National Schizophrenia Fellowship

Cricklade Road

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?	Inadequate
Is the service well-led?	Requires Improvement

Overall summary

We inspected Cricklade Road on 7 December 2015. This was an unannounced inspection. We also visited on 8, 15 and 29 December to continue our inspection. Cricklade Road is a care home run by the National Schizophrenia Fellowship, also known as Rethink Mental Illness, where up to six people who are experiencing a mental health crisis can stay. The aim of the service is to help people move on to more independent accommodation by providing support that meets their changing needs. At the time of inspection there were six people living at the home.

There was a registered manager at the service at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, 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.

People said they felt safe. However, we found significant risks to people due to the management of medicines. We also found risks to people's environment that meant people were not protected in the event of a fire. Staff did not have relevant risk assessments in place to ensure their safety. Safety checks on gas and electric and water temperatures had taken place.

Summary of findings

Accidents and incident reporting had been effectively undertaken. Staff had training on keeping people safe and understood the process of reporting concerns. Staff had been checked to ensure they were suitable before starting work in the service.

During the inspection we had received concerns there was not enough staff to meet people's needs. The registered manager was aware of the concerns with staffing. There was an ongoing recruitment campaign but they acknowledged it was difficult to attract staff to work in the service. Therefore there was a large reliance on agency staff who sometimes worked alone in the service. Agency staff did not have the necessary knowledge of people's needs to look after them safely and to protect their own safety. Care staff had received some training but not all relevant training had been provided, such as caring for people with physical health problems for example, diabetes or epilepsy. Staff said they felt supported but support meetings between themselves and management had not taken place regularly.

Staff had an understanding of the Mental Capacity Act 2005 and had received training. However, where risks were present such as self-neglect and the risk of fire due to people smoking in their rooms, capacity assessments had not taken place in consultation with other relevant professionals. This is important to consider people's capacity in making unwise or risky decisions which could affect them and other people in the service.

People told us the food was good but some relatives expressed concern about their relatives gaining weight and the effect this was having on people's health. People were supported to access health professionals or appointments. However, the service felt it was not always effectively supported by health professionals in their care of individuals. These concerns had not been followed up by the provider. Staff did not have regular team meetings to enable them to raise concerns and discuss issues collectively.

People in the service felt cared for. Staff spoke with warmth and care about the people in the service they supported and made an effort to get to know them well.

Due to staff being busy, some people felt they did not get to spend much time with the staff. People did not always get all the information they needed about the service despite them requesting this in the yearly survey.

People in the service did not receive care and support that was individualised to their needs. The method of support planning did not always consider all options other than setting goals to be achieved. Some people would not engage with goal setting and the flexibility to tailor support individually did not easily fit within the reporting progress used by the service. This meant that people did not always have the opportunity to be provided with care outside this model. Some goals that had been identified, had been noted as achieved but with no action recorded of how the goal was met. People did not have any organised activities but recognised that staff were very busy. People's days were therefore largely unstructured.

People in the service had little opportunity to be involved in saying or making changes they would like to see. Complaints were managed and monitored but people in the service had not been provided with information to tell them how to complain or report concerns if they needed to.

The service had systems and processes to assess and monitor that the service was of a good quality. However, these systems were not effective as they had not identified the issues we found at the inspection. The service did not have a clear vision of what they were hoping to achieve.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering the action we will be taking.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

Summary of findings

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. Medicines were not safely managed. Medicines were not being recorded properly and stocks not accounted for.

Fire risks were not managed to ensure people remained safe.

Risk assessments were not thorough and did not provide the information needed to keep people safe.

There were not enough staff to keep people safe.

People told us they felt safe.

Is the service effective?

Requires Improvement

The service was not always effective. Not all staff had been checked that they had the skills and knowledge to support people in the service.

People did not benefit from staff who applied the principles of The Mental Capacity Act 2005.

Staff did not always receive regular one to one supervision meetings to support them.

