Spectrum (Devon and Cornwall Autistic Community Trust)

Silverdale

Inspection report

10 Trewirgie Road
Redruth
Cornwall
TR15 2SP

Tel: 01209217585

Date of inspection visit:
29 June 2021

Date of publication:
20 August 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**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 to four people with a learning disability and/or autism. It is part of the Spectrum (Devon and Cornwall Autistic Community Trust) group, a provider with 15 other similar services across Cornwall. Silverdale is a detached two-storey property with an enclosed front garden. It is located in Redruth, Cornwall within walking distance of shops and other local facilities. At the time of our inspection two people were living in the service.

We expect health and social care providers to guarantee autistic people and people with a learning disability with the choices, dignity, 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 providing support to people with a learning disability and/or autistic people.

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

Right Support,
Low staffing numbers had restricted people's choices and meant they were unable to go out for a walk or live like ordinary members of the community. People were not always supported by enough staff on duty who had been trained to do their jobs properly.

Right Care,
People received care and support that was person-centred. However, people had not been consistently supported by staff that knew them well due to the staffing shortages at the service.

Right Culture.
The organisation exhibited many of the risk factors and warning signs associated with the existence of a closed culture including; people's level of dependence on staff for basic needs, reliance on staff support to enable them to access the community, staff working excessively long hours , consistent staff shortages, and a lack of effective external oversight. In addition, the provider had failed to appropriately respond to staff requests for support and guidance on how to manage a complex issue.

People's experience of using this service and what we found
At this inspection we again found that the service was inadequately staffed to meet people's needs with higher permanent staff vacancy rates than those identified during our March 2020 inspection. Rotas and other records showed the service had regularly been operated at emergency minimum staffing levels and reports to the providers senior management demonstrated the service had been short staffed since December 2020. The action plan developed by the provider following our last inspection in March 2020 had failed to ensure the service was appropriately staffed.

Low staffing levels restricted people's freedoms and unnecessarily exposed them to risk of harm. Staff reported that low staffing levels had prevented people from leaving the service and that they had come in on their days off to enable people to go outside.

Five days prior to the inspection, the provider had introduced the use of agency staff at Silverdale in response to inspection findings and safeguarding investigations related to staffing levels identified during previous inspections of four other Spectrum services.

The agency staff had limited knowledge of the people they supported at the time of our inspection. In addition, the commission is concerned about the sustainability of these arrangements as the agency staff were from Northampton and were being accommodated locally by the provider. Documents showed the provider's senior managers had been aware that the service had been short staffed since December 2020. Managers had phone the service daily to check on staffing levels and any issued relating to the COVID pandemic. Staff had consistently reported the understaffing of the service, but this issue had not been resolved prior to the introduction of agency staff.

At the time of our inspection the registered manager, deputy manager and a member of care staff had resigned and were working their notice periods. Staff were consistently complimentary of the registered managers leadership but reported the provider's systems for supporting the service were ineffective.
The provider required its registered managers to raise safeguarding issues internally for review and approval by senior managers before safeguarding alerts were made. This was contrary to best practice and introduced risk of delayed.

Medicines were managed safely and we were assured there were appropriate infection control procedure in place.

Care plans reflected people's current needs and had been regularly updated. However, on the day of our inspection specific guidelines used to recognised one person's engagement with tasks and activities were not being used. We have made a recommendation in relation this issue.

People's communication needs had been identified and recorded. Staff varied the style of their communication, and used stock phrases, objects of reference and other tools to support people to make choices and decisions.

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 (published 2 May 2020). The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we again found the service was short staffed and in breach of regulation 18. In addition, issues were identified with the leadership and quality assurance systems which is breach of regulation 17.

The service remains rated requires improvement. This will be the second inspection that the service has been rated overall as requires improvement.

Why we inspected
We received concerns in relation to staffing at a number of services operated by the provider. As a result, we undertook a number of focused inspections to inspect for these concerns. At this service we reviewed the

key questions of safe, responsive and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions of Effective and Caring. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Silverdale on our website at www.cqc.org.uk.

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 relation to staffing and good governance. 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 for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always Safe.	**Requires Improvement**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**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 Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by two inspectors.

