Spectrum (Devon and Cornwall Autistic Community Trust)

Silverdale

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Silverdale is a residential care home providing personal care for up to four people with learning disabilities. At the time of our inspection the service was supporting one person. The service is a detached two-story property with a front garden. It is located in Redruth, Cornwall within walking distance of shops and other local facilities.

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

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

Right Support
The design and culture of the service did not maximise the person's choice, control and independence. Staff were planning to support the person to change the furnishings in their flat, to better reflect their tastes; but had not been able to because they could not access their own bank account.
The care model did not always focus on the person's strengths or identify clear paths to achieving their aspirations and goals. The person's control over their own lives was limited which meant they did not consistently have a fulfilling and meaningful everyday life. The person's capacity had not always been assessed before staff made a decision on their behalf.

Staff had not all received the right training to help ensure restrictive practices were only used by staff if there was no alternative. Plans to guide staff on how to support the person who experienced periods of distress were not all up to date.

Safety checks of the service had not all been completed as required.

Staff were supporting the person to reduce the number of medicines they took.

The person was supported to join discussions about their support in a way that limited their anxiety.

Right care
Significant risks to the person had not been assessed and therefore control measures to protect them from abuse and poor care were not all in place.

The person was doing more than at the previous inspection, but this was still affected by limited access to their finances and staffing. The service did not have enough appropriately skilled staff to meet their needs. The person did not always receive support that met their needs and aspirations, focused on their quality of life and followed best practice.

The person was able to communicate with staff and understand information given to them.

Right culture
The ethos and values in the service did not always meet best practice. This meant the person did not always experience an inclusive and empowered life. Staff did not always have a good understanding of best practice models of care. The service was based on restrictions and a punitive approach to the person's behaviour.

There was not enough management time or support by the provider to enable real development or improvement in the service. The provider had failed to minimise the risk of a closed culture forming at the service.

The culture created in the service meant the person was not always treated as an equal. The staff team had not been designed in a way that met the person's preferences.

Various professionals were involved in monitoring the person's care.

The person was not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not effectively support staff to maximise the person's choice and control.

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 requires improvement overall (published 20 August 2021), but was rated inadequate in well led. As a result, we required the provider to report to us on a monthly basis on staffing levels, details of any gaps in staff training and experience, and the number of hours the manager was unable to complete management tasks because they were required to support the person living in the service. We also required them to detail how they had assessed their staffing capacity for the following month. We received these reports on a monthly basis.

At this inspection we found the provider remained in breach of regulations. This is the third time the service will have been rated below 'good'.

At our last inspection we recommended the provider sought advice from a reputable source on how to support staff and ensure they understand and follow agreed guidelines. At this inspection we found some guidelines were out of date; however, staff understood and were following up to date, agreed ways of working.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the 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.

We have found evidence that the provider needs to make improvements.

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 breaches in relation to person-centred care, the safety of the service provided, safeguarding the person from abuse, and the recruitment processes. We also identified a breach relating to the requirement on the provider to notify us of certain events. We identified continued breaches in relation to the governance of the service and staffing.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'.

We began the process of preventing the provider from operating this service. However, before the provider's representations against our proposal had been reviewed, the provider took the decision to transfer the service to another provider.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Silverdale

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
Two inspectors carried out the inspection.

Service and service type
Silverdale is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Silverdale is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
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 not a registered manager in post. A manager who was registered to manage a different service run by the same provider was overseeing the service.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During the site visit we viewed a range of records including the person's medicines and health records, as well as health and safety checks completed on the service. We spoke with the manager overseeing the service and the acting deputy manager. We spoke to the person living in the service, but they were unable to share their views with us, so we observed how staff interacted with them.

