Spectrum (Devon and Cornwall Autistic Community Trust)

Rosehill House

Inspection report

Ladock
Truro
Cornwall
TR2 4PQ

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

Summary of findings

Overall summary

We carried out a comprehensive inspection at Rosehill House on 4 January 2017, the inspection was unannounced. Rosehill House is a newly registered service and this was their first inspection.

Rosehill House provides care and accommodation for up to five people who have autistic spectrum disorders. At the time of the inspection four people were living at the service. The service is part of the Spectrum group who run several similar services throughout Cornwall, for people living on the autistic spectrum. The people living at Rosehill House had previously lived at another Spectrum service which has now closed. They had moved into Rosehill together in November 2016. Staff and relatives told us the move had been well managed and people had settled in well.

There was a registered manager in post. 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.

People's social needs and preferences were not being met. There were four staff vacancies at the time of the inspection. The registered manager told us this was being addressed and two new members of staff, plus a new deputy manager, were due to start working at Rosehill House in the next few weeks. However, the rotas for December showed there had been several occasions when staffing levels had dropped below the minimum identified as necessary to meet people's needs when they were at home. Additional staff were required to support people to access the community and take part in individual pastimes. People's daily records showed they were seldom going out to take part in activities which had been identified as meaningful and important to them. The records showed three of the four people frequently went on drives as a group but staff told us people usually stayed on the bus as there were not enough staff to support people safely in the community.

Records of the care and treatment people received were kept. Some of these records were incomplete. For example, we found gaps in daily records and records of when one person had received prescribed topical medicines. This meant we were not consistently able to establish the care people had received. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental capacity Act 2005 (MCA). The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). One person was subject to a Deprivation of Liberty Safeguards (DoLS) authorisation. There were conditions attached to the authorisation regarding the recording of activities the person had taken part in. These conditions were not being met.

Care plans were informative and regularly reviewed. They were very focused on people's individual needs, describing their likes and dislikes, communication preferences and styles and personal histories.

Staff knew people well and understood their communication styles and how they preferred to be supported.

We saw examples of positive interactions during the inspection when staff supported people in line with their care plan. People were encouraged to do things for themselves and staff showed compassion and patience in their approach.

Regular audits were carried out to monitor the quality of the service provided. However, these had not highlighted the problems identified at this inspection.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the end of the full version of the report.

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 entirely safe. There were insufficient staff to make sure people's needs were consistently met.

Staff had access to information to help them protect people from identified risks.

There were effective systems in place to support people with their finances.

Is the service effective?

Requires Improvement

The service was not entirely effective. Conditions associated with DoLS authorisations were not being adhered to.

Training was mainly up to date. However, training in respect of the specific health needs of two people had not been refreshed.

Not all staff had received supervisions and no staff meetings had taken place since the service opened in November 2016.

Is the service caring?

Good

The service was caring. Staff demonstrated a genuine concern for people's well-being.

Care plans were person centred and contained information about people's preferences.

Staff supported people to do things for themselves appropriately.

Is the service responsive?

Requires Improvement

The service was not responsive. There was a lack of meaningful activities for people which reflected their individual interests.

There were gaps in records intended to document how people spent their time.

The transition to Rosehill House had been well planned and people had settled in well.

Is the service well-led?

Requires Improvement

The service was not entirely well-led. Pressure created by low staffing levels had resulted in a lack of time for administrative duties to be completed.

Audits had failed to identify problems and action to address staffing levels had not been carried out in a timely manner.

Staff had access to on-line policies and procedures.

Rosehill 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 4 January 2017 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we 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 we were not able to ask people who lived at the service about their experience of the care and support they received. Instead we observed staff interactions with people. We spoke with the registered manager, a member of Spectrum's senior management team and six care workers including some bank staff. Following the inspection we contacted an external healthcare professional and three relatives to hear their views of the service.

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

Requires Improvement

Is the service safe?

Our findings

There was not always sufficient staff on duty to make sure people's needs could be consistently met. Accommodation within the premises was split into three areas. One person lived in a separate self-contained annexe approximately 500 yards from the main house. Two people lived in the main house and one person lived in a self-contained flat on the ground floor of the house which had its own entrance. The flat could not be accessed directly from the house. The people living in the annexe and flat required continual support during the day. People in the main house needed one member of staff to be available to support them at all times. Two people needed additional support when going on trips out to ensure their safety. This meant there needed to be a minimum of three staff on duty during the day if people were staying in the service. This rose to four when the people requiring additional support when in the community, took part in individual activities outside of the service.

