Silvermead Plymouth Ltd

Silvermead Residential Home

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Silvermead Residential Home, hereafter referred to as Silvermead, is a residential care home that provides personal care and support for up to 13 people with a learning disability, autism or who have complex needs associated with their mental health. At the time of the inspection there were 13 people living at the service.

People's experience of using this service and what we found
People who were able to share their views with us told us they were happy living at Silvermead. We found the service was not operating in accordance with the regulations and best practice guidance. The providers oversight and governance of the service was ineffective in identifying the serious failings in relation to the safety, quality and standard of the service as detailed in the safe and effective sections of this report.
Given the level of concerns identified at this inspection. We requested an urgent action plan from the provider to tell us what immediate action they have taken or proposed to take to address the concerns identified at this inspection to ensure people received safe, effective, high quality care and support. We have also shared the information with Plymouth City Council.

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. This meant we could not be assured that people who used the service were able to live as full a life as possible and achieve the best possible outcomes.

People were not always protected from the risk of avoidable harm. We found where some risks had been identified, sufficient action had not always been taken to mitigate those risks and keep people safe. Key pieces of information relating to people's care and support were not always being recorded, followed up or accessible.

Medicines were not being managed safely.

There were insufficient numbers of suitable qualified, competent, skilled or experienced staff on duty to meet people's needs safely.

People were not always protected from the risk and spread of infection. We were not assured that Infection Prevention and Control (IPC) practice was safe and the service was compliant with IPC measures.

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 (published 22 September 2020). In February 2021 the provider wrote to the Care Quality Commission to request an inspection. They were confident that all the concerns identified by the inspection undertaken in 2019 had been fully addressed and were concerned about the impact this rating was having on their business. An inspection was carried out in March 2021, the draft report has been issued to the provider as per our process and will be published shortly.

Why we inspected
The inspection was prompted by concerns we received about risks associated with nutrition and hydration, staff recruitment, induction, training and staffing levels. A decision was made for us to undertake a targeted inspection to examine those risks.

CQC have introduced targeted inspections to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in regulation in relation to safe care and treatment, staffing and governance. Please see the action we have told the provider to take at the end of this report.
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
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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, 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.

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question, we had specific concerns about.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Silvermead Residential Home

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check whether the provider was meeting the legal requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to specific concerns we had about the management of risks associated with nutrition and hydration, staff recruitment, induction, training and staffing levels.

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
This inspection was undertaken by one inspector.

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

The service did not have a manager registered with the Care Quality Commission at the time of the inspection. A manager had been appointed by the provider to oversee the running of the service and had made an application to register.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered provider, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed the information we held about the service, including information we had received about the service since the last inspection, information related to the specific concerns raised with the Commission and attended a multi-professional safeguarding strategy meeting.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spent time with people living at the service, we spoke with two members of staff, the manager and the provider. To help us assess and understand how people's care needs were being met we reviewed three people's care records. We also reviewed a number of records relating to the running of the service. These included staff recruitment, induction and training records.

After the inspection
We continued to seek clarification from the service to validate evidence found. We spoke with the provider and shared information with Plymouth City Council.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

Assessing risk, safety monitoring and management

At our last inspection we found the provider was failing to ensure they were doing all that was reasonably practicable to manage and mitigate risks. This was a continued breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made or sustained and the provider was still in breach of regulation 12.

• People continued to be exposed to the risk of harm associated with their complex care needs and / or their environment. At our last inspection in March 2021, we found one person had been assessed at high risk of choking as they did not understand what foods were safe for them to eat and would consume anything. In order to mitigate this risk a lock was fitted to the larder door to prevent unsupervised access to this area. During that inspection we found this door was open and staff were not around on more than one occasion. We brought this to the attention of the management team who took immediate action and locked the door. At this inspection we found this door was again open and staff were not around.
• People and staff were placed at risk of avoidable harm as they did not have all the information they needed to meet people's needs safely. One person had been admitted to the service approximately six weeks prior to our inspection. Staff were unable to tell us why this person had been admitted, what their care needs were or how they were being met. A recent referral made by the manager to the local authority reported this person was drinking alcohol to excess, refusing medication, being aggressive to staff, scaring other residents and expressing suicidal thought. Staff said they had not been provided with any guidance on how to manage this person's complex mental and physical health needs, should a further incident occur. One staff member said, "We were just told to call the police should this person start again". This person did not have a pre-admission assessment, care plan or any assessment of risks associated with providing care and support. This potentially placed this person, staff and others at an increased risk of avoidable harm.
• At our previous inspection we identified concerns with the management of one person's epilepsy. Following that inspection advice was provided by health and social care professionals and a visual/audio 'monitor' was purchased for the use in the safe management of this person's epilepsy. The manager told us this should always be held by a staff member and constantly monitored. When we arrived at the service, we found the monitor had been placed in a cupboard in the kitchen. Staff told us they had not been provided with any guidance in the use of this equipment. One said, "I know we need to keep it on to monitor […] seizures. I would have a look about every 30 minutes." Throughout the inspection we heard this device making a noise, we were told this was because it was out of range.
• Another person had recently been discharged from hospital for end-of-life care. Staff we spoke with were not confident in how to manage this person's end-of-life care needs. For example, in relation to pain management or what action they needed to take if the person's health declined or they passed away. One