Following the site visit, we continued to request and review records. These included the person's care plan and information about how they spent their time, as well as recruitment records and risk assessments. We spoke with the person's relative and three professionals who worked with the person and the service. We also spoke with two staff members. We wrote two letters to the provider requesting they provide us with the person's records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- The person was not protected from improper care or an overly restrictive environment. They had several restrictions placed on them but there was no clearly planned way to review or reduce these in line with good practice. A record was in place to review restrictive practices, but it was not up to date. Some restrictions in place were not listed in the record, and others that were no longer applicable were still listed.
- The record had not been used for the provider's intended purpose to prompt a review of the restrictions on the person to help ensure these were the least restrictive. Staff felt some of the restrictions the person faced were no longer needed but a column entitled, 'action taken to reduce or remove restrictions' was blank for all of the restrictions listed.
- The record had not been used to identify other restrictions that could have been reviewed to find a less restrictive option. Staff discussed a person's locked wardrobe with us. This did not appear to be the least restrictive option available for the reason given, but this had not been identified or reviewed by the provider. The acting deputy manager told us the person now asked staff to lock their wardrobe at certain times of day. This indicated the person had become institutionalised and used to a restrictive environment.
- Due to an ongoing, but inactive health condition, the person's access to the communal kitchen had been restricted. This created a restrictive environment that was not adequately recorded or reviewed to ensure it was the least restrictive option on the person's movements.
- The person's records, including their care plan still reflected the higher level of restriction, which included physical restraint, which staff said was no longer used. This meant staff reading these records could understand that physical restraint was an option in certain circumstances rather than use less restrictive options. This was of particular concern because the provider relied heavily on agency staff to support people; one of whom had not had training in how to physically restrain people safely.
- The provider was responsible for the person's finances. They had mismanaged this responsibility and therefore had not protected the person from the risk of financial abuse. Staff who had been signatories to support the person to withdraw their money from the bank had left and no longer worked for the provider. This meant the person could not access their money. As a result, for nearly a year, they had needed to borrow money from the provider instead. This had put them in debt to the provider. The provider had not taken sufficient action to ensure this was resolved promptly for the person so they could access their own monies.
- We requested evidence from the provider showing the trail of the person's money from when it was paid by the Department of Work and Pensions (DWP), to when it was paid into the person's personal account to assess whether the person's account was credited with the full amounts. We were not provided with all the information we requested. The information shared raised concerns about the safety and adequacy of the provider's system in ensuring the person got the correct amount at the intervals it was paid by the DWP.
- The person had a vehicle available at the service to use. We requested information about how this vehicle

was paid for but this was not provided. The provider shared the costs involved in the vehicle. These showed amounts for leasing the vehicle and for a tracking device used by the provider. No further information was supplied about who met these charges or who they were paid to. The information shared showed there was a charge for a vehicle that was not the vehicle available to them at the service.

● It was difficult to identify whether the person's money had been managed safely in the service. At times, the person had been supported to borrow money from staff's personal money or from the service's food allowance. Staff had not recorded these transactions clearly, which made accounting for where and how the person's money had been spent, difficult.

● Staff were responsible for supporting the person to manage their money in the service. They had been charging the person for two staff member's bus fares when they went out but were not sure if this was the correct procedure.

● We requested evidence from the provider showing safe oversight and management of the person's money. The provider did not supply all of the information requested.

● Due to a change in the national benefit system, part of the person's benefits had stopped being paid in October 2019 to be replaced with a new benefit. The provider had not taken sufficient action to ensure the person received this benefit.

● Staff had completed training in safeguarding; however, an allegation of abuse raised by the person had not been reported to CQC or the local safeguarding authority as required.

We shared these concerns with the local safeguarding authority.

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

● Following the inspection, the manager overseeing the service told us they had discussed with an external professional how they could start reducing some of the restrictions. The professional confirmed this was the case.

● Following the inspection the responsibility for managing people's finances was transferred to the local authority.

Assessing risk, safety monitoring and management

At our last inspection we found the provider had failed to ensure staff were adequately trained and skilled to keep people safe. This formed part of an ongoing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the service was still in breach of the regulation.

