Silvermead Plymouth Ltd

Silvermead Residential Home

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
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 were happy living at Silvermead and told us they liked the staff that supported them. Relatives we spoke with did not raise any significant concerns and spoke positively about the staff and the care and support they provided.
Whilst we found a number of improvements had been made following the last inspection, the service was not operating in accordance with the regulations and best practice guidance. This meant people were at risk of not receiving the care and support that promoted their wellbeing and protected them from harm.

During the inspection, we made five safeguarding referrals to the local authority and asked the manager to make another, which they did.

Systems and processes in place to monitor the service were not undertaken robustly. This meant they were ineffective, did not drive improvement and did not identify the issues we found at this inspection. These included concerns with regards to recruitment, staffing, infection prevention and control, fire safety, care planning, management of risk, nutrition and hydration and the implementation of The Mental Capacity Act 2005 MCA.

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. Neither the manager or staff were aware of the Right support, right care, right culture guidance or how these underpinning principles could be used to develop the service in a way which supported and enabled people to live an ordinary life, enhanced their expectations, increased their opportunities and value their contributions. 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 supported to have maximum choice and control of their lives and staff were not supporting people in the least restrictive way possible and in their best interests.

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 needs were not always being recorded or followed up. Other risks were well managed.

People were not always protected from the risk and spread of infection. We were not assured the provider was admitting people safely or that staff were using personal protective equipment (PPE) in accordance with the government guidance. Following the inspection, the manager confirmed action had been taken to resolve the concerns in relation to PPE.

People were not protected by safe recruitment procedures and staffing levels were not always sufficient to meet people's needs and to keep them safe.

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). The provider completed an action plan after the last inspection to show what they would do and by when the improvements would be made. At this inspection enough improvement had not been made and the provider was still in breach of regulations.
Why we inspected
The inspection was prompted by concerns raised by the provider regarding their current rating and the impact this was having on their business.

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, safeguarding people from abuse, the need for consent, staffing, recruitment, nutrition and hydration, notifications, and governance. We have also made recommendations in relation to training, medicines, management of complaints and person-centred care. 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our effective findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Silvermead Residential Home

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 team consisted of two inspectors and an Expert by Experience who had consent to phone and gain feedback on the care provided by the service from people's relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
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
Whilst the provider was given advanced notice of the inspection the date of the inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed the information we held about the service, including notifications we had received. Notifications are changes, events or incidents the provider is legally required to tell us about within required timescales. We used this information to plan the inspection. 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 seven people living at the service, we spoke with six relatives, six members of staff the manager and the providers legal representative who had been asked by the provider to attend on the second day of the inspection. To help us assess and understand how people's care needs were being met we reviewed seven people's care records. We also reviewed a number of records relating to the running of the service. These included staff recruitment and training records, medicine records and records associated with the provider's quality assurance systems.

After the inspection
We continued to seek clarification from the manager to validate evidence found. We looked at training data and quality assurance records. We spoke with two health care professionals, five staff members, Plymouth City Council's quality assurance and improvement team (QAIT) and Devon and Somerset Fire and Rescue Service.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse

At our last inspection we found people were not always protected from the risk of abuse or avoidable harm. As the systems in place to investigate and report allegations of abuse were not effective. 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. At this inspection, whilst we found some improvements had been made the provider was still in breach of regulation 13.

• People were not always protected from the risk of abuse or avoidable harm. Following the previous inspection, the manager had introduced a new system to monitor safeguarding incidents. We found the systems in place had not been effectively established or embedded. For example, we reviewed 13 safeguarding incidents that took place between February 2020 and March 2021. Records for four of these incidents did not show they had been reported to the local authority's safeguarding team and the manager did not know when we asked. None of the incidents had been reported to the Care Quality Commission as legally required, and incident records contained limited information of any actions taken by staff to reduce the risk of reoccurrence. Where actions had been suggested we found this information had not been used to inform/update people's care plans or risk assessments. For example, following a number of incidents during mealtimes, staff had suggested changes to people's seating arrangements. This information was not used to inform, or update people's care plans.
• The manager reviewed accidents and incidents monthly. However, these had not been sufficiently reviewed. Themes or trends had not been identified to keep people safe from harm. For example, multiple incidents between the same people and mealtimes.
• At the last inspection we raised concerns about how the service managed one person's finances. At this inspection we have identified further concerns about the way in which people's finances were being managed. We have shared our concerns with Plymouth City Councils safeguarding team.

The systems to protect, investigate and report allegations of abuse were not effectively operated and placed people at an increased risk of harm. This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Other referrals had been made to the local authority's safeguarding team when appropriate.
• Records showed staff had attended safeguarding training and staff we spoke with were able to tell us the correct action to take if they suspected people were at risk of harm or abuse.
• Following the inspection, the manager confirmed they had reviewed and updated their management of incident guidance.