People had access to health care professionals.

Is the service caring?

Requires Improvement

The service was not always caring. People said staff did not have enough time to spend with them.

Staff cared about the people they were supporting and worked hard to support them.

Staff respected people's privacy and dignity.

Is the service responsive?

Inadequate

The service was not responsive. People did not receive support that was personal to them.

People were not given opportunities to access the community with the support they required.

People were at risk of social isolation.

Is the service well-led?

Requires Improvement

The service was not well led. The service had systems for monitoring and auditing the safety and quality of care in the service. However these were neither effective nor embedded within the day to day running of the service.

Summary of findings

The service was not achieving effective partnership working with stakeholders and professionals that were necessary to ensure people had a good outcome.

The service did not have a clear vision of what outcomes were being sought for people in the service.

Cricklade Road

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 7, 8, 15 and 29 December 2015 and was unannounced. The inspection team consisted of two inspectors, including a pharmacy inspector on 29 December 2015.

Before the inspection we reviewed information we held about the home, this included previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with three people who were living at the service and two relatives. We also contacted a health professional for feedback.

We spoke with four staff which included two mental health recovery workers, a service manager and the registered manager. We looked around the home and observed the way staff interacted with people.

We looked at records which included the care records and risk assessments for four people, medication administration records for all people living at the service and recruitment, supervision and training records for three staff. We looked at audits for maintenance, infection control, control of substances hazardous to health and legionella water temperature checks. We checked fire safety records including equipment, testing of the alarm, lighting and the regularity of fire evacuation tests, and information relating to incidents, and complaints. We reviewed audits and minutes of residents meetings and staff team meetings.

Inadequate

Is the service safe?

Our findings

People we spoke with felt safe, one person told us "Yes I'm fine thanks". We spoke with two relatives and they said their relatives had never expressed any anxiety about not feeling safe. However, a professional we spoke with expressed concern about people's safety in respect of medication and the staff's ability to manage a concern raised with the professional. They stated "To my shock, the project appeared to be very apprehensive about removing this medication even on my advice".

People in the service were not safe due to the management of medicines in the home. The home did not keep complete records of what medicines people were taking. We were told by staff that the people attended GP appointments, drug rehabilitation services, mental health services and pharmacies independently to receive medicines. For example, we found an empty pack of prescription drugs on a bedroom floor. People were also encouraged to buy their own simple remedies (e.g. paracetamol). However, the medicine policy stated that homely remedies should be recorded on a Medicines Administration Record (MAR) chart. This was not happening so staff were unable to know what medicines people were taking. This meant it was not possible to ensure people in the service always received a safe combination of medicines.

The medicine policy said that all persons should have a MAR chart. We saw that two people did not have a current MAR chart but were self-administering prescription only medicines. The home had a process that enabled people to self-administer their medicines which aimed to promote independence. We saw that one person was self-administering medicines but did not have a completed risk assessment. Therefore, it was not possible to say if the individual was safe to manage their own medicines.

The MAR charts were often handwritten but the care home medicine policy was not always followed to ensure that the entries were signed by two people. We saw allergy status, patient details, medicine details and dates missing on handwritten MAR charts. The information on the MAR charts was not sufficient to ensure that people received the right medicines.

We saw a dosette box for one person that had medicine packed for the wrong time of day and the pack also contained a medicine that had been stopped in August 2015. Staff were removing the discontinued medicine and changing the time that one medicine was given. When the person went on leave, the medicines were secondary dispensed into another container. The staff did not have the training to carry out these processes safely. We also observed a staff member using medicines from the returns cabinet as a person's current medicines had run out. The following day this returns medicine was still being used. A call was made to the pharmacy by a different worker on duty requesting a new dosette pack from the pharmacy which was in place from 11am. Agency workers had not been assessed for competency for administering medicines. This increased the risks of drug errors as at times only agency staff were on duty.