● Two staff members had not completed all training required by the provider, to understand how to support the person if they used their behaviour as a form of communication. One of these staff members worked alone as the only member of staff awake through the night and the other staff member worked long hours at the service most weeks, which increased the need for them to be competent in using the correct approaches. The lack of training meant the provider had not protected the person from the risk of improper use of restraint if it was needed, or ensured staff were adequately trained in person centred approaches that focused on the least restrictive options. The manager overseeing the service told us the staff member was not trained because of the pandemic. They told us they had requested these staff receive the training as soon as possible.

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

● Risks had not always been assessed adequately. The service was not designed to have staff living on site, nor was it usual practice. However, three staff members who worked for the provider were living in the service. Two of them worked at the service but one did not. They had access to communal areas of the house as well as access to the area of the service where the person's private flat was.
● The impact this might have on, or the potential risks this created for the person living at the service, had not been assessed adequately. A risk assessment had been completed but it did not assess the impact on the person's wellbeing and the significant risk of a closed culture developing. It did not include detail of how the provider had assured themselves the three staff were safe to live with a vulnerable adult.
● Two staff members were providing the majority of support hours to the person. This meant they were working an unsafe number of hours. A risk assessment that was regularly reviewed, stated they would work a maximum of 84 hours a week with one full day off per week (that is no day, sleeping or waking night shift); however both staff members had exceeded this amount in March and April 2022.
● One staff member had worked 22 out of 24 days between the 28 March and 20 April 2022. This was mostly 14 hour shifts during the day but also included 'sleep in' shifts and shifts when they were required to be awake all night.
● The second staff member also regularly worked more than 6 days in a row without a full day off. Between the 17 March and 14 April 2022, they worked 28 days with only one full day off. Working these excessive hours with limited opportunities for rest exposed both the staff member and the person they supported to significant risk of harm.
● The risk assessment noted a risk to the agency workers of working long hours and having no break from the service, but did not assess the risk to the person of being supported by staff who worked long hours and didn't have a regular opportunity to have a break from the service.
● The staff members were employed at the service via a staffing agency. They were working for the provider long term, living in the service and completing long hours each week; however, the provider had not taken all steps to assure themselves the staff were safe to work and live with vulnerable adults.
● Checks to ensure the service met relevant health and safety standards had not been completed consistently, or prompt action taken when faults occurred. Regular testing of the fire alarm had been raised as a concern in 2018. Some improvements had been made but a check of records in October 2021 showed it was still not being tested frequently enough. An audit in February 2022 also highlighted that alarm tests were not regularly carried out and documented. At the inspection the frequency had increased but this was still not in line with the provider's policy.
● A record showing testing of emergency lighting in the service showed the emergency light in the dining room wasn't working on 16 October 2021. An entry on 16 November 2021 reported, 'a few' lights weren't working. The record did not show all lights working consistently until 4 February 2022. This demonstrated that environmental risks were not addressed in a timely fashion to keep people safe.
● Action had not been taken when water temperatures fell outside the limits stated in the provider's guidance on the relevant record. This showed the provider was not ensuring staff were acting promptly to protect people from the risk of harm.

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

● A personalised emergency evacuation plan (PEEP), was in place to guide staff on how to support the person to leave the service in an emergency.

Staffing and recruitment
At our last inspection we found an ongoing breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, due to the service being short staffed.

● At this inspection we found the service was still understaffed. The person's commissioned number of support hours were met in the unsafe manner described above. Further, the provider had not deployed sufficient staff to meet the person's preferences. Staff had identified the person benefited from being supported by a range of staff, rather than seeing the same staff all the time. Due to staff shortages, the staff rota could not be designed to suit these preferences
● The service was short of two full time and two part time staff, so the majority of shifts were filled by the same two staff members. The manager overseeing the service used staff from other services when gaps in the rota needed to be filled to help meet this preference. However, overall the rota showed that the person's preference for variety was not taken seriously or plans put in place to help ensure it was consistently met.
● The person had their own vehicle to use but there was a lack of staff who were able to drive it. A staff member and a professional described this as a shortfall at the service. The person enjoyed travelling by public transport, but the lack of drivers meant that when the person wanted or needed to use their vehicle, this was not always possible.