staff member said, "I would call 999," the other said, "I would wash and dress them, cover with a sheet and call the district nurse." Both members of staff said no information had been provided to them if the person passed away while they were on duty. They told us when they asked, they were advised not to call the on call as there was nothing, they would be able to do. We found end of life care records for this person had not been updated following their discharge from hospital. The manager told us they had not had time to document information and guidance provided from the hospice or district nurse team in relation to this person's care.

The provider had failed to ensure all risks to the safety of people receiving care and treatment were appropriately assessed, mitigated or effectively managed. This placed people and staff at increased risk of avoidable harm. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Using medicines safely

At our previous inspection we recommended the provider sought guidance from a reputable source and reviews medicine practices to ensure the service is compliant with best practice guidance. At this inspection we found people's medicines were not being managed safely. This placed people at an increased risk of harm.

• Records showed that one of the people living at the service had been prescribed rescue medicines to be used in the management of their epilepsy in an emergency. When we arrived at the service staff did not have access to these medicines as they were locked in the office and they did not have a key.
• Medicines due to be returned to the pharmacy for safe disposal were not stored securely. For example, these medicines were stored in a place which could be accessed by all staff.

The failure to manage people's medicines safely is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection we found the provider had failed to ensure that risks relating to infection control and the transmission of Covid 19 were being effectively managed. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made or sustained and the provider was still in breach of regulation 12.

• People were not always protected from the risk of and spread of infection.
• We were not assured that the provider was doing everything possible to prevent visitors from catching and spreading infections. Staff did not always ensure visitors were given clear instructions in relation to the services' infection control procedures or challenge poor practice.
• Visitors were not always prompted/directed to wash their hands, use hand gel or wear an appropriate fluid repellent surgical mask known as Type IIR as set out in Public Health England's, 'How to work safely in care homes guidance'. There was no screening of visitors for symptoms of acute respiratory infection. For example, on the day of the inspection we observed a visitor walk straight into the service wearing only a cotton face covering. This was not challenged by the manager or staff until we asked.
• Staff were not always using PPE effectively and safely. For example, throughout the inspection we saw staff supporting two people who were within their period of isolation. Staff were not wearing full PPE in accordance with Public Health England's current Covid 19 guidelines (Covid 19: How to work safely in care

homes). Staff we spoke with were not aware that they should be wearing full PPE.
• We were not assured that the provider was promoting safety in relation to hygiene practices. The service appeared clean, however, we did not observe staff carrying out enhanced cleaning of frequently touched surfaces, such as handles, remote controls and kitchen appliances. This included the sanitising of areas and objects used by one person, who was within their isolation period. Staff were aware of the need to carry out enhanced cleaning to reduce the risk and spread of infection but told us they didn't have time due to staffing levels.
• At our previous inspections in December 2020 and March 2021 we were not fully assured the provider was meeting shielding and social distancing rules. Following these inspections, we were told changes had been made and there were now two meal sittings and whilst it was difficult to maintain social distancing in the lounge. The lounge was less likely to have enough residents in it at any one time to need this. At this inspection it was not evident from our observations or conversations that staff were supporting or encouraging people to socially distance in line with Public Health England's current Covid 19 guidelines (Covid 19: How to work safely in care homes). For example, throughout the inspection we saw people living at the service freely sitting next to each other, this included one of the people who should have been in isolation. We did not observe or hear staff support or encourage people to socially distance. When we asked staff how they supported people at mealtimes. Staff told us, "We're supposed to have two sittings at mealtimes, but we don't, everyone has their meals together. I'm only doing it today because you're here [meaning inspector] we don't have the time or staff to have two meal sittings."

The provider had failed to ensure that risks relating to infection control and the transmission of Covid 19 were being effectively managed and this placed people at an increased risk of harm. This was a continued 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 accessing testing for people using the service and staff.

We have also signposted the provider to resources to develop their approach in relation to social distancing, testing, the use of PPE and admitting people safely.

Staffing

At our last inspection we found the provider had failed to provide/deploy sufficient numbers of staff to meet people's care and treatment needs safely. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made and the provider was still in breach of regulation 18.

• Staffing arrangements within the service during the day and at night were not sufficient to meet people's needs safely.
• When we arrived at the service, we observed a member of staff returning from the local shop accompanied by one of the people living at the service. This meant one member of staff had been left to provide care and support to 12 people with a variety of complex care needs. When we asked what they would do if there was an emergency, staff said they would call the staff member on the phone and ask them to come back or ring 111.
• We found staffing levels were not always planned or deployed in a way that met people's specific health care needs. For example, one person's care plan identified that this person would need to be repositioned with the use of a slide sheet and two carers to minimise the risk of pressure sore development. Staff told us they were having to reposition this person and provide personal care on their own as the other person was given medicines, answering the phone and keeping an eye on the other people living at the service.