The home had a safe process for the disposal of unwanted medicines. Medicines administered by the staff were stored securely and at the correct temperatures. However, medicines in people's rooms were not always stored securely. Staff were not aware of what medicines were in the rooms. This meant that people could access medicines that were not intended for their use and which could potentially harm them. Checks on medicines kept in people's rooms were on the weekly room check list. However, these checks had not taken place since October 2015. This meant it was uncertain if staff knew whether these medicines were securely kept.

We saw a care record stated a person was at risk of not taking their medication. A note was seen stating 'Staff should monitor all medication and check for swallowing'. A staff member we asked was not aware of this guidance. This meant there was the risk of this person coming to harm if staff had not checked the medication had been taken and swallowed.

People were smoking in their rooms which presented a fire risk. These incidents of smoking meant the fire alarm went off regularly. Due to the frequency of these alarms people in the service were not responding. There was a covered area for smoking, but people in the service did not use this often and mostly smoked in their bedrooms. During the inspection, the fire alarm went off and only the inspectors and staff left the premises. All people in the service remained in the house. A member of staff said the fire

alarm goes off regularly during the night. People were free to leave the building as they wished and did not sign out. Therefore, staff would be unsure who was in the house in the event of fire.

The risk of fire was increased due to the state of the bedrooms which were heavily littered with rubbish and mattresses and duvets had no bed linen on them and were stained. This presented a risk due to people smoking in their rooms and the amount of flammable items which increased the risk of fire further. As room checks had not taken place these conditions were not being effectively monitored and managed. The fire risk assessment had been reviewed in March 2015 and rated as medium risk. It stated that all tenants should adhere to the smoking policy which states no one is able to smoke within the house unless an assessment is carried out and that fire checks should be done weekly. The weekly fire checks were completed but we saw a note stating 'Set off by person in room smoking'. During our inspection we saw no evidence that this was followed up and what actions were taken to mitigate further risks.

We also saw the fire policy had been updated in January 2014 and was due for review in January 2015 but had not been done. This policy stated 'where smoking is permitted in bedrooms/flats heat detectors linked to the fire alarm are recommended with the addition of separate smoke alarms (not linked to the alarm) which will reduce false alarms'. We saw a note that the fire service had suggested installing heat detectors. This had not been followed up by the service which, if it had, would have been a protective factor.

Risk assessments were not always in place and were not always reviewed regularly. A risk assessment for the Administration and management of medicines was rated as low risk. This was completed on 9 December 2013 and should have been reviewed in December 2014. This had not been done. Other risk assessments such as the cleaning of rooms where people smoke had not been updated since February 2014. It was scheduled to be reviewed in Feb 2015 but had not been completed. Risk assessments had not been carried out for people who smoked in their room. This put people at risk of harm as accurate risk assessments had not been carried out.

We saw a local policy on 'lone sleep in shifts' dated January 2013. This outlined the process staff followed for safe working practices for sleeping in. Staff are expected to retire to the sleep in room after the other staff member leaves and after building checks completed. It stated all staff should have a risk assessment which should be reviewed regularly. We saw no individual risk assessments for staff and were informed by the registered manager that these were not available. We spoke with staff who said they did not always feel safe at night working alone and were concerned at times when they had to leave the locked sleep in room to use the bathroom. The risk assessment for agency workers stated that if they were working in the service on a sleep in 'please ensure that the sleeping in the services lone working risk assessment is printed off and read and signed by the agency worker as well as the contingency plan prior to their shift commencing'. We found no evidence of these on any records.

Risks to people had not been fully assessed. Safety management plans had not been completed for all people. The safety management plans provided information that formed the basis of 'safety alerts'. These safety alerts were designed to provide staff with accessible information of up to date risks that people presented. We saw an audit of Cricklade Road in October 2015 which identified that not all safety management plans had been completed. When we inspected in December 2015, some had been updated and we saw an alert for one person on smoking risks and regarding finances. However, this person was also at risk of falls, and there was no alert or management plan for this risk. Only safety alerts deemed high risk were in place for staff to refer to but we saw some alerts about challenging behaviour had not been undertaken. Another person was prescribed some emergency medication but there was no risk alert or explanation about the use of this. The service had ensured this was updated following our first inspection visit.

