National Schizophrenia Fellowship

Cricklade Road

Inspection report

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Date of inspection visit:
03 November 2016

Date of publication:
05 December 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced inspection on 3 November 2016. 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 three people living at the home.

At a comprehensive inspection in December 2015 the overall rating was Inadequate and the service was placed into special measures by the Care Quality Commission (CQC). Four breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 were identified. 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. People and staff did not have relevant risk assessments in place to ensure their safety. People in the service did not receive care and support that was individualised to their needs. Following our previous inspections we had concerns with the general leadership and management of the home. A management team had been put in place to oversee the day to day running of the home until the appointment of a registered manager. Following the inspection, we received regular action plans which set out what actions were to be taken to bring the service up to standard.

We undertook another inspection on 4 May 2016 in line with our special measures guidance to see if improvements had been made. We could see that some action had been taken to improve people's safety but further improvements were needed to ensure people were safe. For example, risk assessments had not been completed for people that self-medicated and not all actions had been completed to improve fire safety. Staff had not undergone lone working risk assessments and were not receiving regular supervision to support them. Complaints had not been processed in line with the complaints policy. Systems and processes in place to ensure the regulations were met had not identified the issues we found in the inspection and therefore were not effective in keeping people safe. There were continued breaches in Regulation 9, Regulation 12 and Regulation 17 with an overall rating of Inadequate. Therefore, the service remained in special measures meaning significant improvements were required, or further enforcement action could be taken. Following this inspection we asked the provider to submit monthly actions plans.

At this inspection on 3 November 2016, we found considerable improvements in the service. The environment had improved noticeably and health and safety audits meant any issues that may cause concern were picked up on swiftly and actioned. The management of medication had improved, although there were some areas to improve upon. We have made a recommendation about the management of some medicines.

Staff had received appropriate training to support them in their roles and staff told us they felt well supported.

We observed pleasant and friendly interactions between staff and people who used the service. The people

with whom we spoke told us they were happy with the care they received

People had care plans in place which were person centred and provided relevant guidance for staff about how to care for and support people. These were reviewed at regular intervals and updated where necessary. We found that people were receiving support that was relevant to their circumstances and person centred to identify achievable goals to help them towards independent living. Activities had been discussed and were offered regularly to people in the service.

We found there were effective systems in place to monitor the quality of the service provided and regular checks were undertaken in all aspects of running the home. Commissioners had reported improvements in the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's medicines were not always accurately recorded. Where people managed their own medicines, their risk assessments were not regularly audited to ensure it was still safe.

The environment was safe and well maintained.

Sufficient experienced and trained staff had been deployed to work in the service and recruitment was ongoing to ensure suitable staff were employed.

Is the service effective?

Good

The service was effective.

Staff had the right skills to support people effectively.

Staff had received sufficient training and support enabling them to do their jobs effectively and safely.

People were provided with a choice of food and drinks to ensure their health care needs were met.

Appropriate arrangements were in place to assess whether people were able to consent to their care and treatment.

Is the service caring?

Good

The service was caring.

People we spoke with told us they were happy with the care provided.

People were treated with dignity and respect.

Staff demonstrated they understood and cared for people in the service.

Is the service responsive?

Good

The service was responsive.

Care records contained sufficient information to guide staff on the care to be provided. The records were reviewed regularly to ensure information was reflective of people's care needs.

People were being encouraged to become more involved in the community to avoid social isolation

Is the service well-led?

Requires Improvement

The service was not always well led.

The service did not have a manager registered with the Care Quality Commission (CQC) at the time of the inspection.

Staff spoken with told us they felt the management team were approachable and supportive.

The provider had listened to and responded to concerns raised by CQC and other interested stakeholders. This meant that people were receiving an improved quality of service.

Improvements made needed to be embedded into the service to ensure ongoing plans were sustained.

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 3 November 2016 and was unannounced. The inspection team consisted of one inspector and a pharmacist inspector.

Before the visit we reviewed previous inspection reports. We also reviewed the monthly audit plans the service had sent us after the last inspection in May 2016 to update the Care Quality Commission (CQC) on ensuring the regulations were being met. We reviewed notifications. Services tell us about important events relating to the care they provide using a notification which is a requirement of law. The methods that were used to inspect the service included observing people using the service and interviewing staff. We used pathway tracking which is capturing the experiences of a sample of people using the service.

During the inspection we spoke with five members of staff, and the person managing the service. We looked at three people's care records and three people's medicines records. We reviewed the staffing rotas for the past month and looked at three staff files.

We contacted the commissioners of the service to obtain their views.

Requires Improvement

Is the service safe?