Service and service type
Silverdale 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 had a manager registered with the Care Quality Commission. 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. The registered manager had handed in their notice and was due to leave the service in the week following the site visit.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We did not request provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. We used all of the information

available to us to plan our inspection.

During the inspection
We met with both people who used the service. We spoke with five members of care staff, the deputy manager, the registered manger and the providers regional manager and Deputy Head of Operations. We completed some brief informal observation of the quality of care and support provided by staff.

We reviewed a range of records. This included both people's care records and medication records. We looked at a staff files in relation to recruitment and various records relating to the management of the service, including rotas and incident reports.

After the inspection
We reviewed evidence requested during the site visit. We also spoke via telephone with four additional staff one person relative and two professionals who supported people living in the service.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment
At our previous inspection on 13 March 2020 we found the service was short staffed. Rotas showed that due to staffing shortages the service was regularly operated at emergency minimum staffing levels. Documents showed staffing levels had contributed to the numbers of incidents occurring in the service. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we again found that the service was staffed such that people's needs were not adequately met. This is an ongoing breach of the regulations.

- The provider had introduced the use of agency staff in response to inspection findings and safeguarding investigations related to staffing levels identified at four other Spectrum locations inspected in May and June 2021.
- Two agency staff had been allocated to Silverdale on 24 June. For the five days, 24 to 29 June with the addition of agency staff there had been enough staff on duty to meet people's needs. However there continued to be high numbers of permanent staff vacancies at the service and the benefit of the agency staff was limited as they lacked knowledge and understanding of people's needs. We noted during our inspection that agency staff tended to focus on domestic and other task as opposed to engaging directly with people.
- Staff told us, "We have five staff most of this week with the agency which is refreshing" and "It is good to have agency, but they don't know people they support so can be hard work. At least we have staff in building and [Person's name] especially can always have chance to go out." The commission is concerned the improvements in staffing level as a result of the use of agency staff may not be sustained.

- Prior to the inspection we received information of concern from a whistle-blower that indicated the service was short staffed. During the inspection, we completed an analysis of the service's rota records and staff allocation grids. These documents showed the service had 180 hours per week of day staff vacancies which equates to 4.5 full time posts. In addition, one member of day staff was on long-term sick leave.
- The registered manager told us, "490 hours is our weekly commissioned hours. That is five team members from 08:00 till 22:00 each day". The business continuity plan for the service identified that, in extreme emergency situations, the emergency minimum staffing level was three staff during the day. This document identified that in these extreme situations people would not be supported to engage with activities.
- Analysis of rotas and staff allocations showed that the service had regularly been short staffed before the arrival of agency staff on 24 June 2021. In the period 6 to the 23 June we reviewed the staffing level during the morning and evening shifts. Of these 36 shifts, only five had been fully staffed while we identified16 shifts

where the service had operated at emergency minimum staffing levels. During this period there was no evidence of a direct impact of the COVID pandemic on staffing levels within the service. The providers failure to appropriately staff the service prior to 24 June 2021 had restricted people's choices and exposed them to risk of harm.

● Staff consistently told us the service had been short staffed for a significant period prior to the introduction of agency staff. Their comments included, "For a period of time we have been regularly operating on three staff, a few [staff] left and it just never recovered", "Staffing levels have been a nightmare", "Recently it has been a little bit stressful with the amount of staff, we have been on a skeleton crew. We have all been working ridiculous hours to keep the place going. It has been really hard" and "Staffing was awful, there were days if the manager had not been in, there would have only been 2 staff on."

● A professional involved in supporting people who live at Silverdale told us, "It has been short staffed since December but there was a point last year when staffing levels did improve". Documents showed the lack of consistent staffing at Silverdale had prevented an agreed reduction in one person's medicines, planned in accordance with STOMP principles.

The provider had failed to ensure safe staffing levels were consistently achieved. This is an ongoing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager recognised the service was short staffed and records showed they had regularly been reporting staff shortages at Silverdale to the provider's senior managers since December 2020. Issues in relation to the provider's failure to take timely action to ensure the service was appropriately staffed are discussed further in the well led section of this report.