At the time of the inspection there were four full time staff vacancies. We looked at the rotas for December and saw there had been seven occasions when four members of staff had been on duty during the day. On five occasions, only two members of staff had been on duty. When we arrived at the service on the morning of the inspection at 9:20 am there were only two members of staff working, another member of staff arrived at 10:00 am. As it was necessary for a member of staff to work in the annexe at all times this meant the remaining member of staff was required to divide their time between the main house and the ground floor flat. In one of these people's care plan it was recorded; "Due to [person's specific health condition] they are supported by one member of team member (sic) at all times." The information in the rotas showed this was not always happening. This meant people could have been at risk as they were not receiving support in line with their plan of care.

Incident reports showed there had recently been an occurrence when one person had acted in a way which could have resulted in them harming themselves or becoming unwell. At the time of the incident they were being supported by a member of staff. We were concerned that, if a similar event occurred when staff were not immediately available to support the person, there was an increased risk to their health and well-being.

The two people living in separate accommodation were both female and required female staff to support them when having personal care. This could be difficult when staff numbers were low as it could mean one member of staff needed to work across the two living areas at key times of the day in order to support people according to their preferences. Staff told us, although there were usually three members of staff on duty, this was often not arranged until the last minute with high dependence on the use of Spectrum's on-call system to arrange cover. Staff told us they were often required to stay later than their shift was scheduled until more staff turned up. Comments included; "I've been stranded more than once", "There have been occasions when I haven't been relieved", "We're always scratching around for staff" and "I sometimes have to stay on because there's no-one to take over."

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

The registered manager told us two vacancies had been filled and the new employees were going through the induction process and recruitment checks before they could start working at the service. A deputy manager was due to start work at Rosehill House at the end of January 2017.

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.

People's medicines were stored securely in locked cabinets. Medicines Administration Records (MAR) were completed appropriately. We checked the number of medicines in stock for one person against the number recorded on the MAR and saw these tallied. Training for the administration of medicines was up to date for all staff with responsibility for administering medicines. There were clear processes to follow when staff administered any additional medicines in response to need, for example paracetamol. Before administering additional medicines staff were required to obtain authorisation from a manager. If one was not on duty in the service at the time Spectrum's on-call system ensured there was always access to a manager. Information on how to support people with specific health conditions was in place to help inform staff.

Some people required creams to be applied to their skin. We checked one person's charts which were used by staff to record when these topical medicines had been applied. There were some gaps in the records and none had been completed at all since December 2016. The records of the care and treatment provided did not enable us to establish if the person had received their medicines as prescribed.

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

People were protected from the risk of abuse because staff had received training to help them identify possible signs of abuse and knew what action they should take. Staff told us if they had any concerns they would report them to the registered manager and were confident they would be followed up appropriately. They said if they were not satisfied their concerns were being dealt with appropriately they would raise them with the Care Quality Commission or local safeguarding team. Notice boards in the office displayed details of the local authority safeguarding teams and the action to take when abuse was suspected.

Incident reports were completed following any untoward incident. These were analysed on a monthly basis by Spectrum's internal behavioural team in order to highlight any trends. They would then advise if it was felt that any changes to the person's care plan were necessary in order to keep them safe. The staff team had received training in Positive Behaviour Management (PBM) in order to help ensure they were able to support people effectively if they became distressed or anxious.

Care plans contained detailed information to guide staff as to the actions to take to help minimise any identified risks to people. For example, how to support people if they became unwell or distressed. The information was contained within the relevant section of the plan. There was also clear guidance for staff on how they could avoid situations developing which could present a risk to people or others. One person could become distressed resulting in them acting in a way which might be difficult for staff to manage. The care plan described what might trigger this distress. For example, "Being told what to do" and "Having food cut up in front of him."

Effective systems were in place to support people with their finances. Robust records were kept when staff supported people to make purchases and receipts were kept. These records and the balance of any monies held were audited regularly. We checked the amount of money held for people against the records and

found these tallied.

All fire-fighting equipment had been regularly serviced and other necessary safety checks completed by appropriately skilled contractors. Fire drills were completed regularly and staff understood how to support people in case on an emergency. Personal Emergency Evacuation Plans (PEEPS) had been developed for each person and these were kept either in the annexe, main house or flat as appropriate.

Requires Improvement

Is the service effective?

Our findings

Staff had received training in the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards (DoLS). 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 so that they can 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. There were some restrictions in place for people and mental capacity assessments and best interest meetings had taken place and were recorded as required. Meetings had included external healthcare representatives and family members to help ensure the person's views were represented.

Applications for DoLS authorisations had been made to the relevant local authority. One person was subject to a DoLS authorisation and there were conditions in place regarding records to be kept when the person went on outings into the community. We checked if this was being done and found the records did not contain the level of detail required by the authorisation. For example, it was not always possible to establish the duration of a trip out and whether other people had taken part in the trip without cross referencing the daily logs. There was no record of the outcomes of outings as stipulated in the DoLS authorisation.