Staff we spoke with were not always aware of risks that some people could present. For example, an agency worker was not aware of potential risks that a person presented to women. This was despite this information being available in care records along with actions staff members could take to mitigate the risk.

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

Staffing levels consisted of two people per shift with two shifts per day and one staff member sleeping in overnight from 10 pm. We were told that staff numbers are assessed on basis of risk and that another staff member can be

Is the service safe?

deployed if a person's risk increases due to them becoming mentally unwell. A member of staff told us that "We are very pushed for time and can't spend much time with individuals" and "We spend a lot of time on paperwork and now cleaning rooms". Another staff member said they felt: "Disillusioned and would like to do more therapeutic support with individuals than the current staffing allows for". The current staffing levels were not sufficient to cover the routine care and support, alongside managing and supporting people with high level risks associated with complex mental health issues.

There was a high usage of agency staff and checks regarding their suitability were managed by the agency. Agency staff had not been assessed by management at Cricklade Road to check their competency of managing medication and other risks such as challenging behaviour. We were told that agency staff undertook two or three shifts with permanent staff before working alone but we saw no evidence of paperwork confirming this in their induction paperwork. It was stated to us that agency staff worked frequently in the service and at times only agency staff were on shift. This meant people were being supported by staff without their suitability and experience being assessed to ensure they were safe to work alone with people at Cricklade Road.

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

Prior to staff starting at the service, the provider checked their suitability to work with people who lived there. This included references from their previous employers and Disclosure and Barring Service (DBS) checks. The DBS assists employers by checking people's backgrounds to prevent unsuitable people from working with vulnerable people. The provider ensured that, as far as possible, the staff employed were suitable to support people who lived at the service.

The provider had in place a system that managed accidents and incidents. Staff were responsible for recording these incidents which was then reviewed by the provider. This system included prompts as to when the service should inform external agencies such as the local safeguarding team and CQC. This information was then used to update risk management plans which were reviewed and analysed by the provider. This meant the provider was able to review any accidents or incidents to see what needed to be put in place to minimise them happening again.

Staff understood how to recognise and report abuse. Comments included: "I would speak with my line manager and record it in daily records", "If I was dissatisfied I would go further up the structure", "I would go to CQC, social services and the police, report to manager and if I wasn't happy then I would take it further". Staff had received training about safeguarding adults and understood the different types of abuse. Staff acted on concerns as one staff member said "We suspected financial abuse with [person]. We arranged a meeting with the Community Psychiatric Nurse (CPN), care coordinator and the person's relative. The CPN raised the safeguarding alert". We saw information on safeguarding was available in parts of the home and a whistleblowing statement was in office.

Safety of the premises has been audited and we saw an electric and gas safety check had been carried out in the past year. Water temperatures and legionella checks had been completed. Fire extinguishers had been checked and there was carbon monoxide monitors in the kitchen and laundry area.

Requires Improvement

Is the service effective?

Our findings

People were free to come and go from the home. At the time of the inspection, staff told us that no one living at the home lacked capacity to make a decision. Staff were aware of the requirements of the Mental Capacity Act 2005 (MCA). Staff expressed some understanding, for example stating, "In mental health (MCA) could be affected by state of mind". Another staff said "We have it to safeguard and support people in their own interests and encourage them to do their own thing and support them". One staff member explained how they would carry out a best interest decision and who they would involve "I would involve the family, care coordinator and other professionals". Training had been undertaken about MCA and mental health.

