Spectrum (Devon and Cornwall Autistic Community Trust)

St Erme

Inspection report

St Erme
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Ratings

Overall rating for this service	Inadequate

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

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
St Erme is a care home providing personal care for up to twenty autistic people. At the time of the inspection 12 people were living at the service.

Accommodation is across three separate houses all within the grounds. The houses are known as The Lodge, The House and St Michaels. There is also a small office building on site. The service is part of Spectrum (Devon and Cornwall Autistic Community Trust) which has 15 active services in Cornwall providing care and support for autistic adults and/or adults with a learning disability.

People's experience of using this service and what we found
The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Staff and relatives told us there had been a high turnover of staff and recruitment drives to recruit permanent staff had not been successful. The provider relied on agency staff to increase staffing levels. These agency staff routinely worked very long hours. Some agency staff were committed to the service and hoped to move to the area and become permanent members of the team. However, there remained concerns about the stability of the team and new staff not knowing people well or having a good understanding of their needs in order to provide good outcomes for people.

Inadequate staffing levels impacted on many aspects of the service. This included providing support in line with commissioned hours, developing trusting relationships with people and supporting people to take part in activities outside of the service. This was compounded by a lack of drivers working at St Erme to support people to go out and do things.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

There had been a high turnover of managers at the service. The last registered manager deregistered in August 2021. Two external consultants were working at the service as manager and deputy manager. The manager had applied for registration until a more permanent manager could be appointed. Neither of the consultants lived locally and were not at the service at the weekend. They were particularly focused on The

House and a service manager had day to day oversight of The Lodge and St Michael's. Staff, relatives and professionals told us the management situation had improved although there remained concerns about the temporary arrangements for managing the service.

Right Support
The service is based in a campus style setting. People had exclusive possession of their own rooms, in shared accommodation. The environment was not well maintained, and people's sensory needs had not been considered when designing the service.
People were not consistently supported in the least restrictive way. At certain times of the day people were unable to move around communal areas freely. Cupboards and doors were routinely locked and some people were not able to access drinks or snacks when they wanted. The new manager was working to reduce some of the restrictions in place.
Staff recorded any incidents, including when people had been restricted. There was limited learning from incident records which meant the risks of similar incidents reoccurring were not reduced.
Staff supported people to receive their medicines safely and in the privacy of their own rooms. People did not always have access to homely remedies and we have made a recommendation about this in the report.
Staff enabled people to access health and social care support in the community.

Right Care
The service did not have enough appropriately skilled staff to meet people's needs and preferences. This placed further restrictions on people as they were not able to go out when they wanted.
People's access to activities was limited, both in and out of the service. There were few opportunities to try new experiences. People generally went on local walks or shopping trips.
People's care plans did not always accurately reflect their needs. Staff were unaware of some of the information which described how to support people when they were sad or anxious.

Right Culture
People were not leading inclusive and empowered lives because the provider and staff had low expectations for them. There was a culture of presuming people were unable to progress, gain skills or set goals in order to live full and rich lives.
Staff turnover was high; recruitment practices did not focus on quality. People were not receiving consistent care from people who knew them well and were committed to delivering a high-quality service.
People's rights were not respected. The provider had failed to make reasonable adjustments for people to manage their sensory sensitivities.

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

Rating at last inspection and update
The last rating for this service was inadequate and there were breaches of the regulations (published 14 December 2021).

At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
We undertook this inspection to assess whether the service was applying the principles of Right support right care right culture and to check if improvements had been made following our last inspection.

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.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified seven breaches in relation to the provision of person-centred care, dignity and respect, safety and risk management, safeguarding people from abuse, the maintenance of the premises, staffing levels and management of the service. Six of these were repeat breaches.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service effective? The service was not effective.	**Inadequate**
Is the service caring? The service was not caring.	**Requires Improvement**
Is the service responsive? The service was not responsive.	**Inadequate**
Is the service well-led? The service was not well-led.	**Inadequate**

St Erme

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 Health and Social Care Act 2008.

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
Four inspectors, a specialist professional advisor with experience of working with autistic people 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
St Erme 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

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was no registered manager in post. The manager had submitted an application to the CQC to register as the manager of the service.

Notice of inspection
The inspection site visits took place on 3, 6 and 7 May 2022. This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. This information helps support our inspections. We used all of this information to plan our inspection. 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.