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 breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found insufficient improvement had been made and the provider was still in breach of regulation 12.

• People were not always protected from risks associated with their complex care needs. For example, where staff had been provided with guidance by health and social care professionals, this was not always followed. For example, one person had been assessed by a Speech and Language Therapist (SALT) and required a texture level 5 'mashed moist' diet. During the inspection we observed this person was given a sausage roll for lunch. This placed the person at an increased risk of choking.
• Another 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 a tour of the service with the manager and deputy we found this door was open and staff were not around. The manager took immediate action and locked the door. Later that day during a second tour with the deputy manager we found this door was again open and left unattended.
• We found the keys to the services medication cabinets had been left unattended in the kitchen. We brought this to the attention of the deputy manager who took immediate action.
• People's care files included risk assessments based on their support needs. Whilst some records contained information about people's risks, we found that other records did not give staff sufficient information to mitigate and manage those risks. For example, one person, who was living with diabetes was having their blood glucose monitored daily by staff. Records did not contain information about the safe blood glucose range for this person or guidance for staff on what to do if the person's blood glucose was too high or low. We spoke with staff about this person's care and not all staff knew what signs and symptoms would indicate a low or high blood glucose level or what action they needed to take in those circumstances. This placed the person at risk.
• Another person had been identified as being at high risk of developing pressure ulcers and had been provided with a pressure relieving air mattress. We found the pressure mattress was not set correctly for the person's weight. When asked, staff on duty did not know how to reset the mattress. The deputy manager told us there was no system in place to ensure that mattresses were regularly checked to ensure they were set correctly. This meant the person was at increased risk of pressure damage.
• Risk assessments had identified the need for this person to be regularly repositioned. Their care plan and guidance from health professionals said they needed staff to reposition them two to three hourly. Records did not demonstrate this had always taken place. At night, this person could not be turned two hourly because there were insufficient staff.
• People were not always protected from the risk associated with their environment as routine environmental checks in relation to hot water temperatures and window restriction were not taking place.
• Where risks had been identified, the provider could not demonstrate that sufficient action had been taken to mitigate those risks and keep people safe. For example, at our previous inspection in November 2019, we identified concerns relating to the services fire safety arrangements. At this inspection, records showed a fire risk assessment had been completed in January 2020, which identified a number of actions which needed to be completed within a specified time frame.
We discussed the fire risk assessment with the manager who explained some action had taken place. For example, a hold open device had been removed from the kitchen door. However, actions relating to the services fire doors were still outstanding and were due to take place in the next couple of weeks. We asked the manager what action they had taken to mitigate the fire safety risks whilst they were waiting for the work

to be completed. The manager said that no additional action had been taken.
• During a tour of the building with the deputy manager we found the kitchen door, which was a fire door, was being held open with a fire extinguisher; the hallway door (fire door) was wedged open with cardboard; and the fire alarm system was showing a fault. The deputy manager did not know how to reset the system. We asked them to call an engineer. When we spoke with the service 8 days later the manager had been unaware that the system was showing a fault and an engineer had not been contacted. Following our conversation, the manager took immediate action.
• At the previous inspection we found people's individual personal emergency evacuation plans (PEEP's) for emergency situations, were generic and did not reflect people's individual needs. At this inspection we found people's PEEP's had been updated, they were person centred and reflective of their needs. However, people remained at risk. Five of the seven staff we spoke with had not read them. Staff gave different explanations of what actions they would take if there were a fire. This meant they did not know what actions to take in the event of a fire. For example, one staff member said, "Once everyone is out, I will go back in and sit with [person's name]. I wouldn't want them to die on their own." Another told us they wouldn't need to call the fire brigade as "the fire alarm system is linked to the fire station." Following the inspection the manager informed the Commission that all staff had been asked to read people's individual PEEP's and records showed staff had attended fire warden and fire safety training.
• We have shared our concerns with Devon and Somerset Fire and Rescue Service and Plymouth City Council.