However, the service was not acting in accordance with the principles of the MCA as capacity around their choices had not been fully assessed in view of risks to themselves and others in the service. For example, issues around neglecting their health, not taking medication, smoking in their rooms and not evacuating the premises when the fire alarm was activated. There were no best interest decisions documented about the impact on people and their capacity around making these choices.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). No person in the service had the need for a DoLS authorisation. A staff member we spoke with confirmed their understanding that people had no restrictions on leaving the property and therefore were not subject to the DoLS legislation.

Staff we spoke with said there was a high use of agency staff and difficulty with recruiting permanent staff. One staff member said, "There's an ongoing issue with recruitment". We were told that once staff were recruited there were long delays processing staff through the central recruitment team at Rethink. Staff told us people often didn't start working at the service as they had to wait so long to start. A member of staff we spoke with said it had taken three months from being selected to starting to work at the service. As a result of these delays there was an impact on sufficient and suitably qualified staff being recruited and deployed to work in the service.

Permanent staff were supported to ensure they had the skills necessary to support people in the service. Permanent staff had an induction period in which they undertook training and shadowing duties with more experienced staff members. We spoke with two staff who described working with other staff when they first joined the service. They also said they had medication training and were observed three times to check their competency before being allowed to administer medication on their own.

Staff had completed training that included safeguarding, emergency first aid, basic mental health skills, managing conflict and personal safety, risk assessment, professional boundaries and fire safety procedures. One health professional we contacted said they did not feel that staff had a good knowledge and management of mental health issues and required more training. However, they said that staff would contact them if there were any concerns with people who lived at Cricklade, and the professional commented 'which is encouraging'. Records demonstrated how the manager had worked with staff individually to improve their career needs. For example, setting objectives for career progression. We saw one member of staff requested support to improve their communication skills. The manager had taken action following the request as the staff member had been booked on training for 'solution focused communication'.

Staff confirmed they were encouraged to increase their learning and told us about national qualifications. One staff member said that training in certain areas such as health support would be helpful in the having full knowledge for needs that people presented with. We did not see any evidence that staff had any training relating to complex mental health conditions, drug related issues, or how to support a person with epilepsy (other than that covered in emergency first aid). We asked the service manager how they checked staff understanding of the training they had received. They told us that they did this through group supervision. However we saw no evidence this had taken place from records or staff.

Staff did not have consistently regular support meetings with their managers. However, care staff told us there was

Requires Improvement

Is the service effective?

an 'open door' policy where they could approach management for advice at any time. Staff records did not evidence regular supervision meetings. This meant staff were not having regular opportunities to reflect on the way they were delivering their support in a highly challenging environment.

Team meetings for staff were not held regularly. These meetings are held to enable staff to discuss issues relating to the service and to give staff the opportunity to discuss subjects like safeguarding and any updates in practice. We were told that these should take place monthly. However, we only saw minutes of meetings in April and September 2015. Two staff members told us these meetings hadn't taken place regularly due to staffing levels.

People were encouraged to meet to discuss menu planning weekly. People using the service prepared their own food for breakfast and lunch and an evening meal was prepared for them. Staff said as people were free to come and go they would often eat food whilst out and also bring food back. This meant managing healthy diets was a challenge. People were encouraged to help prepare meals and sitting together for a shared meal was encouraged as much as possible in the evenings. One person stated "We get fed well" and another said "The food's okay". We spoke with two relatives who expressed concern at the amount of weight their relatives had gained and were worried about the effect on their health. However, the relative acknowledged that staff could not control what the person ate and were therefore restricted in what they could do to manage the person's diet if they went out of the service and ate.

People were supported to attend routine health care appointments and seek medical advice when needed. Care records included details of the outcome of these appointments and we saw information that people's care co-ordinators had been updated. However, concern was expressed by staff that once people were placed in the service, that requests for support to jointly support people with issues in the service, such as self neglect, were not always responded to when requested. For example, a staff member said advice had been sought about a person refusing medication but said they had no response back about this.