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

Training identified as necessary for the service was updated regularly. Staff also had training specific to people's needs such as Autism Awareness. Staff told us the training was good and they were prompted when anything needed to be updated. One told us; "I have been sent the links and passwords to do some on-line training." An external healthcare professional commented; "All staff whom I have seen supporting my client appeared knowledgeable and competent." Two people living at Rosehill House had a particular health condition requiring specialist care. Staff training in this area had not been updated for some time.

Staff supervisions had not been taking place although three members of the seven staff, including two night workers, had received supervision within the two weeks preceding our visit. The supervision notes had not been written up at the time of the inspection. There were no further supervisions planned and the registered manager told us that, due to the pressures created by low staffing numbers they were, "Having to do them when I can."

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

The premises were well decorated and the furnishings were up to date and in good condition. A member of staff told us; "It's much more homely than where they used to live. They seem to have settled in well." The windows in the kitchen of the ground floor flat did not open and the kitchen door opened directly onto the lane. We discussed with the registered manager and a member of Spectrum's senior management team, the possible problems this might present in the summer when the weather was hot. They told us they would look at how the ventilation might be improved. Although the drive leading to the annexe was steep, staff told us the person living there did not need to walk down the lane as they had their own vehicle which was always available. A relative confirmed to us that access to the annexe did not cause any problems for their family member.

The main property was accessed by steps and a relative expressed concern about the safety of this and people's ability to negotiate them in wet and slippery conditions. We discussed the accessibility of the property with the registered manager who told us people were able to leave the building using a separate entrance and we saw this used on the day of the inspection. They told us people's mobility was under constant review and adaptations would be made as required to help ensure people's safety and independence.

The core staff team knew people well and had a good understanding of their needs. There was frequent use of bank staff and these were staff who were familiar with the service and people's preferences. People had allocated key workers who worked closely with them to help ensure they received consistent care and support. A relative told us they always knew the staff who supported their family member.

New staff went through an induction process consisting of a mix of training and shadowing and observing more experienced staff. New employees were also required to complete the Care Certificate. One member of staff told us the induction had been, "Excellent. I can't fault it, it told me everything I needed to know"

People's dietary needs and preferences were recorded in their care plans. For example, one person's care plan documented that they had low iron levels. There was information for staff on how to support the person's well-being in this aspect. This included a list of foods high in iron and another of foods that might impact on the amount of iron absorbed into the body. Daily notes recorded what people had eaten and drank throughout the day. The information was vague and merely noted what the meal had been with no indication of how much the person had eaten.

People were supported to access other health care professionals as necessary, for example GP's, opticians and dentists. Since moving to the new service a GP had made a home visit to meet with people.

Good

Is the service caring?

Our findings

People were relaxed and at ease with staff. Staff spoke of people with affection and respect and a concern for their well-being. A member of staff told us; "Staff are compassionate and kind to people."

Information in care plans was relevant to people's individual needs and reflected their likes and preferences. As well as facts regarding people's health conditions there was information about their social and communication needs and things which were important to them. For example, one person liked to have physical head to head contact. This was explained in their care plan and we saw staff respond to requests for this contact during the day. People's communication styles were outlined with information on how best staff could initiate successful communication. When people used specific and consistent vocalisations to indicate certain things these were clearly described.

Care plans contained detailed life histories describing people's backgrounds and personal circumstances. This is important as it enables staff to develop an understanding of the events which may have contributed to who people are today and the importance of their habits and routines.

People were encouraged to develop and maintain independent skills. This was documented in their records and we saw staff encouraging people to do things for themselves. For example, we heard staff ask people if they wanted to go and choose what to eat. People were offered choices in line with their care plan. This could be by offering a limited choice, i.e. jam or peanut butter, or by presenting the person with the actual jars. This meant people were given information in a way they could understand it and make a meaningful choice. When getting ready to go out for a walk one person indicated they wanted staff to fasten their coat. The staff member gently persuaded the person to do it themselves. This was done with humour and patience.

People's bedrooms and living areas were decorated to reflect their personal interests and taste. Staff asked people if they would mind us looking at their rooms and encouraged them to accompany us to do this.

People's privacy and dignity was respected. As outlined in 'safe', staffing levels meant it was sometimes difficult to ensure people received personal care according to their preferences. However, staff assured us they worked to ensure this was always respected. Relatives told us they considered staff to be caring.

Requires Improvement

Is the service responsive?

