a cautious optimism about the new manager. Their comments included, "Manager has now been here a few months, seems all under control, she listens and deals with things, hopefully a more settled path and will keep running smoothly" and "I'm feeling with everything crossed that it's heading in the right direction".

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The manager and the staff team understood the provider's values and all staff spoke of a more positive and inclusive atmosphere within the home where they felt valued. They all felt this was having a positive impact on morale. For example, one staff member told us, "They [The manager] are bringing life and joy to the home" and another said, "Compton is once again a place that you would be happy to visit and work at".
● All staff felt able to raise concerns with the manager without fear of what might happen as a result.
● Many of the relatives we spoke with, told us that the culture and atmosphere in the service had improved since the new manager came into post. One relative said, "They treat him as a normal person, he's never judged with his disability at all" and another told us there was "On the whole, a nice family atmosphere".
● Staff praised the way in which the manager spent time working directly with people, leading by example and providing modelling, direct support and guidance. We also observed this in practice.
● When we were speaking with one of the people using the service, they asked that the manager sit in on the chat, indicating that they confident that the manager had a genuine interest in their views and wellbeing.
● Staff spoke about people warmly and used positive and respectful language when describing the individuality and uniqueness of each of the people they supported. For example, one staff member told us how they loved the intensity of one person's laughter.
● The permanent, longer term, staff knew people well. They were able to describe people's unique way of communicating. For example, we were told how one person would fetch their towel in a box when they

wanted a bath and of the words used by another person to communicate that they wanted a biscuit.
● We saw many positive interactions. For example, at lunch a member of staff was using Makaton to communicate with one person. The interaction appeared positive. Staff were also observed to encourage people to express their views using picture symbols displayed around the home.
● We observed a staff member supporting a person to choose what to view on their tablet. The person seemed happy and was affectionate toward the staff member who appeared to know what programme the person was looking for.
● We saw staff doing 'high fives' with people, ruffling a person's hair in a friendly manner and playing games. These interactions were relaxed and friendly. Staff were observed to be joking with one person about their favourite foods, teasing them that perhaps it was 'squirrel stew' which the person laughed at.
● Staff sensitively and discreetly offered or prompted people with their personal care needs. In one example, the staff member lent down to a person's eye level, used open body language and gave the person time to process their request. The staff member waited until the person was ready to get up and thanked him when he stood up.
● Staff asked people before providing assistance and were observed to respect people's decisions and private space.
● Using the symbol based communication tool, people told us they were happy about the staff, their room, their medicines, making choices, the garden, the food and their contact with their family and friends. One person told us how they felt that they got to make choices about their life and that staff respected their privacy.
● Another person told us they were happy with most aspects at Compton House, however they also said that they wanted to leave the service as they 'Didn't feel like part of the family' and that he had 'No friends at the home' because the other people who lived there did not use words to communicate. Staff were aware of this person's wishes and plans were in place to seek a more suitable home for them.
● Visiting professionals commented positively on the relationships between staff and people. For example, a healthcare professional told us, "They genuinely care for the residents and know them well".
● One social care professional told us, "When I visited Compton House, I experienced the interaction between residents and care staff to be that of a friendly one" and another told us, the person they visited was "Very positive" describing staff as "Lovely". They told us that they also observed positive interactions between staff members and people throughout their visit saying, the person had a "Good rapport" with staff and was "relaxed in their company".
● We did see a small number of neutral interactions where some of the agency staff were less engaged with the person they were supporting. For example, we observed occasions where the member of agency staff supporting people just sat watching the person from a distance, not attempting to offer any meaningful engagement. Another person was clearly becoming distressed but the agency worker supporting them could not understand what it was they wanted in terms of support. A permanent staff member was able to step in and support the person.
● Senior staff acknowledged that the high use of agency staff did have an impact, at times, on the quality of support being provided, because for example, the staff member did not know the person so well, or perhaps lacked confidence at trying a range of styles and interactions to engage the person. To mitigate this, the deputy manager told us how they were focussing on making sure that people were, wherever, possible well matched to their designated support worker. They understood that when this happened, people were more at ease, happy, engaged and stimulated. During the inspection, we saw that the staff supporting people was swapped around in direct response to a person's request that they be supported by specific staff.
● We have spoken in more detail about the measures that the provider is taking to recruit more staff and to mitigate the impact of the high agency use whilst recruiting in the safe domain.
● There was some evidence that people were being supported to undertake meaningful activities that it was known they enjoyed. For example, a social care professional told us, "My client is supported to go to a local