The manager told us they used a 'Physical Health Check' tool which supported people to identify their physical health needs. We were informed before the inspection that relevant professionals such as a diabetic nurse and GP's were involved with people in the service. However the physical health check tool had not been completed on all care files and there was no documented evidence that the person had declined to be involved in completing this tool. We saw a blank health check tool in one file. This meant that not all people had relevant information about their physical health that they may need support with.

Requires Improvement

Is the service caring?

Our findings

We witnessed mostly positive interactions between staff and people using the service. Feedback from people we spoke with at the service confirmed they felt staff were kind. When asked what the staff were like, one person told us, “They are okay”. Another person said “Yeah, I feel supported”. We saw results from a yearly survey done in July 2015 which asked people if they felt they were treated with dignity and respect and four people out of six had responded positively to this question. We spoke with two people in the house and both expressed they would like to spend more time with staff but were aware they were often busy in the office.

During the inspection we observed people wandering around with no particular purpose and people sat looking at the radio with no other stimulation. Whilst being showed around the house we were introduced to a person in the kitchen with bare feet. The staff member directly referred to having to wear shoes around the house but no explanation why. An inspector added that the person’s feet may get cold and got a positive response to this reasoning. We later discussed this interaction with the staff member who said they felt frustrated at times about people not responding to staff’s attempts to motivate them to help them move toward more independence. This has at times led to staff feeling frustrated. They said “Staff have given up with being too nice and just want people to listen”.

However, we saw other interactions that were friendly and demonstrated a good relationship. A professional we contacted said, “The staff always seem to be friendly and spend time with the service users which I am always pleased to see”. We were talking to a person about living in the service and they were joking with the staff member and appeared to have a good rapport, discussing about when they went for a walk together. We spoke with two members of staff who clearly had a good knowledge of people in the house and their likes and dislikes, i.e. people’s dietary preferences and how people liked to be interacted with in a particular way.

A staff member told us about buying birthday gifts and how they tried to ensure that the gifts were relevant to the person, for example, a personalised t-shirt and a book that someone wanted. Talking to all staff during the inspection, it was clear from the way that they described people and spoke about them that they cared very much. They spoke of how keen they were to try and improve people’s outcomes. However, there was a sense of frustration that they would like to be able to spend more time with people and being able to go out more often with them. They expressed that they hoped this would happen when they had a service manager full time in the service.

Information was not always provided to people about the service. The service stated in information provided before the inspection that people have access to a welcome pack to provide them with information about the service and other things like local facilities. We did not see the welcome pack as it could not be located at the inspection.

People told us that their privacy was maintained. Staff knocked on the bedroom doors before entering and asked permission to go in. People had signed an authority to process and disclose information.

Inadequate

Is the service responsive?

Our findings

People were not receiving person centred care. People's support plans were standardised across all Rethink services and were modelled on the Recovery Star. This meant people identified their own goals of what they wanted to work towards so that staff could support them in this. A self-assessment was completed by people to identify how much assistance was needed to help them manage aspects of their lives such as self-care and mental health. Goals were set about achieving certain tasks and were reviewed to provide evidence of people's progress. However, some paperwork had not been completed. We spoke with the manager about this who stated "He doesn't want to do it; we don't have an alternative option". We asked about other options but a staff member told us that this was the support model for the service. This meant that appropriate care and support was not always provided in a person centred way.

Some staff questioned the effectiveness of this model of support planning as they felt that some people did not have a realistic view of the support they required. Staff felt motivation for people to complete goals was not achieved as staff did not always have the time to work with people on meeting them. The recovery star required goals to be achieved in certain timescales. For example, a person had set a goal in April 2015 of 'Staff to assist [person] to go and purchase seeds and plants where applicable'. This was recorded as achieved in September 2015 but we saw no evidence whether this had happened or not. This meant the planning and reviewing of people's support needs and care were not person centred.