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

● Approaches to staff recruitment did not demonstrate a strong focus on quality. The recruitment information that was supplied showed that some checks had been completed after one staff member started working at the service.
● The provider had relied on a staffing agency to complete recruitment checks for some staff. The employment agency had not sought a full employment history, as required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not queried or acted on this omission.
● A staff member who lived at the location but worked at another of the provider's services had a DBS check that did not show the same place of birth as their passport and was not completed by the staffing agency. The provider had not queried or acted upon this concern either.

This is a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection the provider shared a new DBS check for the staff member concerned. They told us they had spoken with the agency about seeking a full employment history for staff.

Learning lessons when things go wrong
● The manager overseeing the service and the acting deputy took action where possible to improve aspects of the service when things went wrong. However, the lack of management time in the service meant it was difficult for them to ensure they were identifying all areas where things had gone wrong. They also had limited time to check lessons had been learned and improvements implemented effectively.

Preventing and controlling infection
● Records showed that deep cleaning tasks had not been completed as frequently as allocated. Some weekly tasks had not been recorded as completed since March 2022. The manager overseeing the service was aware of this. They and the acting deputy manager were putting steps in place to ensure this was rectified.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● Staff supported the person to maintain important relationships. There were procedures in place to enable safe visiting in line with current government guidance.

Using medicines safely
● Staff and the manager overseeing the service understood the risks and impact on people of taking a high number of medicines. They had engaged the multidisciplinary team to support them and the person, to reduce the number of medicines the person took.
● The person took some medicines, 'as required' and there was clear guidance in place about when staff should offer the person these medicines.
● Medicines were counted on a daily basis and then checked each month to help ensure any administration errors were identified. Small discrepancies had been identified in the last four months, so this had been discussed with staff at a recent team meeting.
● Staff had completed medicines training and assessments of their competency to administer medicines had been completed.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

We did not rate this question at our last inspection. At the previous inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- Strategies used to support the person to feel or remain calm did not reflect best practice. The person had a reward chart in place. Guidance stated, if [person] 'behaved' well all week, [they] would get a reward. It also explained, "If [person] gets 3 crosses in the week they don't get a good [person] reward, which is usually on a Saturday." This was a punitive approach which is not in line with best practice. Staff and professionals told us they thought the person benefited from the approach, but it had not been reviewed to establish whether this was still the best option for them.

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

- The person's care plan contained relevant assessments, such as communication, behaviour and sensory assessments.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support

- The person was at risk of weight loss but also of high cholesterol, there was no guidance for staff about how to ensure the person's diet helped reduce both these risks. Following a GP visit in 2019, staff had been asked to monitor the amount of fatty foods the person ate. Staff recorded what the person ate but there was no evidence of monitoring the food's nutritional value.

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

- Staff told us the person was supported to choose the meals they wanted each week and then to buy all the items they needed from the supermarket. However, there was no information about their food or meal preferences in their care plan.
- Staff told us the person ate a balanced diet and staff encouraged them to eat fresh fruit and vegetables. They also understood how to minimise the person's risk of choking.
- The person had a hospital passport to help ensure that if they were admitted to hospital, hospital staff would be able to support them in the way they needed.
- The person's relative said they thought the staff supported the person to stay healthy.

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

● Staff told us they thought the environment was suitable for the person but needed updating. One staff member told us, "[Person] needs new things in there. They could do with making it brighter and more homely, it's a bit dowdy." Due to ongoing problems accessing the person's money, no further action had been taken to improve the environment.

● The person had a shed in the garden which they used to relax in. They had decorated it according to their tastes.

Staff support: induction, training, skills and experience

● The provider had not ensured staff had completed all relevant training. Only one staff member had completed training in person centred care and equality and diversity. This contributed to the poor culture of the service.

● Staff from a nearby service supported the person at times, there was no evidence they had been inducted into the service or the person's needs. We were told agency staff had completed shadow shifts with the person when they first started but there was no record of these either. Following the inspection, the manager overseeing the service told us they would ensure these records were in place in the future.