● The provider's recruitments practices were safe. All necessary pre employment check were completed to ensure new staff were suitable for employment in the care sector.

Systems and processes to safeguard people from the risk of abuse

● Staff understood their role in protecting people from all forms of abuse or discrimination. Records showed that had taken action and provided appropriate support and reassurance during events which had caused people anxiety.

● The provider requires it's registered managers to report any safeguarding information to them rather than directly to the local authority. Senior managers then reviewed the information and made a decision in relation to whether they believe the information provided met the threshold for a safeguarding alert. This is contrary to best practice and unnecessarily introduces a risk that safeguarding alerts may be delayed.

Using medicines safely

● People received their medicines safely and as prescribed. Medicines administration records were fully completed and had been appropriately audited.

● Staff received training in the administration of medicines and there were robust systems in place for the management of 'as required' medicines.

● Medicines were stored securely and there were systems in place to ensure any unused medicines were disposed of correctly.

Assessing risk, safety monitoring and management

● The provider aimed to use Positive Behaviour Management (PBM) techniques to ensure the safety of people and the staff who supported them. However, staff reported the practical aspects of this training had not been completed during the COVID pandemic. Experienced staff said, "Half the staff have not done the full PBM training, just watched a video. We don't feel we always have the support we need because the other

staff do not have either the training or the experience". Staff members recruited during the hight of the COVID pandemic when face to face training was not possible had not completed the full PBM training syllabus by the time of this inspection but continued to support people on their own.
The provider had failed to ensure staff were adequately trained and skilled to keep people safe. This forms part of an ongoing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● Some people could behave in ways which put themselves or others at risk. These risks had been assessed and people's care plans included information on events likely to cause anxiety and clear guidance on how to support people if they became upset or anxious. We observed staff effectively using these approaches while supporting one person in the garden.
● Records showed, and staff reported, the use of physical restraint had reduced since our last inspection.

● Personal emergency evacuation plans were available and provided guidance on the support each person would need in the event of an emergency evacuation. Firefighting equipment had been regularly tested by appropriately skilled contractors.

Preventing and controlling infection
● 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 somewhat assured that the provider was using PPE effectively and safely. Staff were not always wearing masks within the service when people were not present.
● 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.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong
● Incidents and accidents that occurred were documented and reported to the registered manager and the provider's positive behaviour support team.

Requires Improvement

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 good. At this inspection this key question has deteriorated to Requires Improvement. This meant people's needs were not always met.

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

- The registered manager, one person's relative and involved professionals, had identified that one person was regularly declining activities and had become reluctant to leave the service. They felt this behaviour had developed in response to a combination of COVID-19 lockdown restrictions and low staffing levels limiting the person's ability to leave the service. , because they had not been able to leave the service because of the long period when staffing was too low and activities out of the home could not be supported.
- The provider's business continuity plan for the service indicated that in extreme emergency situations when the service was operating on only three members of staff, people were not to be supported to engage with any activities or other tasks in the service. Staff rotas showed the service had regularly operated at emergency minimum staffing levels which had meant people could not leave the service if they wished.
- Staff and the registered manager recognised that the staffing arrangements over the past months, had restricted people's freedoms, their ability to access the community, and had caused a decline in people's behaviours. Rotas showed that in the period 6 to 23 June there had not been enough staff available during 31 of 36 shifts to support people to access the community.
- Staff comments on the impact of low staffing level on people's ability to access the community included, "Sometimes there were only three of us. We would come in on our days off to cover because three staff is not enough, so we would come in so people could go out. I find it quite distressing as it is impacting on [Person name] through no fault of [their] own. We need five but often it was four dropping down to three".
- Staff also told us, "If we don't have the right staff for [person's name] it can be quite difficult to manage [them] and then [they] don't get to do activities. This can make [the person] more heightened and [they] are not able to live normally. We can't even offer to take [the person] out. [person name] is 3:1 and [The other person] is 2:1 so even when we are on four staff we can't get [Person's name] out. We can't even offer it so we can't support [The person] to get used to going out again. It is a shame because before lockdown it was more likely we could get [the person] out.