Whilst we found no evidence that people had been harmed, systems were either not in place or robust enough to ensure people's safety was effectively managed. This placed people at risk of harm. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Preventing and controlling infection
• People were not always protected from the risk of and spread of infection.
• People were not being admitted safely because procedures were not in accordance with Public Health England's current COVID 19 guidelines (Admission and care of residents in a care home during COVID-19). This placed people, staff and visitors at an increased risk of harm. For example, one person regularly stayed at the service for a number of days/nights each week before returning to their family home. Contrary to guidance, this person was not required to isolate for the recommended 14 days and was freely mixing with other people living at the service. This placed those around them at increased risk of transmission of COVID-19. Staff told us this person did not have to isolate as they were not living at the service. We asked the manager why this person was not required to isolate. The manager told us that they didn't know the guidance applied to people who were on respite (short term placements). We asked the manager to seek advice from Public Health England, refer the matter to Plymouth City Council's safeguarding team for further follow up, and review the current infection prevention and control arrangements for this person. Following the inspection, the manager confirmed the placement had been terminated to prevent the spread of infection via this route.
• Staff were not always using PPE effectively and safely. For example, throughout the inspection we saw staff were supporting one person who was in a 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 when supporting this person.
• We were not assured that the provider was promoting safety in relation to hygiene practices. The service appeared clean; cleaning schedules had not been enhanced as a way of preventing the spread of COVID-19. A cleaning schedule was in place for staff to follow at night. However, there were no cleaning schedules in place during the day. This meant the provider could not be assured staff knew how often cleaning should take place or what enhanced cleaning should take place in light of the Covid-19 pandemic. Enhanced

cleaning should have included cleaning of frequently touched surfaces, such as handles, remote controls and kitchen appliances.
• The way the layout of the building was being managed was not supporting good hygiene control and practices. During the first day of the inspection we saw that the laundry room, which was also used as a donning and doffing area for PPE, was cluttered, disorganised with no clear separation of clean and dirty laundry. We saw clean clothes stored in an open top basket next to a clinical waste bin where staff were disposing of their used PPE. We brought this to the attention of the manager who took immediate action.
• At our previous inspection in December 2020, we were not fully assured the provider was meeting shielding and social distancing rules. We recommended the provider undertook a review to ensure they were meeting best practice guidance in relation to social distancing. Following that inspection, the manager told us they had made changes to mealtimes. 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 we found 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 in the lounge, this included the person who should have been in isolation. Whilst we observed staff regularly coming in and out of the lounge, we did not observe or hear them support or encourage people to socially distance. When we asked staff how they supported people at mealtimes. One staff member said, "We're supposed to have two sittings, but we don't, everyone has their meals together."

Whilst we found no evidence that people had been harmed. 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 breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We were somewhat assured the provider was preventing visitors from catching and spreading infections. Visitors to the service were asked to wear PPE, have their temperature checked, wash their hands, complete a health declaration questionnaire and provide evidence of a negative test result, or take a rapid lateral flow test (LTD) before they would be allowed to enter the main part of the building.
• We were somewhat assured that the provider was accessing testing for people using the service and staff. Most people and staff took part in regular COVID-19 "whole home" testing.

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.

Recruitment

At our last inspection we found the provider had failed to establish and operate effective recruitment procedures. This was a breach of Regulation 19 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 19.

• People were not always protected by safe recruitment procedures.
• We looked at the recruitment files for three staff members. Whilst some recruitment checks had been carried out, others had not. For example, records for two of the people we looked at contained limited information about previous work history and the registered provider had failed to obtain previous employment references for one person. This meant the provider was unable to demonstrate they had followed a thorough recruitment process in accordance with Schedule 3 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

Whilst we found no evidence that people had been harmed. The failure to establish and operate effective recruitment procedures is a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing

At our last inspection we recommended the provider reviewed the system in place and took action to ensure the rota reflected the hours being delivered. At this inspection we found improvements were still needed.

• Staffing arrangements at night were not sufficient to meet people's needs safely.
• 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 every 2-3 hours with the use of a slide sheet and two carers to minimise the risk of pressure sore development. Staff told us this person was not being turned during the night hours as there was only one member of staff awake. Care records showed this person was not been turned between the hours of 10pm and 7am.
• The manager told us staff were employed in sufficient numbers to meet people's changing needs and were regularly reviewed. 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. Staff we spoke with told us they did not feel there were enough staff to meet people's needs. One said, "I think there's enough staff on nights unless there is an emergency. Daytime, I don't think there's enough staff to meet people's needs, it always feels really rushed and there is not enough time to sit with people." Following the inspection, the provider wrote to us to confirm that the manager/ deputy will always step in to help even at the weekends.
• Nutritional and SALT assessments were not being followed with regards to the support they received from staff. For example, one person's SALT assessment said they needed staff to support them on a one to one basis to ensure they safely ate their meal. During the inspection we observed this person did not get one to one support.
• We have made a referral to Plymouth City Council's safeguarding team for further follow up and review.