● The acting deputy manager told us they were providing staff with a specific policy each week which they then discussed to help ensure understanding. They had also started providing staff with regular one to one supervision sessions.

● Team meetings had been used to update and increase staff's knowledge of all aspects of care including the person's needs and staff responsibilities. A staff member told us, "If there's anything we're not happy with we can all discuss it and we keep up to date with anything new, or changes."

● One staff member who had worked at the service temporarily, told us they had been impressed with how much the team achieved considering the small number of staff currently in it.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The person's capacity to make some decisions had been assessed, but not others.

● A DoLS authorisation had been appropriately applied for and authorised due to the restrictions placed on the person's life to keep them safe. The authorisation required the service to send regular reports about how the person had spent their time. This had been complied with.

● Staff had identified that restraints were not all now used with the person; so they intended to request they be removed at an upcoming review of the person's DoLS.

● The person was unable to understand and consent to the content of their care plan. A best interests decision had been made in conjunction with people who knew the person well, that involving them in reviews of their care would create undue stress.

Staff working with other agencies to provide consistent, effective, timely care

● The person's care and support was regularly reviewed by several professionals. They told us the service shared relevant information and kept them up to date with any changes to the person'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.

We did not rate this question at our last inspection. At the previous inspection we rated this key question good. At this inspection the rating has changed to requires improvement: 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

- Language used in the person's records was not always appropriate for the person's age. For example, one record described how to react if the person was 'naughty' or 'good.' Staff often described the person as having been 'good' or 'well behaved' in their records.
- In addition, they did not describe activities in a way that suggested the person was an equal but instead suggested an imbalance of power in favour of staff and the service. For example, daily records included, "[Person] asked staff for a cigarette and was taken to his shade [outside]" and "[Staff] walked [person] to Darren's Chippy". The manager overseeing the service told us they would review language used by staff in a staff meeting.
- The person's relative and a professional reported that staff had a good rapport with the person.
- The person's records provided insight into their sensory perception and processing. They provided guidance on how to ensure the person was protected from exposure to environmental factors they could find stressful. Staff understood these and considered them when planning the person's day with them.

Respecting and promoting people's privacy, dignity and independence

- Staff encouraged the person to be involved in household tasks, which helped maintain their independence; however, there was no clear aim or guidance for staff to follow to increase the person's skills or independence. This meant it was difficult for them to increase their skills and independence.
- A staff member who did not work at the service was living there. They had access to the same communal areas as the person. They had worked with the person before and so understood their needs; however, due to their proximity to the person, it was possible they could become aware of changes to the person's needs or preferences. This had not been assessed as a risk to the person's privacy or confidential information.
- Staff understood the need for the person to spend time alone sometimes; they respected this whilst still ensuring the person's safety.

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

- The person was not always able to communicate how they were feeling. Information was available that described how to identify if the person could be in pain.
- Information was also available for staff to understand how to recognise different moods the person might be feeling.
- The person was supported to attend a regular meeting with external professionals to discuss the support they received.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement: This meant people's needs were not always met.

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

At our last inspection we recommended the provider sought advice from a reputable source on how to support staff and ensure they understand and follow agreed guidelines. At this inspection we found some guidelines were out of date; however, staff were aware of and following up to date, agreed ways of working.

● The provider's approach to staffing had not enabled the service to operate in a way that met the person's preferences. Staff had identified the person benefitted from being supported by a variety of staff. They had found creative ways to provide this at times and improve the person's wellbeing, but were unable to consistently provide variety.
● Due to a lack of management and provider oversight, records about the person's needs and wishes had not all been kept up to date.
● The person's care plan did not reflect best practice. It was not strengths-based and there was little information about the person's future goals and aspirations, or evidence of skills teaching.

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

● Professionals reported they were happy with the support the person received. A staff member told us, "We're upbeat and happy, we give choices, let [person] lead the way and go at their own pace."

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 our last inspection we found the provider had failed to ensure enough staff were available to enable people to engage with activities and access the community. This was part of a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found some improvements but failings by the provider were still impacting on the person's quality of life.