During the inspection
We met with all the people who used the service and we spoke with eleven relatives about their family member's experience of the care provided. People who used the service who were unable to talk with us used different ways of communicating including using basic Makaton, pictures, and their body language.

We spoke with 20 members of staff including the manager, deputy manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with eight professionals who have contact with the service.

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

Inadequate

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 inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

At the last inspection the provider had failed to provide sufficient numbers of staff to ensure people living at the service were safe. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● There were not sufficient numbers of skilled staff available to support people in line with their identified needs. There is a condition on the registration of St Erme whereby the provider is required to provide information about staffing levels to CQC every month. The records provided for April 2022 showed the service had failed to have the commissioned number of staff hours on 14 days. On one day they fell below the provider's contingency levels. This was the minimum number of staff required to ensure people were safe as defined by the provider. This meant the provider had exposed people to the risk of unsafe care.
● There were occasions when there were not enough staff to enable people to go out when they wanted to. Staff meeting minutes read; "Due to staffing shortages and no drivers [Name] has not been able to go out."
● Commissioners had assessed some people needed support from two members of staff for a period of the day. Rotas showed people did not always receive this planned support. An external professional confirmed they had observed people did not get their allocated support. Low staffing numbers impacted on the quality of care provided and people's opportunities to live full and meaningful lives in the way they wish.
● There was a heavy, frequent reliance on agency staff who worked long hours. This meant that if they had unplanned leave their shifts were difficult to cover at short notice. This was compounded by the service frequently being staffed at low numbers which did not enable people to have support from two members of staff. This meant there was a risk people would not be able to take part in planned activities or attend appointments if staffing numbers fell below the expected level.
● On the first day of the inspection it was one person's birthday. A member of staff had planned to take them out for the day, but they were absent due to sickness. There were not enough staff available to rearrange this, so the person was unable to go out.
● Relatives commented; "There has been a turnaround which has meant a loss of continuity" and "There has been a shift because of losing staff, not getting the hours [name] needs with the right people and skills."
● External professionals told us staff did not always have the skills required to support people. Comments included; "Staff I have directly worked with have tended to lack understanding and training of learning disability, autism and communication skills for some time after they start working with complex individuals" and "There continues to be high numbers of agency staff and/or new Spectrum staff working with the

individual, who are unfamiliar to them, and are not confident in supporting them and do not understand their needs, such as important routines."

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

● Recruitment checks were not always robust. One person had not been asked for references from their previous employment where they had provided care and support to older people. This was contrary to Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● Following the inspection we highlighted this to the provider who subsequently requested and received a reference from the previous employer.

Assessing risk, safety monitoring and management

At the last inspection the provider had failed to ensure people received safe care. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Risk assessments had been completed for staff working long hours. These stated staff should not work more than 84 hours per week with a minimum of one day off each week. These assessments recognised that staff tiredness could impact on the accuracy of record keeping, medication management and on the staff members psychological wellbeing. However, the risk assessments did not identify any risks in relation to the quality of support provided by tired staff, working excessive hours.
● These risk assessments had not been complied with. On the week beginning 24 April 2022, three members of staff had worked 14 hour shifts on seven consecutive days; a total of 98 hours. Working this number of hours significantly increased the risk of staff becoming tired. This unnecessarily exposed both the staff member and people they supported to a risk of harm to their health and well-being.
● Staff had access to walkie talkies so they could call on each other for help if they needed it. This was particularly important as some people were often supported by a single member of staff in their own accommodation. If staff needed additional support walkie talkies could enable them to request this without leaving the person alone. We found walkie talkies that had not been charged so staff could not rely on them if they needed to.
● Fire checks were not consistently completed. For example, no tests of fire extinguishers in The House had been recorded since the 6 March 2022. Fire alarms and automatic door release devices were last recorded as having been tested on 20 January 2022. There were no fire exit signs in place throughout the service.
● A list of fire safety competent staff and wardens listed five members of staff. None of them were still working at the service. This meant staff did not have access to the most up to date information.

This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At the last inspection the provider had failed to ensure systems to prevent the spread of infection were embedded. This contributed to a breach of Regulation 12 (Safe care and treatment) of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● We were not assured that the provider was preventing visitors from catching and spreading infections. During the inspection inspectors were not always asked for proof of a recent negative lateral flow test and temperature checks were not always completed before they were admitted into the service.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● 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.