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

Learning lessons when things go wrong
• Records showed accidents and incidents were being recorded. However, we found this information was not being robustly analysed or reviewed and there was no evidence to show what action had been taken to prevent reoccurrence. For example, we reviewed two people's care records following recent incidents and found neither the care plan or risk assessments had been reviewed or updated following these incidents. This meant the provider could not be assured that lessons had been learnt or sufficient action had been taken to keep people, staff and others safe from harm. We discussed what we found with the manager who said they recognised that the process in place needed to be improved.

The failure to assess, monitor and improve the quality of the service placed people at an increased risk of

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

Using medicines safely

At our last inspection we found people's medicines were not being managed or stored safely. This was a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection whilst we found improvements had been made and the provider was no longer in breach of regulation 12, some improvements were still needed, and we have made a recommendation.

• People's medicine administration record (MAR) charts were not always completed when medicines were given. For example, the administration of people's prescribed topical skin creams was not always recorded. This meant it was not possible for the provider to be assured that people had received their skin creams as prescribed.
• Medicines were stored securely. However, storage temperatures were not always recorded and monitored to make sure medicines would be stored safely and effectively.
• Although medicine audits were being completed, these had not been effective as they had not identified any of the issues we found at this inspection.
• At the last inspection we identified there was no guidance in place for staff to follow for people who had been prescribed medicine to be used 'as required' (PRN). At this inspection we found PRN protocols were now in place.
• Only designated staff who were appropriately trained administered medicines. We observed part of a medicines round. This was managed in line with best practice guidance. Staff completed medicines administration training and were checked for competency before administering medicines to people unsupervised.

We recommend the provider seeks guidance from a reputable source and reviews medicine practices to ensure the service is compliant with best practice.

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.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

At the last inspection we found people were not always supported to have maximum choice and control of their lives. Assessments of people's capacity and best interest decisions had not been recorded. This was a breach of regulation 11 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 11.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

• People were not supported to have maximum choice and control of their lives.
• Following the last inspection, the manager introduced a new system/forms to demonstrate and document how the service was assessing people's capacity and recording best interest decisions.
• We reviewed a number of people's capacity assessments and best interest decisions and found the forms had been poorly completed. Some of the information recorded showed a lack of knowledge and understanding of the principles of the MCA. For example, none of the MCA assessments contained any information about how people were being supported to understand, retain, weigh up or communicate their decision. Information contained with MCA suggested that conclusions had been reached before the assessment had been completed. For example, one person's MCA assessment prompted the decision maker to state why the person might lack capacity to make the particular decision. The manager recorded 'I feel it's a best interest decision as […] is unable to make decisions that he understands'. This did not evidence their capacity or decision-making ability but suggested the conclusion had been reached before the assessment had been completed.
• Records showed relatives had been asked by the manager to provide consent on a person's behalf. However, we found these family members did not have lawful authority to provide consent or make decisions on the person's behalf.
• In relation to receiving the Covid 19 vaccine, one person's mental capacity assessment recorded a viable option of "[Person's name] is not told just vaccinate him with everyone else."
• Information within another person's MCA related to two different people.

• One person was making decisions about their diet which could have an impact on their health. Staff had not assessed this person's capacity in relation to this decision, or in relation to their understanding of the long-term health effects this might have.
• We discussed what we found with the manager, who acknowledged there was still some learning that needed to take place and accepted that this was reflected in the quality and standard of documentation.

The failure to properly assess and record people's capacity and best interest decisions risked compromising people's rights. This was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, the manager confirmed they had purchased the following codes of practice to aid their understanding. The Mental capacity Act 2005, Deprivation of liberty safeguards and Mental health act 1983.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• We found where some restrictions had been placed on people's liberty to keep them safe, the provider had worked with the local authority to seek authorisation to ensure this was lawful.

Staff support: induction, training, skills and experience

At the last inspection we found staff were not provided with appropriate training necessary for them to undertake their role. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was no longer in breach of regulation 18. However, improvements were still needed.

• Records showed one member of staff had recently been employed to work at night. They had not completed any training prior to commencing their shift. Recruitment records for this person did not contain details of their qualifications. We discussed what we found with the manager who told us the person had recently worked at the service as an agency worker and as such was confident this person had the skills to meet people's needs safely. When asked the manager was unable to tell us what qualifications or training this person had completed.

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 breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• 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. However, the provider did not have a system in place to record what information was provided during induction, when induction took place, or who provided the induction. Staff told us their induction process consisted of shadowing experienced staff and asking questions about what they needed to do. One member of staff who did not have any previous care experience said. "I didn't have a formal induction; I just completed a tick sheet and was asked to complete my training online. No one ever asked me any questions or checked my knowledge." Staff records did not contain any assessment of competences following their induction.