work project, which he really enjoys. [Person] also said he is supported to go to the local pub, shopping, meals out, family visits and trips further afield – such as Isle of Wight and Weymouth".
● People had also been supported to go to a football match, to see a pantomime and have lunch out. During the inspection, people were supported to go for walks and for a picnic.
● However, more still needed to be done to ensure that people were adequately supported to take part in their chosen social and leisure interests on a regular basis.
● One person told us how they had once enjoyed going to Marwell Zoo, horse riding and swimming, but no longer did this.
● Whilst people had an individualised weekly activity timetables, neither records nor our own observations indicated that people were, in practice, being consistently offered opportunities to undertake these activities.
● We reviewed four people's daily records for a period of two weeks and saw only limited evidence of people being supported to undertake a range of activities or access their local community.
● The records also indicated that there were missed opportunities to use evenings as a time when people could be further supported to undertake hobbies or leisure interests.
● Where daily notes did refer to activities taking place, it was not clear how these activities were meeting people's individual interests or aspirations or supporting the development of life skills. For example, records often recorded that people had been for a 'drive', it did not always record where to, or how this had, for example, contributed to the person's wellbeing. On one occasion, an afternoon nap had been recorded as an activity. Instead most daily records indicated that people were spending long periods of time on either laptops or tablets rather than being supported to access a range of preferred activities.
● In our discussions with relatives, the need to improve the quality and quantity of activities was the most common theme of areas the home needed to improve on. One relative expressed a frustration that there were so many facilities available in the local community but that these were not being made the most of and another said, "They need to do more with lads, take them out in the mini bus, do something, they need to get out, trips out to the beach, fishing trips". One relative hoped that they would soon be able to get back to doing more events that the family could get involved in, for examples, "Barbeques or a talent show". We discussed this feedback with the manager, they were able to describe plans for improving the activities and told us how they were hoping to take some people to a nightclub and had a found a choir for another person to join. We were also advised that an activities coordinator had just been recruited to focus on delivering more person centred activities.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● More needed to be done to encourage people to be involved in the development of the service.
● There was a lack of evidence as to how key worker meetings were being used to achieve positive change for people. Where people had indicated that they would like something to change, there was no evidence of how this had been addressed.
● Care plans recorded that people had been a contributor to their support plan, but it was not clear in what way this had been facilitated or what their views had been.
● A number of people had a goal recorded that their support plan should be provided in easy read format to aid the person's involvement. This had not yet taken place.
● There were missed opportunities to involve people in some aspects of the running of the service, for example, by being supported by staff to carry out health and safety checks.
● Whilst staff feedback was not clearly evident in the minutes of recent staff meetings, staff all told us that they were encouraged to make suggestions and to be involved in developing the service. For example, one staff member said, "You can bring up any concerns you may have or any ideas as to how you think you can improve, and they are listened to and taken on board with management well" and another said "I always

feel listened to and supported".

● Staff understood the importance of people maintaining contact with their families to their quality of life. Visits with family were facilitated both at the home and within the community. Some people had regular overnight visits to stay with their families.

● Overall family members felt that the manager and staff kept them informed about the wellbeing of their relative, although some felt this was an area where improvements could be made. For example, one relative said, "Sometimes they ring me a week later and say did nobody tell you, as if I should know, how do you know if they don't call me"? One relative told us they were still waiting for photos they had been promised back in February. They said, "If they say they're going to do something, do it, no point in promising and not doing it". A third relative expressed a wish to be more involved and informed about what their family member was doing saying they would like an "Activity plan every week to see and follow up on what gets accomplished and talk to him about it. A diary of food what he's eating, I love having connection to what he's doing".

Working in partnership with others

● There was some evidence of partnership working with health care professionals which helped to improve and maintain people's wellbeing. For example, a health care professional told us, staff referred people to them in a timely manner for appropriate healthcare needs and followed their advice and treatment plans. A social care professional told us, "The care home were open to discussions and also recommendations". However, another social care professional told us that they felt more could be done to promote their involvement in annual reviews and best interest's decision making.

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 17 HSCA RA Regulations 2014 Good governance The systems in place to assess and monitor and improve the service were not effective. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014