Learning lessons when things go wrong

At the last inspection the provider had failed to learn from untoward incidents. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Systems to support learning from incidents and accidents were not robust. Incident reports were shared with a Positive Behaviour Support practitioner based at head office who then used the information to help them understand why people were becoming distressed and how they might be better supported. Daily records sometimes indicated people had become distressed leading to incidents. Corresponding incident reports had not always been completed. The failure to complete the records meant opportunities to drive improvements might be lost.
● When risks had been identified action to minimise the risk was not always taken. CQC had received a notification in respect of an incident when one person had left the service without support when they were not being observed as appropriate. Similarly, during the inspection we saw staff inappropriately leave the person alone whilst they attended to laundry. This indicated no measures had been put in place to minimise the risk of the person again leaving the service without the correct level of support putting them at risk of

harm.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At the last inspection the provider had failed to ensure people were safeguarded from abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 13.

● People were subjected to restrictive practices that were not proportionate or appropriate. One person had their access to drinks restricted due to health reasons. This could cause them to become anxious and distressed. Daily records showed staff had improperly used access to drinks as a reward. For example; "Due to his behaviour we were waiting for some good, calm company from him so that he could have coke as a reward, and that was communicated to [Name], but that never came" and "On the way back [Name] asked to have lemonade. I offered him other drinks as fizzy drinks are used to reinforce positive behaviour and thus it was not applicable, which I explained to [Name]. [Name] then went into incident in the garden." This potentially restrictive practice was not in their care plan and was not in accordance with good practice.
● At the last inspection we noted people were not able to keep to their preferred routines and were restricted about where they went and when. This remained the case at this inspection. One person routinely got up early and indicated they wanted to come downstairs but were often told it was 'too early.' This approach was not consistent, on occasion they would join night staff downstairs while at other times they were told they needed to wait until day staff came on shift. This had sometimes resulted in the person becoming distressed leading to an incident when they had set fire alarms off disturbing other people living at St Erme.
● Systems to ensure people had access to their own money were not robust. A manager who had the sole mandate to people's accounts had been absent for several months. This meant no-one was able to withdraw money on people's behalf so people did not have access to their money. There had been some surplus cash available, but this had now run out and the provider had loaned people money. The manager told us they expected the situation to be resolved in the next two to three weeks.
● Further restrictive practices were in place which were not fully understood by staff. This is covered in the 'effective' section of the report.

This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager told us they were working towards removing the restriction on fizzy drinks to give the person greater choice and control.
● Staff had received safeguarding training and safeguarding processes were discussed at staff meetings. The training was refreshed every three years.
● A safeguarding flow chart directed managers and staff to initially report any possible safeguarding concerns to the senior management team. This meant there might be a delay in reporting safeguarding incidents to the relevant agencies. This had been recognised by the manager. Team meeting minutes stated;

"When we have a safeguarding concern, we as a home report directly to the local authority and CQC. This cuts down the reporting time and ensures that we are being transparent with all our activities."
● An external healthcare professional commented; "I have seen some recent improvements in reporting and sharing of risks with MDT's and safeguarding."

Using medicines safely
● People did not have access to over the counter medicines or homely remedies for treatment of minor ailments. Staff contacted the GP for all medicines. This meant that people might have had a delay in obtaining medicines that could be bought over the counter.
● Medicine records were not always clear. Although accurate in terms of medicine name, dose and directions, handwritten medicines administration records did not contain all the required information, for example additional warnings about drowsiness or gaps between doses.
● There was a recent audit of medicines systems and processes that identified some areas for improvement.

We recommend the provider ensures that medicines processes meet best practice guidance.

● People were supported by staff who administered, stored and disposed of medicines safely.
● People had been assessed under the Mental Capacity Act 2005 and decisions about medicines were made in their best interests.
● Where possible, people were involved in helping staff to prepare and check their medicines.
● Staff assessed, planned and delivered the support people needed to take their medicines safely.
● The service ensured people's behaviour was not 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. Staff could talk about how people were more alert and engaged following reduction of some of their psychotropic medicines.
● Staff worked with healthcare professionals to review people medicines and to monitor the effects on their health and wellbeing.

Inadequate

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 inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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.