• The provider monitored staff training on a training matrix which showed what training staff had attended. Staff confirmed they completed online training, however some staff felt some of the courses had been of a poor quality and did not enhance their skills/knowledge. For example, one member of staff said, "We have done lots of training, but I don't feel that I have learnt a lot." Another said, "It's all online, I completed my NVQ 3 in a week, it was only 60 questions."
• We found during our discussions with staff there were gaps in their knowledge for example in relation to infection prevention and control, fire, MCA, nutrition and hydration, diabetes management as well as catheter and stoma care. None of the staff we spoke with including the manager were able to describe the underpinning principles of Right support, right care, right culture guidance (choice, control, independence, inclusion) and how this might increase people's quality of life. Following the inspection, the provider sent the Commission competency assessments for six members of staff which included the manager. Competency assessments were in relation to hand hygiene, donning and doffing PPE and medicines. In addition the provider completed a carer competency form, which included the management of catheters, stomas and promoting independence.

We recommend the provider undertake a review of the effectiveness of their training programme and implement 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.

• Staff had opportunities for regular supervision and appraisal of their work performance.

Supporting people to eat and drink enough to maintain a balanced diet

At the last inspection we found improvements were still needed to improve people's mealtime experiences. At this inspection we found improvements were still required.

• Records showed five of the people living at the service had been assessed by healthcare professionals as needing additional one to one support and/or supervision at mealtimes. Most people had a nutritional plan which set out the level of support required as well as the person's individual dietary requirements. We found staff did not always use this information to support people to manage their dietary needs. For example, one person was at risk of choking when eating and drinking. This risk was managed through a specific support plan. They had been assessed as needing a 'Minced moist level 5 Dysphagia diet' and normal fluids (only half a cup at a time). Staff were instructed to provide one to one supervision and place a 'mealtime mat' (A (A 'mealtime mat' is a laminated easy read document) next to the person for staff to refer to for strategies and recommendations. Staff were to support this person by using two plates and only giving them small amounts at a time, On the third day of the inspection we observed lunch, and found this person was not being supported in this way or provided with one to one support. Five of the staff we spoke with, were not able to tell us about this person's mealtime needs. This person remained at risk of choking.
• Another person was at risk of weight loss. They were prescribed nutritional supplements to support weight gain. Staff told us this consisted of supplement drinks and yoghurts which the person regularly refused. In addition, staff told us they sprinkled a powder on this person's food and within drinks. Four of the staff we spoke with gave us varying accounts of how much this person should have. We looked at this person's nutritional care plan and found this had not been updated since 2017. Neither this person's care plan nor nutritional records contained any reference / or guidance for staff to follow on the use of this nutritional supplement. Following the inspection, the manager confirmed that the powder was Maxijul (Maxijul is a weight gain supplement prescribed by the persons GP), directions were contained within the Medicine Administration Record (MAR) and they would update this person's nutritional care plan accordingly.
• Another person living at the service had been assessed as needing a gluten free diet. Records showed and staff confirmed this person was regularly having foods which contained gluten. For example, whole grain

breakfast cereal. Staff told us that they always offered a gluten free option, but it was their choice. One staff member said, "If they choose a pie that isn't gluten free. I always make sure they have gluten free gravy with it." We found staff did not recognise this as an opportunity to work with the person to expand their knowledge of what else was available to them or seek advice. We discussed what we found with the manager, who said the records were inaccurate as the person didn't like whole grain breakfast cereal, they normally have [….]. Records showed that this person's capacity or understanding of the impact this might have on their health, had not been assessed nor had the service referred the person to a dietician or GP.
• Records showed staff recorded people's food and fluid intake daily. We reviewed the entries recorded for one person with the manager, who confirmed the information recorded for this person was inaccurate, this meant these records could not be relied upon. We have shared our concerns with Plymouth City Councils safeguarding team.

The failure to provide safe care and treatment placed people at an increased risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff told us and we saw people could help themselves freely to food and snacks throughout the day and we saw the kitchen was well stocked with tea, coffee, and soft drinks.

Assessing people's needs and choices; Supporting people to live healthier lives, access healthcare services and support.
People's needs were assessed before they started using the service, the information gathered during assessments was used to develop care plans which helped staff to get to know people and meet their needs. The manager told us they had adapted their approach to undertaking assessments due to the pandemic. For example, by carrying out virtual assessments and relying on information provided by healthcare professionals.
• People were encouraged and supported to use a range of healthcare services and staff supported people to attend appointments were appropriate. Records showed some referrals had been made to healthcare professionals. People had the opportunity to see other healthcare professionals when required such as a dentist, albeit in line with Covid 19 restrictions.
• Each person had a 'Hospital Passport', which contained important information about them and their needs.