The provider failure to ensure enough staff were available to enable people to engage with activities and access the community forms part of the continued the breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Plans had been developed to try to support one person to return to going out of the home, but this was likely to take some time to achieve. Additional equipment was being purchased to encourage the person to access the home's garden.

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

preferences
● Care plans were detailed, informative and provided staff with sufficient information to meet people's individual support needs. These documents had been regularly reviewed and updated in response to any changes in people's needs. Staff told us, "The care plan has enough to tell you what to expect from people" and "I think the care plans are pretty good, [Person's names] changes pretty often".
● People's care plans included one page profiles and other information designed to new help staff quickly gain an understanding of people likes, interests and preferences.
●One person's care plan included guidelines about a system used to recognise when they had engaged with and completed domestic tasks and other activities within the service. These guidelines included instructions to report to the person's multi-disciplinary support team if the person repeatedly failed to complete these tasks on consecutive days. We asked both the person and the staff member supporting them about this system. From these conversations it was clear these guidelines were not currently being used. The registered manager was unaware these guidelines were not currently in use and this had not been reported to the multi-disciplinary team.
We recommend the provider seeks advice from a reputable source on how to support staff and ensure they understand and follow agreed guidelines.

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.
● Details of people's communication needs, and preferences were recorded in care plans and understood by established staff. Care planning documents were available in accessible formats to enable people to participate in review processes.
●Individualised communication approaches and tools were used to help people understand and process information. This included social stories to help people understand complex information and the use of reference objects and stock phrases to enable people to make decisions about which activities to engage with.

Improving care quality in response to complaints or concerns
● There were systems in place to ensure any compliment or complaints received were documented, investigated and addressed.

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 requires improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Understanding quality performance, risks and regulatory requirements

- Following our last inspection in March 2020, the provider produced an action plan detailing the improvements they intended to make to resolve the staffing shortages at the service. This plan, dated 29 May 2020, reflected the needs of the people the service currently supports and recognised at that time understaffing of 138 hours per week. The provider intended to recruit additional staff and told the commission they would provide enhanced scrutiny and support to the service. This would include new processes to, "ensure any vacancies are recruited to as a priority as soon as team members serve notice".
- At this inspection on 29 June 2021 we again found that the service was short staffed with staff vacancies equating to 180 hours per week. Documents showed the service had consistently been short staffed since December 2020 and the provider's senior leadership team had been repeatedly informed of this situation by the care home. No effective action had been taken to address the staffing shortages prior to the introduction of the use of emergency agency staffing on 24 June 2021.
- The service's registered manager, a deputy manager and a member of care staff had resigned prior to our inspection and were in the process of working out their notice periods. On the day of our visit, contrary to the provider's action plan no additional staff had, so far, been recruited to fill either these newly vacant roles or the existing vacancies.
- In response to the COVID-19 pandemic, the provider had introduced a daily call to each service by a senior manager to monitor staffing levels and gather information about any outbreaks or changes in people's support needs. These calls had been completed and staff reported they had routinely raised concerns about understaffing in the service. Staff told us, "They [senior management] do a phone around every day to ask how many staff we have, we tell them but that is it, basically nothing is done to help. We are supposed to phone the rest of the team to ask [them to help] but when everyone is doing so much extra it is hard to ask people to come back in" and "Every day they [senior management] ring round and you tell them that we are low, but nothing is done to support us. We are overlooked and ignored". Although the provider had been aware of the staffing shortages at Silverdale for more than a six months, effective action to recruit permanent staff or deliver the staffing required to meet people's needs had not been taken prior to 24 June 2021.
- Both the providers quality assurance systems and action plan following the last inspection had proved ineffective in ensuring people received the level of staff support they required.
- As detailed in the safe section of this report, the use of agency staff was introduced at Silverdale on 24 June 2021. This involved employing workers from outside Cornwall and supporting them with temporary accommodation. While this had addressed the immediate staffing numbers at Silverdale it did not address the long-term challenges the provider has experienced in staffing Silverdale.

Managers and staff being clear about their roles

● The registered manager had resigned prior to our inspection and was due to leave the service the following week. Staff were consistently complementary of the leadership and support provided by the registered manager. They told us, "[The registered manager] is good, I am sad to know she is leaving", "The manager has been really good but she does not get support from senior management" and "[The "[Registered manager] is frustrated, she tells them what we need but does not get any support. Anything that goes wrong [the manager] gets blamed but their hands are tied because of the senior management team. They do not even answer the phone or reply to emails from us."