• At the previous inspection March 2021, we identified that people's nutritional assessments were not being followed with regards to the support they received from staff during mealtimes. At this inspection, we saw that the member of staff responsible for preparing and serving lunch was also responsible for supervising people during mealtimes to ensure they safely ate their meals. This included one person who had been assessed as needing one to one support. This placed this person at risk of chocking.
• Staff we spoke with told us they did not feel there were enough staff to meet people's needs safely. One said, "We don't have enough staff to do everything we're supposed to do and the managers never help." Another said, "we can't do everything, I love working here and the people, but we don't have time and we're always rushed. I haven't even had the time to read people's care plans."
• The manager told us that due to recent events (sickness, dismissals) staff were not employed in sufficient numbers to meet people's changing needs.
• Records showed each person had an individual dependency score which was being reviewed on a monthly basis. However, this information was not being used to identify how many staff would be needed to meet those needs safely.
• The manager was not aware of which people living at the service had in place additional funded one to one support. This meant people were not receiving the care and support they had been assessed and funded for.
• Staffing arrangements at night were not sufficient to ensure people's safety. Current night-time staffing cover consisted of one waking staff member and one sleeping staff member who was in a separate building/office within the main site. This meant that should the staff member need support in an emergency or to provide routine care such as repositioning or personal care they would have to contact the 'on call' member of staff who might take some time to arrive and provide support.
• We have shared our concerns with Plymouth City Council's safeguarding team for further follow up and review.

The provider had failed to provide sufficient numbers of staff to meet people's care and treatment needs safely. This placed people at an increased risk of harm. This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

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 requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

Staff support: induction, training, skills and experience

At the last inspection we found the provider had failed to ensure that care and treatment was provided by staff who had the qualifications, competence, skills and experience to do so safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had not been made and the provider was still in breach of regulation 12.

• Prior to the inspection we received concerns that newly recruited staff did not have the skills to meet people's needs safely as they had not received an induction and had not completed any training. We reviewed training records for four members of staff employed since our last inspection. Records showed none of the four members of staff had not completed basic training to help ensure they had the knowledge and skills to meet people's needs safely. For example, first aid, safeguarding, epilepsy, nutrition and hydration and palliative care. One of these members of staff was a lone worker at night. We discussed what we found with the manager who told us they had booked online training for all staff, but was unable to tell us how this was being monitored or managed to ensure people had the skills to carry out their roles and responsibilities.

The failure to ensure that care and treatment is provided by staff who have the qualifications, competence, skills and experience to do so safely, is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we recommended the provider implemented a suitable induction that follows the Care Certificate standards to ensure all staff are supported, skilled and assessed as competent to carry out their roles. At this inspection we found no action had been taken.

• The manager told us all staff including agency staff completed an induction and did not work unsupervised until they had been assessed as competent to do so. None of the staff records we viewed contained any evidence of an induction or checks of staff competencies. We discussed what we found with the manager who was unable to tell us if these staff had completed an induction or if there had been any formal assessment of their competences.

The failure to provide staff with an induction and appropriate support and professional development as necessary to enable them to carry out their duties is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

At our last inspection we found the provider had not ensured the quality and safety of the service had been adequately assessed, monitored or improved to ensure it met with regulatory requirements and best practice guidance. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made and the provider was still in breach of regulation 17.

• The service did not have a manager registered with the Care Quality Commission at the time of the inspection. A manager had been appointed by the provider to oversee the running of the service following the last inspection. An application had been made to register this person, but it had not been successful, a second application is currently being processed.
• The providers oversight and governance of the service was ineffective in identifying the serious failings in relation to the safety, quality and standard of the service as detailed in the safe and effective sections of this report.
• On the day of the inspection there was no management structure in place to oversee the day to day running of the service. The manager had started maternity leave and was working from home. They had not been replaced, there was no deputy in place and the provider had not made any arrangements to provide suitable management cover. Following our inspection, the provider informed as they had appointed a Care Consultancy service to commence on May 31st.
• Records and checks undertaken by the manager and staff were not always completed accurately and as such could not be relied upon. For example, Care plans of service users were incomplete or blank. They did not describe people's needs and did not give staff instructions on how to meet those needs.
• On the day of the inspection people's care and support records along with their monies and medicines had been locked in an office to which staff did not have access.
• There were insufficient numbers of suitable qualified, competent, skilled or experienced staff on duty to meet people's needs safely.
• Staff we spoke with did not feel supported and told us they had been advised not to call the deputy or manager out of hours.
• Feedback from an inspection conducted on 31 March, 01 April and 08 April 2021 had not been acted upon.

The providers ongoing failure to ensure sufficient oversight to effectively monitor the quality of the service or ensure it met with regulatory requirements was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.