● Staffing impacted on the how the person spent their time. A record describing what options the person should be given each day stated, 'If [person] goes out for the day he is given a choice of two places, depending on drivers, money and handover times etc.'
● What the person could do and how they could spend their time had been limited as staff could not access

the person's bank account on their behalf. Instead, they were borrowing money from the provider. They had been supported by staff to create a list of things they would like to do but staff had not been given clear guidance about the person's income and therefore how much they could spend. As a result, the person was not given enough money as staff limited their access because they were cautious about getting the person into debt. Therefore, the provider had not supported them to meet all their wishes for how they spent their time.

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

● The person's relative and professionals reported that the person went out regularly and did things they enjoyed.
● The person went to visit their relative on a weekly basis and enjoyed these visits.
● Guidance was available for staff which detailed the person's preferred routines and how they liked to spend their time.
● There was a plan in place for the week which included things the person liked to do. Staff were planning to introduce a new communication board to make it easier for the person to show what they wanted to do each day but this was not in place at the time of inspection.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Guidance was available to guide staff on how to present choices to the person and how to help them understand options.
● Guidance was available describing the best way to give the person different types of information, this included pictures and social stories.

Improving care quality in response to complaints or concerns
● There was a procedure in place to deal with any complaints.

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 our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Failings by the provider meant the design and culture of the service did not meet best practice and was not consistently achieving good outcomes for the person.
- The provider had failed to ensure the person had ongoing access to their money. This had impacted on how they could spend their time and their ability to achieve their wishes.
- The provider had not acted as a strong advocate for the person to ensure they were receiving the benefits they were entitled to.
- The way staff spoke about and treated the person demonstrated an infantilising culture within the service. For example, when the person had not become anxious during the day, staff gave them 'good [person] ticks'. Staff reported the person would then get "A weekly treat. Maybe to go in the bigger garden and play with the things out there; or have a movie day and treats." This did not show they were treating the person as an adult.

These failings contributed to a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

At our last inspection, we found the provider's systems and processes for ensuring compliance with the regulations were ineffective and action plans developed in response to previous breaches had proven inadequate to provide adequate staffing at Silverdale. This was a breach of regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the same concerns.

- There was limited evidence of the provider's motivation to continually drive improvement at Silverdale. Despite the last inspection report raising concerns in August 2022, no provider level audit was completed of the service until February 2022. This was a basic audit and had not produced a detailed action plan to help guide the manager overseeing the service about how to improve care delivery.
- Our last report stated the service and the provider exhibited many of the risk factors and warning signs associated with closed cultures. Risk factors included people's high level of dependence, their complete reliance on staff for their basic needs and access to the community. The warning signs included but were not limited to, staff working excessively long hours, consistent staff shortages and the lack of effective

oversight by the provider. At this inspection we found the provider had failed to take the concerns seriously or reduce the risk to the person.

● The service was still short staffed and was relying on two staff to fill most of the hours on the rota. At times these staff had worked 98 hours per week and completed sleep in shifts in addition. This left the person at high risk of being impacted negatively by a closed culture within the service. The manager overseeing the service was aware of this risk and had recorded that further recruitment was needed; however the provider had not assessed the risk or taken action to mitigate it.

● A professional raised concerns that problems with staff not being able to support the person to access their bank account had happened before. This showed insufficient learning and safeguards had been put in place to stop it happening again.

● Areas of the service where the manager overseeing the service and the acting deputy manager had tried to implement improvements, had not always been sustained as they did not have the capacity to complete regular checks. For example, they had requested staff improve completion of a daily staff communication and handover book. However, it had only been completed on two mornings in the first five days of May 2022.

● The commission has completed a programme of inspections of all Spectrum services, including Silverdale, since May 2021. At the majority of these inspections we identified staffing and oversight concerns.

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

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

● The provider had not ensured there was adequate leadership or oversight of the service. Professionals raised concerns about the inconsistency in leadership at the service. They told us there had been frequent changes which meant that agreed tasks had not always been followed through. They reported that the consistency of the staff team and management at the service was better but that they did not have confidence it had been completely rectified or would be maintained in the long term.