● The roles and responsibilities of staff, the deputy manager and registered manager were well understood. However, staff consistently told us the service had been left isolated and unsupported by the provider's senior leadership team. Staff told us senior leaders often ignored information they provided or disbelieved their reports. Staff comments in relation to this issue included, "It is like the house is its own contained bubble and we don't get a lot of support from outside of it" and "There is just a lack of engagement with the units from head office and when you report things nothing gets done until one of the senior manager sees it. [The registered manager] has to deal with things without support".

● The provider operated an on-call manager system that was deigned to ensure services were appropriately staffed. Two managers were on call each day and available to go to services and provide care and support if required. However, significant staffing shortages in a number of the provider's services meant these managers were not able to support individual services when requested. Staff told us, "We run on three pretty regularly, that is not an uncommon occurrence so we don't call anyone for that. Which I don't think is right to be honest." While staff who had completed shifts as on-call managers told us, "On-call was impossible to manage. The main issues are staffing shortages and trying to find cover and [as required medication] calls. I could get three calls from services with staff shortages and where do you go" and "On-call is also hard, you always got called as there are staff shortages in lots of services due to sickness and vacancies. You then have three or so services all short staffed and need to think about which service you support. You have to weigh up the risk, it's a horrid responsibility".

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

● A number of staff specifically raised with the inspector concerns about the lack of support they had received to manage and resolve a long running issue of concern. Staff told us they had repeatedly raised this issue via their supervision and with senior managers both directly and in writing. Staff and the registered manager reported that during particularly challenging circumstances they had sought guidance from senior managers on how to respond if similar situations reoccurred. No guidance had been provided, no action taken or support provided to address this situation, until it was subsequently directly witnessed by one of the provider's senior managers.

● We raised this concern with a member of the providers senior leadership team as part of this inspection. They stated that the provider's senior leadership had been unaware of this situation prior to the direct observation by the senior manager. Records viewed during the inspection showed this situation had been raised by staff and the register manager via supervision processes and that staff members had written directly to senior leaders to raise concerns about this issue.

Continuous learning and improving care

● 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 their complete reliance on staff support to enable them to access the community. The warning signs included but are not limited to; staff working excessively long hours , consistent staff shortages, the lack of effective oversight by the provider, and the inability of the wider health system to visit

due to restrictions on professionals during the COVID-19 Pandemic.
● In response to whistleblowing concerns the commission has completed a programme of five inspections of Spectrum services, including Silverdale, during May and June 2021. Each of these inspections has identified staffing issues.
● Staff consistently told us they did not feel valued and that Spectrum's senior leaders did not listen to them. There comments included, "As an organisation I think Spectrum has a high turnover. They do not invest in their staff and there is no incentive to stay. I have never worked in another provider where you are not encouraged to do your NVQs", and "It is all organisational, their dedicated staff are doing 60 to 70 hours [a week] but then they get ill and you don't even get sick pay", and "I don't think we are valued, we get paid and that is it" and "There is an arrogance about the senior team, when they can do what they want and they tell the staff if you don't like it leave and sadly that is what is happening".
● Senior managers confirmed that care staff received statutory sick pay while all other staff received enhanced sickness allowances. Senior managers recognised the provider had a significant issue with staff retention. We were also told by senior managers that some changes had been made to staff benefits and pay to improve staff morale and retention.

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.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff had consistently acted to attempt to protect people from abuse and discrimination. Records showed staff had responded to and appropriately challenged discriminatory behaviour directed at the people they supported by members of the general public.

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
●The staff team maintained regular communication with people's relatives and kept them well informed of any incidents that occurred or changes in people's support needs.

Working in partnership with others
● Professionals told us the service's outgoing management team had worked with them openly and effectively. However, they reported it was more challenging to gain information from the provider. Professionals comments included, "[The registered manager] has been good to work with open and transparent" and "I know [The registered manager] has been requesting additional staffing (from the provider) since January and [The registered manager] was always open and honest about this".