Adapting service, design, decoration to meet people's needs
Silvermead is a large spacious building set over two floors with bathroom and toilet facilities. There was a lounge were people could relax and watch television, which led into a conservatory were people were able to take part in arts and crafts and could freely access the large well-kept grounds. There was a large dining and kitchen, which was fully accessible to all the people living at the service. There were several notice boards around the service displaying information. Some of this was in easy read format with pictures. Within the grounds there were four separate bedrooms each with their own en-suite facilities.

Requires Improvement

Is the service caring?

Our findings

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

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

Respecting and promoting people's privacy, dignity and independence

At the last inspection, we found the service had failed to promote people's privacy and dignity. This was a breach of regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was no longer in breach of regulation 10.

• At this inspection we saw that staff treated people kindly and spoke with a genuine affection for the people they supported. A relative said, "The staff speak pleasantly and with respect to people there. It is a happy place."
• People's right to privacy and confidentiality was respected. People's personal records were kept secure and only accessed by authorised staff on a need to know basis. Conversations of a private nature about people were held in private and staff were careful not to be overheard.
• People's support plans now contained more information about what each person could do for themselves, although they continued to be less clear about how people could be supported to develop their life skills and increase their independence.
• People were supported to keep and develop relationships with those close to them and staff recognised the importance of family.

Ensuring people are well treated and supported; respecting equality and diversity
• Relatives spoke positively about the care and support people received. One relative said, "[Person's name] loves it there. It is a very, very nice place and the staff are positive." Another said, "It's the best place [Person's name] has been, a home from home, I have no concerns."
• People who were able to share their views with us, said they like living at the service, and the staff were kind and friendly. One person said, "I like all the staff, they're my friends." Another said when asked, "Yes I like living here."
• People who were not able to communicate with us verbally, looked comfortable with staff and showed in their expressions and behaviours they enjoyed the company of the staff supporting them.
• Staff we spoke with knew people well and understood what was important to them, be this their favourite football team, pastime or toy. However, we found more work was needed to increase people's expectations and ensure people were being fully supported to have equal opportunities within all areas of their lives and valued as individuals.

Supporting people to express their views and be involved in making decisions about their care
• People living at the service were encouraged to make some decisions about day to day matters such as food and clothing. Staff told us people were supported to express their views and were involved as far as possible in making decisions about the care and support provided. However, more was needed to ensure people were truly involved and seen as partners in their care. It was not clear how staff were engaging with people in understanding their rights, supporting them to have increased opportunities or make informed decisions.

We recommend the provider seek advice from a reputable source to develop care and support that is person centred, values people as individuals and supports them to make informed decisions about their care and support needs in line with their human rights.

• Relatives and those acting on people's behalf were provided with a range of opportunities to express their views about the care and support provided. One relative said, "Pre-Covid we had review meetings."

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 requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns
• We received mixed feedback about the way in which the service managed concerns and/or complaints. People who were able to share their views with us said they were able to talk to staff if they were unhappy about anything. One person said, "I can talk to my keyworker." Relatives we spoke with were confident that if they needed to raise concerns with the service this would be taken seriously and addressed. One relative said, "I haven't raised any complaints, it's the best place [person's name] has been." Another said, "Absolutely, I would speak to the manager and if I wasn't satisfied, I would ask to speak to the owner."
• Staff said they felt able to raise concerns, but they were not confident that they would either be taken seriously or acted upon. Four of the staff we spoke with said if you raise any concerns about people, they will listen, but not if its related to staffing or the home. One staff member said, "I'm able to raise concerns but there is no point, they don't listen." Another said, "I can, but the information is not kept confidential and everyone knows what you have said."
• Prior to the inspection we discussed with the manager two concerns raised by relatives. We reviewed the services complaints folder and found, neither of these concerns had been documented. We discussed what we found with the manager who was unable to tell us why this information had not been recorded. This meant the provider could not be assured that concerns had been appropriately investigated and responded to in accordance with the services complaints policy.

We recommend the provider undertakes a review of the systems in place to record and respond to complaints to ensure the systems in place are operated effectively in accordance with Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At the last inspection, we found improvements were still required in relation to people's care plans to help ensure they received personalised care and support. At this inspection we reviewed five people's care records; whilst we found improvements had been made both in terms of personalisation and structure, improvements were still required.