Our findings

At an inspection in December 2015 we found that people's health, safety and welfare were not always safeguarded because there were ineffective systems in place to keep people safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We carried out another inspection in May 2016 and we found a continued breach of Regulation 12 as the management of medicines had not been adequately addressed and risk assessments had not addressed all potential risks, such as the risks around epilepsy. At the last two inspections, staff did not have a lone working risk assessment as stated in their policy. We saw these had been completed at this inspection on 3 November 2016.

People were not keen to speak with us so we respected their right to do so. However, we did have brief conversations throughout the day and observed staff with people. We spoke briefly with three people who, when asked if the service felt safe replied "Yes it is". One person said "Things have got better".

During our inspection, we looked at the systems in place for managing medicines. We spoke to staff involved in the governance and administration of medicines and examined three people's medicine records. There had been significant improvements made to the medicines management in the home. However, there were still some aspects that required improvement.

The provider stored medicines safely. There was a dedicated medicine cupboard and refrigerator and if a resident kept medicines in their room, they locked the door when unattended. The home had a safe process for the disposal of unwanted medicines. There was good stock management and the staff liaised with the GP, pharmacy and mental health provider to make sure medicines were always available. To help the person take their medication more regularly, staff had spoken with the community mental health team about changing the time of administration of a medicine for one resident. The resident had not missed taking their medicine since the change to the administration time.

Staff spoke with people about their medicines to make sure they understood what they were taking and to give an opportunity to ask questions. Staff could refer to the medicine file for information leaflets about people's medication.

While there was a MAR (medicine administration record) in place for all service users, the MARs were not updated every month and we saw two MARs that did not reflect the resident's current medicines. For example, the GP had changed a medicine for one resident but it had not been added to the MAR. Staff regularly made handwritten additions to the MARs but the additions were not always signed by two members of staff; this was against the provider's policy.

We recommend that the medicine administration record should reflect the person's current medicines. MARs should be completed in line with policy and good practice.

While staff encouraged residents to manage their own medicines if appropriate, the processes around risk

assessments and auditing of self-administration were not robust. Staff did not routinely check that residents were managing their own medicines safely. Risk assessments were not completed for all medicines being self-administered and were not reviewed in a timely way when necessary.

We recommend guidance is referred to for when people self-administer medicines in respect of risk assessments and frequency of re-assessment.

All staff had completed online medicine training. We were told that all staff administering medicines will be competency assessed once a year; this will take the form of three observations.

In September 2016 the service started doing weekly medicine management audits. The audits picked up areas for improvement and changes had been made which enhanced the safe use and administration of medicines.

At the last two inspections, we found that risks to people had not been fully assessed. At this inspection risk assessments had been completed and were recorded on one document called a 'Risk Assessment and Management Plan'. For example, a risk assessment detailed self-neglect. The control measures were noted, such as reminding the person to have a bath (staff to run if needed). Another risk gave details of signs of mental health deterioration such as rocking, and music volume. Guidance on seeking appropriate medical support was given. Staff we spoke with confirmed they liked the new risk management document and found it easier to refer to for guidance.

Where there were continued risks in connection with people smoking in their rooms, the service had taken appropriate measures to minimise these. For example, all the bedding and mattresses were flame resistant and fire alarm tests were taking place regularly with people leaving the premises. People were slowly starting to smoke more in the outside shelter but the service was realistic about changing long term habits. However, people were being encouraged to adhere to this, which was in line with the advisory notes from the fire service about staff continuing to challenge people about smoking in their rooms on an ongoing basis. A staff member was specifically responsible to oversee fire procedures and infection control. Control of substances hazardous to health (COSHH) had been developed and the staff member responsible showed us the records kept in respect of these. This meant areas of responsibilities were managed by one person who had a good overview of the situation reducing risk.

Daily room checks were taking place to ensure that risks were minimised in respect of fire hazards due to people still smoking. Staff described this as gradually improving and they had discussed with people about the best ways of maintaining the rooms. This was done respecting individual's choice of time to do this and what level of assistance needed, if any.

There was adequate staff to support people. Agency staff were only being used on an infrequent basis. If agency staff were needed, the service only used agency staff who had worked with the service before. Agency staff were given appropriate training where needed to support people in the service. Staff we spoke with said staffing had improved and a keyworker system had been introduced which improved continuity for people in the service.

Records relating to the recruitment of new staff showed that relevant checks had been completed before staff worked unsupervised at the home. These included employment references and disclosure and barring checks to ensure staff were of good character. People were therefore protected from the risks of having unsuitable staff to support them.

Staff had received training to understand and use appropriate safeguarding policies and procedures. Staff had followed local safeguarding protocols and made appropriate referrals to the local safeguarding team.

Good

Is the service effective?