At the last inspection the provider had failed to ensure they were acting lawfully when people were deprived of their liberty. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

- People had restrictions on their liberty. These were not always understood by staff. One person had snacks kept in a cupboard which was kept locked. One member of staff told us this was because the person would eat all the food if they were able to access it. However, a fridge in the same room also contained snacks and this was not locked. Staff confirmed the person did not take food from here without support. The provider had not identified or assessed whether this restrictive act was proportionate to the risk of harm.
- Another member of staff told us the cupboard was locked because otherwise another person living at the service would enter the flat and take the food although both people were supported at all times by at least one member of staff. The disparity in explanations for locking the cupboard showed staff were unsure of the reasons behind the restrictive practice.
- The service was not acting in line with the conditions of the DoLS authorisation which stated food

cupboards were to be locked when the person was alone. When staff were present, they were to be unlocked to enable the person to help themselves to their choice of snacks.
● Another person had a locked cupboard which contained games and stationery. Staff told us this did not need to be kept locked.

This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other people had DoLS in place with conditions attached to them. These were being complied with. A DoLS assessor told us reports were submitted in line with conditions and things had improved since our previous inspection.
● There were systems in place to ensure applications to renew DoLS authorisations were submitted before they were due to expire.

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

● At our last inspection we found the service was not operating in line with the principles of Right Support, Right Care, Right Culture. At this inspection we found this remained the case. There were plans in place to physically separate the buildings, but this had not been completed. There were no specific plans to address the more basic issue of ensuring people were supported to live a life like any other citizen.
● People's needs were assessed, and the information used to develop care plans. The care records were large with a lot of information. Professionals told us they were difficult to navigate. This was particularly concerning due to the high turnover of staff meaning new staff would routinely be required to gain a good understanding of people's assessed needs.
● Some information was incorrect and staff were unaware of it. For example, one care plan stated staff could use heat pads to distract the person when they were sad. Staff did not know what these were.
● One person had a specific health need. There was no corresponding care plan to guide staff on how best to support the person in this area.

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

● The manager had started to redesign the care files and reduce the amount of information in them. An external professional told us a senior member of staff had created an overview of one person's care needs that helped them get a good picture of their needs.

Staff support: induction, training, skills and experience

At the last inspection the provider had failed to ensure records for staff training and supervision were available. This contributed to a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had been made to how training and supervision records were maintained. However, the service remains in breach of Regulation 17. Please see the Well-Led section of the report for details.

● New staff, including agency staff completed a 'fast track' induction before starting work at the service.
● Staff received training relevant to their role, including Autism Awareness and Positive Behavioural Management.

● Staff told us they received regular supervision. One commented, "It's gone from nothing to almost too much!"

Supporting people to eat and drink enough to maintain a balanced diet
At the last inspection the provider had failed to provide people with a healthy diet in line with their personal preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9 in this particular area.

● People were sometimes able to make personal choices about what they ate. Menu boards in The House showed meal plans were specific to individuals.
● Daily records showed people were supported to make choices about what they ate.

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

At the last inspection the provider had failed to adequately maintain the environment. This contributed to a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17 with regard to good governance. Please see the well-led findings below. The provider was also in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some improvements had been made to the internal environment, flooring had been replaced and radiator covers fitted. There remained areas where improvements were required in order to provide a comfortable and sensory environment which met people's physical and emotional needs.
● One kitchen had damaged worktops. These were unsightly and difficult to keep clean. The top to a tap in the bathroom was missing. Staff told us this was removed at times to stop the person potentially flooding the bathroom. They were unable to locate the missing component. This meant the person could not be supported to use the bathroom sink. Alternative solutions, such as a self-closing tap, had not been considered.
● The outside of the service appeared uncared for. Old chairs had been left outside of The Lodge and immediately outside the front door there were three bins and a recycling box.
● On the first day of the inspection there was an old sofa outside The House, staff told us they were waiting for it to be collected and it had been there several days. When the Nominated Individual arrived, they arranged for it to be picked up later that day.
● A fence had been damaged in storms but had not been fully replaced even though maintenance requests had been submitted since February 2022 meaning the garden was not secure for one person. Because of a risk of the person leaving the service without support this meant they were unable to spend time in their garden if and when they wished.

This failure to ensure the premises were secure and well-maintained was a breach of Regulation 15 (Premises) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection visit a relative told us there were plans to improve their family member's kitchen area.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● One person's care plan directed staff to monitor a particular aspect of their health to ensure they consulted with professionals in a timely manner if there were any changes. The monitoring records were not consistently completed.