• Some of the care records we viewed were personalised, detailed and provided staff with the information and guidance they needed to care for people safely and in a consistent way. However, we found some people's support plans continued to lack detail of the support people needed to meet their health care needs, develop life skills and increase their independence. For example, one person was living with epilepsy. Guidance from health and social care professionals said that this person's epilepsy needed to be closely

monitored to observe for signs of increased tremor or seizure activity. Care plans and risk assessments were in place which detailed and described what type of seizure the person experienced, their frequency and what may trigger a seizure. However, there was no protocol or guidance in their support plan for staff to follow when the person experienced a seizure, such as recording and monitoring the seizure activity in a seizure diary. Staff told us the person had had recent seizures, but these had not been documented. This meant it was not possible to identify how frequently the person was experiencing a seizure to ensure they were on the correct treatment plan.
• Another person's support plan contained very little information about how staff could support them to develop skills by building on their strengths and maximising their opportunities to promote their independence. For example, there was limited information about what they could do for themselves or how staff could/should support them to maintain, increase and develop new skills.
• People's care records now contained more information about people's goals and future aspirations. However, records showed more work was needed to ensure people's opportunities were not limited by their own life experience. For example, people's records contained details of short-term needs/wants and everyday activities that most people take for granted, like buying a new bed, going out for a meal, watching TV or taking part in arts and crafts. Records did not contain any action that had been taken to encourage or support people to broaden their horizons or try new experiences.
• One-person's care records stated that their goal and aspiration was to go on a train. This person had lived at the service since 1986. In 2020, they had achieved their goal of going on a train for the first time. Another one of their aspirations was to go on a bus, at the time of the inspection this had not been achieved. Care planning would be further enhanced if staff were supported to fully understand the fundamental principles of the Right support, right care, right culture guidance which would enable them to support people in living ordinary lives.
• People were not being sufficiently supported or empowered to have choice or control over the way they were cared for and as such were not truly part of the care planning process. For example, there was little evidence to show how people were involved in the development of their care and whilst we saw people's care records were regularly reviewed, this did not involve the person.
• The manager told us each person's support plan was being regularly reviewed to ensure they accurately reflected the person's current care and support needs. However, we found staff did not consistently review all the information available to them as part of this review process. Reviews had not identified where information was missing or needed to be updated. For example, reviews had not identified that staff were not recording one person's seizures or that care records were not being updated following incidents. This meant the provider could not be assured that people were being adequately supported or receiving care appropriate to their needs.

We recommend the provider seek advice from a reputable source to develop care and support that is person centred and in line with the principles that underpin Right care, right support, right culture guidance.

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.

• Care records showed people had a range of communication needs. Staff knew people well and were familiar with people's different communication methods. Care records included information on people's preferred method of communication and whether they required any communication aids, such as glasses or hearing aids.
• Some people were unable to communicate verbally, or had other communication needs due to their

autism or learning disability. Therefore, some people made choices and communicated with the assistance of pictures, signs and symbols. This helped to ensure staff understood how best to communicate with each person.

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.
• Support plan's we reviewed included a list of people's known hobbies/interests. However due to the impact of COVID-19 'national restrictions', we have been unable to fully assess how the service was supporting people to lead normal confident, inclusive and empowered lives which maximises their choices and promotes their independence.
• The manager explained how they worked with people to ensure they were not socially isolated; they described the difficulties that had been placed on them as a service and people due to Covid-19 and the government restrictions. This had meant that due to the national 'lockdown' and people's individual vulnerabilities people had not been able to fully participate in community life or take part in things they enjoyed. However, records showed where possible and in line with government guidance, some people had been able to visit family, go shopping or to places they enjoyed such as the national marine aquarium. A relative said, "I know it's been difficult as [person's name] has not been able to go out, but staff have found other ways to keep [person's name] occupied through cooking, baking, music, dancing, and singing."
• People were supported and encouraged to maintain relationships with friends and family using social media, telephone calls and face to face visits. We saw during the inspection, relatives and people were able to visit in line with the government's national restrictions. Relatives we spoke with told us how impressed they were with the way the service had supported their contact throughout the pandemic. One relative said, "I have been able to visit, and I phone every day, staff keep me updated." Another said, "The staff listen and respond, and will always get back to me if they are too busy to take a call."

End of life care and support

At our last inspection we recommended the provider reviewed the systems in place to ensure people received appropriate end of life care and support.