Support and safety management plans had not all been completed. We saw evidence from an audit in October 2015 which noted that people were not being involved in these and plans were not all signed by the person. Although we saw some evidence that this was in process, there were still a number of support plans that had not been updated. This meant that staff did not have immediate access to important information that they needed on a day to day basis.

Staff were not always aware of relevant and important background information which was recorded on people's assessments. For example, one member of staff was unaware of a person's background and how active they had been in the past. Prior to moving to Cricklade they held a job and had good family relationships. Although these details were recorded in this person's care records, staff were not aware of it. Since moving to Cricklade Road this person had become withdrawn. The provider had not investigated the change in this person. A staff member we spoke with was unaware of what service the person had moved from and the reasons why. We saw no evidence of relevant information being shared adequately when a person moved into the service. We looked at a person's care records and found no evidence of any support provided to them in making informed choices about their care and how to encourage them to return to their previous activities.

Some people's support plans had not been reviewed with the appropriate health professionals. It is important to have regular reviews to ensure that people are getting the appropriate support needs and where these needs change, these are updated and relayed to staff.

There were no planned activities offered to people. A staff member said "We need to do more activities but I feel like a cleaner. We just don't have enough time". A person told us, "I keep myself to myself, I don't really do much". We discussed staffing with the service manager who felt there were not enough staff to give people the input and time to engage with the community that they needed. For example, a person in the service had asked staff to go to town with him. Staff capacity was such that they could not support this, so the person stayed in the home. A staff member said they felt that the skills and training for staff to engage with people with low motivation were needed. This would assist staff to start supporting people at a basic level rather than setting goals that may not be achievable. For example, a staff member stated "[person] is great at cooking you just have to get them in the right mood" and "It's about doing with not doing for".

People told us that their needs were met by the staff team, and we observed staff being responsive to people's needs during the inspection. However, one person told us, "I would like to do more with staff but they are too busy in the office". Another person stated "The only problem I have is that you don't have a key worker so it's hit and miss".

Resident meetings were not held regularly. These should be organised to ensure that people have a say in how the service is run and to be involved in decisions affecting them. A survey to gather people's views on the service had been completed by four people and a question about

Inadequate

Is the service responsive?

whether they had received relevant and sufficient information on the service had stated 'No'. We asked what action had taken place to respond to this and were informed that more information was put in the welcome pack. A welcome pack contains information about useful and helpful information. However, we saw no evidence that a welcome pack had been completed or circulated. This meant people were unaware of what was available in the community for them to do. Staff told us they tried to encourage people to do things like walks or swimming but acknowledged that people would need support to undertake activities initially.

People should be informed how to make a complaint or report safeguarding concerns and information for this should be in the Welcome Pack which had not been completed.

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

Complaints were logged on the database which staff understood how to operate, how to record and the process of reporting. However, there were no complaints about Cricklade Road on the system. We were told that complaints were tracked until completion and reviewed by the head office of Rethink.

Requires Improvement

Is the service well-led?

Our findings

Rethink restructured their services in April 2015. A registered manager is responsible for all three services in Swindon. Each service should have a Service Manager to ensure the day to day management of the services are effective. Due to recruitment problems, the Service Manager had been covering all three services in Swindon and was not full time. This has clearly impacted upon the service being well led. This service presents with a number of risks which have been identified in this inspection report. We were informed that the issues identified in the inspection had been escalated to senior management within the organisation but we saw no evidence that this had happened.

The manager said they had raised issues around lack of reviews and lack of responsiveness from professionals. However, we saw no evidence how these had been raised by the provider and pursued if no response. There was no evidence of how people were assessed as eligible for the service and where the service had declined referrals due to risks or suitability for the service.

Due to the pressures on staff in the service, communication was described as "Grabbed conversations". It was difficult to evidence that there was effective communication between the service manager and registered manager. The registered manager was responsible for three services including Cricklade Road but also had other regional responsibilities which meant his time for all three services was quite limited. On the second day of the inspection, the registered manager and service manager had not discussed the findings raised the previous day despite concerns raised with the service manager. Other staff members felt that communication could be improved between all three services.