● People's access to external healthcare professionals had improved since our inspection in October 2021. Records showed people had attended GP appointments and had met with other healthcare professionals.

● Hospital passports were developed for use if people were admitted to hospital. These provided an overview of people's needs.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

At the last inspection the provider had failed to ensure people were supported to make choices about how they lived their lives and developed their independence. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● At the last inspection we found people were not free to live life according to their preferred routines. At this inspection we found the situation had not changed. One person liked to get up early and often indicated they would like to go to the shared lounge. Daily logs showed staff would normally tell them it was 'too early' and the person needed to wait for day staff to arrive on shift. An action plan stated; "Please ensure all service users can use their own apartments and communal areas without restriction." This was not being complied with and did not demonstrate there was always a caring and courteous approach to supporting people.
● On occasion the person was allowed to sit with night staff in the lounge. This showed the approach of staff was not consistent and caused confusion and anxiety for the person.
● Plans to ensure people had access to sensory experiences were not implemented in a timely way. A sensory shed was planned for one person, this had been purchased but not erected. Records showed requests to maintenance had been made regularly since 3 March 2022. This meant the person's need for sensory regulation and support was not addressed in a caring, therapeutic and timely manner.
● Staff did not consistently support people according to their needs and with respect for their communication preferences. We saw one person indicating they wanted a drink. A member of staff told them they needed to wait an hour. The manager told us the person did not have their fluids restricted and would not understand the concept of an hour.

This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw some examples of positive and patient interactions between some staff and people. We observed staff responding to people when they wanted to interact and taking time to check they understood what the person was asking for.
● Relatives told us that, although staff had not always had the time to develop an understanding of people's

needs, they generally found them to be caring. Comments included; "Staff absolutely treat [Name] in a caring way, with kindness", "I know [Person] is happy, [Person] is always happy to go back. It is their home" and "Yes, they are very kind."
● An external professional commented, "Staff responded effectively to [Person's] basic needs and interacted with [Person] in a caring and interested way."

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

At the last inspection systems to capture people's views and experiences were not well established. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● There were no robust systems in place for capturing people's views.
● There was a culture of not attending to people's views or taking them seriously. Daily records for one person described an occasion when they were agitated. The records stated; "[Name] responded with light physical aggression, mainly in the form of hitting surfaces and shouting out, but this has become standard [Name] behaviour."
● People's opportunities to be involved in day to day decisions were sometimes restricted due to low staffing. On the first day of the inspection a member of staff had come into work to do a food shop for people as this had not been completed the day before as planned. They commented; "Ideally we would support every person to do their own shopping, but we don't have the drivers." Staff meeting minutes stated; "We sometimes struggle with drivers to complete weekly food shopping looking forward we are hoping to get a bank card to make it easier to shop on-line for delivery. Between three flats there will be products available to prepare an evening meal." This demonstrated there were times when people's personal choices about their diet would be limited.

Respecting and promoting people's privacy, dignity and independence

At the last inspection people were not consistently treated with respect or supported to develop their independence. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 10.

● At the last inspection we saw one person did not have suitable equipment in place to support their independence. A kitchen was set up in a small cupboard space and was locked when not in use. This was not working so a tabletop oven was available for use. If placed at the front of the table, the person using it had a habit of forcefully pushing it back against the wall when they had completed any task which meant there was a risk of scalding. If it was placed against the wall it was directly under plug sockets. The wall was not porous and there was no splash back. The equipment made available to them did not respect the development or maintenance of the person's independent living skills. No improvements had been made to rectify this. A member of staff told us; "[Name's] kitchen has not changed; we keep asking but nothing is done. It's as frustrating for us as it is for him."
● We found indicators staff did not always respect that St Erme was people's own home. The area

immediately outside The House was littered with discarded cigarette ends.
● Language used by staff was not consistently respectful. One member of staff referred to 'the su' and another described one person as 'kicking off.'

This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant services were not planned or delivered in ways that met people's needs.