• At this inspection we found systems and processes in place to help ensure people received the care and support they needed to have a pain free dignified death, had improved.
• Care records we viewed had in place an end of life care plan which was detailed, and more person centred; this helped to ensure staff understood people's needs and wishes. However, we found some improvements were needed to ensure people were fully supported to identify their needs and have their contributions recognised and valued. For example, we noted in one person's records some decisions were being made by the person's next of kin.
• All staff had received training in end of life care and the manager was in the process of completing St Luke's hospice 'Six Steps End of Life Care Programme'. They described how they would work in partnership with healthcare professionals to ensure people had a comfortable and pain free death.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people: Continuous learning and improving care

At our last inspection we found the provider had failed to ensure systems were in place to demonstrate the service was being effectively managed. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection whilst we found some improvements had been made, improvements were still needed, 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 registered provider did not demonstrate they had sufficient oversight of the service. The provider had written to the Care Quality Commission to request an inspection, as they were confident that all the concerns identified by the inspection undertaken in 2019 had been fully addressed. The manager and deputy told us they needed more time to fully address all the concerns and would have preferred the inspection to be later in the year, when they felt they would have made more progress in addressing shortcomings identified at the last inspection.
• Systems and processes to monitor the service were not undertaken robustly. This meant they were not always effective, did not drive improvement and did not identify the issues we found at this inspection. Issues included concerns with regards to recruitment, staffing, infection prevention and control, fire safety, care planning, management of risk, nutrition and hydration and MCA.
• Audits carried out by the provider and senior staff contained limited information and could not be relied upon as a source to measure quality and risk. For example, audits in relation to care planning, medicines and recruitment did not identify the issues we found at this inspection.
• We noted the providers monthly audit was being completed by the manager. This audit is designed to measure the performance of the management systems in place which are being operated by the manager. The managers audits contained limited information. We discussed what we found with the manager who told us the general governance and audit process was an area they knew needed to improve but had prioritised other areas of concern.
• An external audit of the service, commissioned by the provider, carried out in October 2020 identified many

of the concerns we found at this inspection. Insufficient action had been taken to address the concerns identified.
• Records were not always accurate or fully completed. For example, the rota did not always reflect the staff on duty. During the inspection the manager and deputy manager gave us examples of how extra staff support had been provided by local care agencies to meet peoples changing needs. However, when we asked how this was being recorded and/or when this took place as it was not evident from the rotas. The manager told us this was not being recorded.
• Poor judgements and decision making potentially placed people at risk of harm. For example, in relation to infection prevention and control as well as the service's fire safety arrangements.
• The provider had not ensured the manager and staff understood the principles of the MCA. This lack of knowledge and understanding risked compromising people's rights.
• The provider, manager and staff cared deeply about the people they supported. However, the culture of the service still did not reflect best practice guidance for supporting people with a learning disability. Neither the manager or staff were aware of the Right support, right care, right culture guidance published by CQC, or how the underpinning principles could be used to develop the service in a way which supported and enabled people to live an ordinary life, enhanced their expectations, increase their opportunities and value their contributions.
• The manager had made a number of changes following the last inspection. We found these had either not been effective or needed more time to fully embed. For example, we saw a number of care records had been updated and improved to reflect people's needs. At the time of the inspection the service employed seven care staff, we spoke with five. The five staff we spoke with told us they had not read them and did not therefore have an improved understanding of people's needs.
• The manager and deputy had been open and transparent throughout the inspection process and spoke passionately about their commitment to getting it right, but recognised they had a lot to learn and the service was not where it needed to be.

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 the last inspection, we found the provider had failed to notify the Care Quality Commission of significant events, which had occurred in line with their legal responsibilities. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4). At this inspection we found insufficient improvement had been made and the provider was still in breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

• The registered provider informed us they were not aware of their legal responsibilities in relation to duty of candour, that is, their duty to be honest and open about any accident or incident that had caused or placed a person at risk of harm. The provider had not notified the Care Quality Commission of significant events, which had occurred in line with their legal responsibilities. This included the notification of safeguarding concerns. When asked, the manager told us they were not aware that they needed to be reported and had not been directed to do so by the local authorities safeguarding team.

This was a continued breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics: Working in partnership with others

• Relatives we spoke with continued to have confidence in the service and told us the service was well managed. Comments included; "They were on the ball." and "I think it's well managed, [person's name] has been so much better since […] has been there." However, one relative said, "Silvermead is small and I think they lack experience on the management team, they need support to make the best use of local services."
• The manager was supported by a deputy manager, two senior support staff and a team of support workers. Each had recognised responsibilities and there were clear lines of accountability.
• The provider and manager had a good working relationship and the manager told us they felt valued, supported and if they needed anything all they had to do was ask.
• The manager told us they met with people living at the service regularly, however it was not evident how people's views were being used to develop and shape the service.
• Regular staff meetings took place to ensure information was shared and expected standards were clear. However, some staff did not always feel listened to or supported to raise concerns due to confidentiality.
• The registered manager and staff had good working relationships with partner agencies. This included working with commissioners, safeguarding teams and other health and social care professionals. However, they felt the support they had received over the last twelve months had been significantly impacted because of the pandemic.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure that recruitment procedures are established and operated effectively. Regulation 19(3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers skilled staff were deployed to meet people's needs safely. Regulation 18 (1)