● The manager who was overseeing the service was also the registered manager of another service, and due to short staffing was sometimes required to work on shift, at Silverdale or at the service where they were registered, this included sleep in shifts and waking nights. This meant their time operating as a manager at Silverdale was limited. Professionals told us they thought the manager overseeing the service was stressed and overwhelmed by this workload.

● The acting deputy had just stepped into the role and was keen to make changes but had little experience of management roles and responsibilities. They were learning the role from the manager overseeing the service. However, they also spent time on shift, so their time together was limited. A staff member told us they thought the acting deputy manager needed more support.

● The provider's processes and procedures had not ensured the required improvements at the service were identified or acted on. The manager overseeing the service had not received sufficient support from the provider to ensure the service improved. They had received no action plan and no regular meetings to discuss the improvements required.

●The manager overseeing the service and the acting deputy manager were aware of some of the areas of the service needing action but had not had the time or support to make improvements. As a result, several records relating to the person and the service were out of date. Records did not always reflect the person's current needs and relevant monitoring and checks of the service had not all been consistently completed.

● An effective system had not been established to prevent abuse. The lack of management time in the service meant important tasks, like reporting allegations of abuse, had been overlooked.

● The provider had not taken adequate action to ensure the person was safeguarded from the risk of

financial abuse. They were responsible for the management and oversight of the person's finances but had not taken sufficient action to ensure the person had ongoing access to the correct benefits, or their bank account. They had not taken prompt action to reinstate the person's access to these when problems arose.
●The provider had not understood or fulfilled their responsibilities to ensure staff who worked and lived in the service, were safe to do so.

This is a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
● The service had not raised a safeguarding alert to the local authority safeguarding team or notified the CQC that the person was at risk of financial abuse and/or mismanagement.
● They had not raised a safeguarding alert following an allegation the person made against a staff member.

The failure to submit necessary notification to the commission is a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009

Working in partnership with others; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● We requested information from the provider to assure us of the safety of their systems around managing the person's finances. These were not all provided.
● There was no evidence that staff or the provider had helped the person understand the difficulties accessing their money and benefits; or the impact that it was having on their financial status.

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

● The senior staff at the service worked with external professionals to regularly discuss and review the care and support the person received.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff attended regular team meetings. The acting deputy manager had supported the person to attend part of a meeting so they could share their views and wishes with staff. A staff member told us the person had attended the staff team meeting recently and discussed some of their future plans with the staff team.
● One staff member told us they had made a suggestion to improve the service and this had been implemented promptly.
● Staff told us they enjoyed working at the service. Comments included, "It's going well. It's nice going into work. The house is looking better, [person] is happier, [the acting deputy manager] is doing a good job and it's a good team. We work well together."

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not ensured we were notified about risk or allegations of abuse.

The enforcement action we took:

We proposed to cancel the service but the provider decided to cancel their registration before their representations against the proposal were reviewed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured all aspects of the service operated in a way that enabled the person to have full choice and control over their life.

The enforcement action we took:

We proposed to cancel the service but the provider decided to cancel their registration before their representations against the proposal were reviewed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured all risks to the person were adequately assessed and mitigated.

The enforcement action we took:

We proposed to cancel the service but the provider decided to cancel their registration before their representations against the proposal were reviewed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not protected the person from abuse.

The enforcement action we took:

We proposed to cancel the service but the provider decided to cancel their registration before their representations against the proposal were reviewed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems and processes had not worked effectively to ensure the person received a good quality service.

The enforcement action we took:

We proposed to cancel the service but the provider decided to cancel their registration before their representations against the proposal were reviewed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provide had not assured themselves that staff working at the service were safe to work with vulnerable adults.

The enforcement action we took:

We proposed to cancel the service but the provider decided to cancel their registration before their representations against the proposal were reviewed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured the service had sufficient staff with the correct knowledge and skills.

The enforcement action we took:

We proposed to cancel the service but the provider decided to cancel their registration before their representations against the proposal were reviewed.