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

At the last inspection the provider had failed to ensure people's care was designed in a way which met their preferences and needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● At our previous inspection we identified one person was often incontinent during the night. There was no continence care plan in place to guide staff on how to support the person in this area. This showed an acceptance of the issue with no drive to improve matters and help the person have more comfortable nights. An action plan developed following the inspection stated care plans should be developed for anyone with incontinence and referrals made for support. This was marked as 'complete'. However, there was no care plan in place and the manager confirmed no referral had been made.
● Low staffing numbers impacted on people's choice and control in their day to day lives. Daily records showed people were unable to go out when they wanted. They were not routinely involved in shopping due to the pressure on the staff team to complete the job with limited number of staff who could drive.
● In The House people had not been supported to identify goals. The manager told us they were arranging for a member of staff from The Lodge to work with staff to develop their skills in this area but this had not yet been completed.

This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

At the last inspection the provider had failed to ensure people's care was designed in a way which met their preferences and needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● At the previous inspection we saw some people used Makaton, a simple signing system, to support their communication. Staff had not completed training in the use of Makaton. At this inspection we identified that staff still had not received the training. A relative told us; "Staff know him, but have difficulty communicating leaving him frustrated." One person's daily logs stated; "Having this one on one time with staff who understand his signs seemed to help [Name] relax." This demonstrated the importance of staff knowledge of people's preferred communication systems.
● Communication tools were not being used to support people's understanding. One person's care plan stated they should have a schedule sheet on their bedroom wall so they would be aware of what was planned for the day. This was not in place.

This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

At the last inspection the provider had failed to ensure people's care was designed in a way which met their preferences and needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● People were not supported to regularly take part in activities that they enjoyed. For example, one person's care plan stated they enjoyed swimming and horse riding. The daily logs for April showed they had gone riding once during this period and had not been swimming.
● One person had an activity plan which outlined a variety of activities the person could do over a fortnight. These included bowling, cinema trips, visits to the pub, shopping trips, walks and visits to local attractions. Daily records for April showed they had played football golf once, gone swimming once and been on a bike ride. Apart from these three activities they had been shopping five times and been on four walks. On one occasion they had been for a drive but this appeared to be to accompany staff to pick up another member of staff from a different Spectrum service. On 16 days in April they had not left St Erme grounds. There was a period of seven consecutive days when they had not left the service.
● Relatives told us access to activities inside and outside of the service had been limited. Comments included: "[Name] does not have any interests. It is important to try", "Things have been limited in that sense. [Name] has had occasional trips to the cinema", "[Name's] world is just to sit in his bedroom, he needs to go out more as that is not good for him. It is all too easy to say; 'he refused to go out', staff need to be more proactive" and "There are no in-house activities. The only break out space is a shed that they have shown movies in, not a full service or social life."
● During the inspection we did not see much evidence of people being involved in pastimes while in the service. There was some involvement in preparing food and drinks. Otherwise people were left alone unless they pro-actively sought out staff support. One relative commented; "People seem to be milling around rather than any meaningful activity. There is no creativity."

This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Two people enjoyed working in the large gardens with the support of a gardener who had worked at Spectrum for many years and knew them well. Relatives told us this was important to those individuals.

Improving care quality in response to complaints or concerns

● There were no systems in place to proactively support and encourage people to make suggestions and raise concerns and complaints.

● Although people's behaviour sometimes demonstrated they were unhappy with aspects of their care and support, for example frequently indicating they were ready to start their daily routine before staff were ready, no action had been taken to adapt the service provision accordingly.

● There were no ongoing complaints at the time of the inspection. A complaints policy outlined the timescales in which any complaints would be dealt with.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At the last inspection we identified the provider did not have effective oversight of the service and had failed to ensure people experienced good outcomes. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● We were not assured there was a positive culture within the service which supported people to be independent, have good outcomes and a good quality of life.
● We observed many restrictive practices in use which were over and beyond those covered by people's Deprivation of Liberty Safeguard authorisations (DoLS) which the service had not identified and addressed. For example, drinks were restricted for some people, people's doors, wardrobes and cupboards were locked. During the inspection we heard an alarm continually going off. Staff told us this was used to alert staff when one person went in and out of their room. The alarm was activated so frequently that it was not possible to ascertain if they were entering or leaving their room. Furthermore, it was loud and could have been disruptive to others living at the service. We discussed this with the deputy manager who decided this should be turned off during the day.
● People were not always receiving appropriate care that reflected their choices, needs and considered their preferences. The provider failed to have systems and processes in place to ensure people received their care in a dignified and respectful way. This meant people's care was provided in a way that was not personalised, appropriate and person-centred.
● There was an established culture of low expectations for people. An external professional commented; "Individuals are perceived as doing well if they have less incidents. Risk assessments are based around risk of incidents but do not take into account risks to quality of life or access to the community or loss of skills."