The provider undertook unannounced visits by a senior manager every 12 weeks to audit areas such as governance, stakeholder involvement, consultation, safety and staff management. We saw the last audit took place in October 2015 which reported that stakeholder involvement took place in the form of monthly meetings with the locality manager. The audit stated that contract compliance had not taken place as Rethink does not have a current contract with commissioners. Therefore, evaluation of how effective the service was could not be checked as monitoring reports were not submitted. Staff management files had not been checked as there was no-one available to access the files during the unannounced visits in July 2015 and October 2015. The audit had also stated that regular residents meetings were not taking place. We saw no evidence of how people were actively involved to develop the service. The providers own audit had also failed to identify all of the concerns we found during this inspection, such as risks around fire safety and administration of medication.

There is no evidence that pre-assessments were completed with people in a person centred way that engaged the person, professionals and stakeholders. Goals were being set with people but not being achieved due to staffing levels and lack of motivation for recovery to commence or continue. Risks had not been fully assessed and we saw no evidence of records of decisions taken in relation to care or references to discussions with people who use the service.

The service did not have a clear and realistic vision of what they were trying to achieve. A staff member said "We have the tools to support a journey but are never clear on the destination". Another staff member said "The service was set up with no infrastructure, staff or even furnishings" and therefore had never really established an identity or vision of what they were trying to achieve for people. It was unclear what outcomes the service was aiming to achieve, for example, moving people towards independence with goals set and achieved, or a care home to assist people in day to day care tasks. This was compounded by the lack of clarity as no contract was in place with the commissioners and there was lack of clarity of people's expected outcomes.

Although the service is meant to support people to gain skills to move onto independent living, it is clear that for most people in the service they are not engaging with the support to enable this to happen. This is partly due to lack of joint working and support from professionals with the service to ensure people are receiving care that meets their assessed needs. There is the potential for people to become institutionalised and not make progress due to lack of relevant training and too few staff for people to be sufficiently supported to gain independent skills. People were not being supported to engage with the community which places them at risk of becoming more socially isolated which could have an impact on their mental health.

Requires Improvement

Is the service well-led?

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People were not receiving care which met their needs and was appropriate. Regulation 9(1) (a) (b) (c) People had not always received appropriate care as the service has not acted in accordance with the Mental Capacity Act 2005. Regulation 9 (2). People had not had regular reviews of their care and treatment with relevant professionals. Regulation 9(3)(a). People were not provided with support to understand all the risks and benefits of choices to enable them to make informed decisions about their care and treatment. Regulation 9(3)(c). People view's were not actively sought about how care and treatment met their needs. Action was not demonstrated about any feedback. Regulation 9(3)(f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People's health and safety risks were not always assessed. Regulation 12(2)(a) Reasonable steps to manage identified risks had not been actioned. Regulation 12(2)(b) People were not always receiving care from people with the right skills and experience. Regulation 12(2)(c) People were living in premises which were unsafe due to risk of fire. Regulation 12(2)(d) People were not protected by equipment (fire alarms) which is used in a safe way. Regulation 12(2)(e).

This section is primarily information for the provider

Action we have told the provider to take

People did not have sufficient quantities of medicines to ensure their safety. Regulation 12(2)(f)

People's medication was not safely or correctly managed. Regulation 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes had not been operated effectively. Regulation 17(1). The quality and safety of the service had not been assessed, monitored or improved. Regulation 17(2)(a). Risks to the health, safety and welfare of people using the service had not been assessed, monitored or mitigated to reduce the risks. Regulation 17(2)(b). Information that had been processed had not been evaluated to improve the practice of the service. Regulation 17(2)(f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not sufficient staff to keep people safe or assist them to receive appropriate care and support. The service had not assessed the skills of staff deployed in the service on a temporary basis. Regulation 18(1).