Our findings

As outlined in the 'safe' section of this report people required additional support when accessing the community. Daily logs showed most people had limited access to activities. Staff told us this was due to the low staffing levels within the service. Although care plans described pastimes which were important to people these were not occurring. For example, it was recorded that one person enjoyed swimming and pub trips but these had not taken place during December. Another person's activity rota showed they were to be supported to visit a local garden centre to buy flowers every week as they particularly enjoyed doing this. Despite the simplicity of this activity it had not occurred in December. A member of staff told us; "The activity rotas are not followed." A relative commented; "[Person's name] is not going out nearly as much as he should do." Most of the activities recorded in people's daily logs were trips in the service's mini bus when people went out as a group. It was not clear from the records whether people got off the bus at any point. Staff told us this did not always happen. One commented; "If you can contain them on a bus you don't need as much staff" and "We can't get off the bus, it wouldn't be safe [due to the low numbers of staff]." The majority of other activities recorded were short walks in the local area. There was no evidence that people's personal preferences regarding activities were sought out or taken into account when planning outings.

Staff and relatives also commented on the lack of in-house activities for some people. One member of staff said; "I've not seen any evidence of anything at all." A relative said; "In-house activities are fairly non-existent."

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

The relative of one person, who lived in one of the self-contained areas, was more positive about the opportunities their family member had. This person had access to their own transport. Due to the high level of support needs it was particularly important they were supported at all times. These factors combined to help ensure the person was able to go out on individual trips into the community.

Daily logs were completed outlining what people had done during the day and information about their emotional well-being. There were several gaps in these records making it difficult to establish how people were spending their time. A member of staff told us records were usually completed in the evening when staff had more time.

This contributed to the breach of Regulation17 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. A front page outlined basic, but important, details about the person's needs. Further sections contained more detailed information to help staff gain an in-depth knowledge of all aspects of people's needs. 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

importance of protecting people's dignity was emphasised. Care plans were regularly reviewed; this meant staff unfamiliar with the person had access to the most up to date information. Relatives were invited to attend annual reviews where appropriate. Staff told us they found the care plans, "Informative and relevant."

People had moved into Rosehill House in November 2016 following the closure of another Spectrum location. Relatives told us the transition had been well planned and managed. People had visited the property several times before the move and had left personal belongings there over a period of time. Staff and relatives all said they believed people had settled in well.

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 had been received. A compliments book had been set up and this contained positive comments regarding how the move to the service had been managed.

Requires Improvement

Is the service well-led?

Our findings

Although there was not a full staff team in place there were clear lines of responsibility. Key workers were assigned to individuals and had responsibility for checking appointments and maintaining family contacts. In addition staff were given responsibility for various aspects of the management of the service such as vehicle maintenance and cleaning schedules. The registered manager had some dedicated administration hours. However, they were often required to forego these in order to cover shifts. This had impacted on their ability to carry out responsibilities such as supervision and arranging staff meetings.

Quarterly audits based on the Care Quality Commissions key lines of enquiry (KLOE) were carried out by the provider. In addition, the divisional manager visited at least once a month to carry out audits on the paperwork. The registered manager told us they were; "Very well supported." Despite these audits problems identified at this inspection had not been highlighted. For example, the lack of recording noted in daily logs and records to indicate when people had topical medicines applied.

Staff were committed to supporting people and were clearly frustrated by the limitations caused by staff shortages. Comments included; "It's very stressful, for staff and service users", "I'm confident things will improve but staff are stressed and that effects energy levels" and "Staff morale is not that good." No team meetings had taken place since the service had opened in November 2016. It is particularly important in a new service, that staff have an opportunity to discuss any teething problems or share any learning regarding how people are supported in a new environment.

This contributed to the breach of Regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us action was being taken to address the problems with staffing levels. This included the recruitment of a deputy manager who was due to start at the end of January. One member of staff commented; "Considering the circumstances [registered manager] is managing quite well but a deputy will definitely help." In addition they had been involved in recruiting staff to the service at a local job centre. This meant they were able to focus on recruiting staff who would be suited to meeting people's specific needs. However, staff told us the staffing problems had been on-going since the service began demonstrating that action to address this had not been taken in a timely manner.

As the service had only been running since November 2016 no action had been taken to gather people's views of the service, or that of their families. Relative's opinions were mixed; while all agreed the transition period had gone well some told us they received little communication to keep them informed of any developments. One commented; "The communication is weak. We would like to hear, on a weekly basis, what [person's name] is doing."

Care records were well organised and informative. Incidents were recorded appropriately and reviewed in order to highlight any trends. The registered manager was able to provide us with any records requested in a timely manner.

Organisational policies and procedures were available on line to enable staff to have easy access to information. Spectrum kept staff informed of any developments in the care sector via emails and a newsletter. Spectrum supported a works council committee in order to facilitate communication between staff and higher management.

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 Care and treatment did not consistently meet people's 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 The registered person did not maintain accurate and complete records in respect of the care and treatment provided to people. Regulation 17(2)(c)

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. Staff did not receive appropriate support as was necessary to enable them to carry out their duties. Regulation 18(1)(2)(a)