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

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At the last inspection the provider had failed to be open and honest with people's representatives when things went wrong. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had been made and the provider was no longer in breach of Regulation 20.

● The manager had an understanding of the Duty of Candour and was proactively communicating with people's relatives to keep them up to date with their family member's needs.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At the last inspection we identified the provider did not have effective oversight of the service and had failed to ensure people experienced good outcomes. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● There had been a high turnover of managers at the service. The previous registered manager had deregistered on 6 August 2021. The manager in post at the time of the inspection had applied for registration. They were an external consultant and did not live in the area. They worked at the service Monday to Friday. There was no managerial oversight of The House at the weekends. Although staff were able to contact the providers on-call system this required them to be pro-active.
● As part of the inspection process two inspectors visited the service on a Saturday. Although meeting minutes stated there was either a specific member of staff working at The House or a senior person working in The Lodge there was no senior on shift in either house. A member of staff contacted a senior who lived close by and they came to St Erme to support the inspection.
● Staff told us the new manager and deputy manager were effective. One commented; "They are doing a good job; they engage the team well. But they are both interim, they could leave quickly, and we would go into no management again."
● Audits of the service were completed by an external consultant. These looked at medicines, infection control and whole service. We requested copies of the audits. The whole service audit was for a different Spectrum service, although we asked to be sent the correct audit this was not received. This meant we were unable to assess whether the service had been audited and how effective and robust the audit had been. The monitoring system was not fit for purpose and the provider had not identified all shortfalls found at the inspection in order to drive improvements to the overall quality and safety of care delivery.
● An external healthcare professional commented; "The current care home manager has been open and honest and I am mindful that he is trying to make significant changes, however my observations over the last 3 years are that head office micro manage from afar, and I am unsure how effective leadership can be demonstrated if care staff and managers are not facilitated or encouraged to do so, with a "top heavy approach" from Head Office."

This contributed to the breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities)

● The manager and deputy had made visits during the early hours to check staff were supporting people appropriately and monitor the performance of night staff.

● The manager understood their responsibilities to notify the Care Quality Commission about significant events.

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

● There were indications of a closed culture within the organisation. Since the beginning of 2022 until 14 May 2022 there had been ten anonymous concerns raised by staff about the service. Seven of those were concerned with staffing and eight referred to poor management and distrust of the organisation. It was concerning that staff did not feel able to share their concerns with the organisation or share their contact details with the Commission. This meant staff were not supported to speak out in line with good practice.

● A relative also expressed their concerns about voicing their opinions. They commented; "It worries me that they are not well-led from the top. I need to voice that; I don't think that the senior management team are good enough. I know I am potentially rocking the boat and I am reticent to say as I am worried for my relative. It worries me to say it."

● People were not involved in a meaningful way in the development of their care and support and information was not provided in a way which met people's individual communication needs. A poor staff culture created a lack of professional challenge that impacted on people's safety.

● All of this reinforced the closed culture within the service

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

Continuous learning and improving care

● The provider did not instil a learning culture and reflective practice at the service in order to improve care delivery. This meant that poor practice, such as disproportionate restrictions and control, continued to be found. Although an action plan had been developed following our previous inspection, and many areas marked as being complete we found only minimal improvements had been made. These had not impacted on people's opportunities or the quality of their day to day lives. The service still failed to support people in accordance with the Health and Social Care Act 2008.

● Approaches to staff recruitment did not demonstrate a strong focus on quality. The provider had a heavy reliance on agency staff from outside of the local area. They frequently worked 84 hours a week and there was a high turnover. This meant people were not always receiving consistent care from staff who knew them well and were committed to the service.

● An external healthcare professional commented; "Staff who are newer to the organisation often do not have experience with other settings and therefore lack the optimism and ambition for their residents to develop their skills and independence."

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

Working in partnership with others

● External healthcare professionals told us there had been improvements in the willingness of the service to engage with multi-disciplinary working. However, they said there were often delays in receiving requested information.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure the premises were secure and well maintained throughout.