Our findings

At an inspection in December 2015 we found that people were not supported in line with the principles of the Mental Capacity Act 2005. 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. Where self-neglect was a risk, people had not been provided with support to understand all the risks and benefits of choices to enable them to make informed decisions about their care and treatment. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we checked whether the service was working within the principles of the MCA. There was an up to date policy and procedure for MCA. We saw evidence in the care files we looked at that people were all deemed to have capacity and therefore no best interest decisions were recorded. Staff had received training on the Mental Capacity Act 2005 (MCA) and showed a good understanding of the principles of the Act. People's consent had been sought to agree with their support provided.

Staff had been supported to carry out their roles and responsibilities. Staff told us they received regular supervision meetings and we saw evidence of this in staff files. Supervision provides the opportunity for staff to discuss their work, training and development and any concerns they may have. How staff wanted to be supported in supervision was documented on their records. For example, a staff member had recorded they "Want to be listened to, helped if needed and come up with solutions". Staff comments included, "Yes I have supervision each month" and "I feel my skills and past experience have been recognised".

Staff completed an induction period where they undertook training and shadowed more experienced staff. One member of staff said they felt confident following the induction and also remarked how helpful other staff had been.

Staff had received training including safeguarding, emergency first aid, person centred care, basic mental health skills, managing conflict and personal safety, risk assessment, professional boundaries and fire safety procedures. Staff had met weekly since the last inspection in May 2016. This had given staff an opportunity to discuss improvements needed in the service and to give support to each other.

People were encouraged to discuss menu planning on an ongoing basis. Staff told us people often discussed this at their evening meal and requests were respected where possible. People using the service prepared their own food for breakfast and lunch and an evening meal was prepared for them. The staff ensured the evening meal was a freshly cooked balanced meal with good vegetable content and people were encouraged to eat healthily.

People were supported to access health professionals when needed such as GP, chiropodists and community psychiatry nurses (CPN). The service kept a book about health appointments and if people

needed any support at these. During the inspection a staff member was asked to support a person at the hospital the following day as the person had requested that particular staff member go with them.

Good

Is the service caring?

Our findings

People were not keen to speak with us on the day of the inspection so we respected their right to do so. However, we did have brief conversations throughout the day and observed staff with people. We saw that people had a good relationship with staff on duty and we heard respectful conversations with appropriate humour. We spoke with staff that clearly had a good knowledge of people in the house and their likes and dislikes. For example, the food people liked and how people liked to be communicated with. This information had been noted so that people's preferences were known. A staff member said how pleased she had been when a person used her name when they spoke to her and thanked her. Staff said people were responding positively with them which was a step forward.

People had been involved in decisions about the general running of the home. Due to the risks in the service, people had been asked at one of the meetings to decide some 'house rules'. This included suggestions from staff but also people in the house were invited to put in what they felt would be helpful. These were then put in a bag and each one pulled out a discussion took place about whether it would work or not. For example, smoking in the house and the risks were discussed and it was agreed to be one of the rules they would try and adhere to. This meant that people were involved in developing a safe household and were not just given expectations that they did not commit to. This showed the service had recognised the importance of working with people to make positive changes in the service. Another person had taken on the job of updating the menu board each day on their own initiative.

Staff engaged with people in a caring way. We saw examples of people being encouraged to make suggestions of what they would like to do. For example, one person wanted to make some cupcakes from a cookbook recipe for the Halloween party. Another person said they would like to go to a car boot sale. Although the person often changed their mind when the time came, there was evidence of ongoing discussions and offers to go with the person to keep the motivation going. This showed that staff were aware of the need to encourage, motivate and persevere so that people felt supported and cared for. It also meant people felt staff hadn't forgotten about their likes and dislikes.

People were treated with privacy and dignity. For example, staff knocked on bedroom doors before entering and asked permission to go in. People had signed an authority to process and disclose their information to people who may need to look at this.

Staff understood when people were having difficult periods in their life and how this impacted upon them. For example, one person was awaiting some medical results and staff understood how this was impacting upon the person's mood and them becoming less motivated and worried. They were aware of the need to support the person and to reassure them.

We also heard that a person's behaviour had escalated following a situation. The staff looked into why they may be behaving that way and they found evidence that the particular situation was a trigger for this person. They put this into the risk assessment and management plan with ways to manage the anxiety. The staff member also came into the service whilst off duty to reassure the person as they knew them well.

We saw in one person's records an awareness that their family dynamics meant that if bereavement were to happen that the person would need extra support due to their close relationship and the impact this would have upon them. This showed staff had an awareness of people's vulnerabilities and the need to make people feel cared for at all times.

Good

Is the service responsive?

Our findings

At the inspection in December 2015, we found that people were not receiving person centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We received an action plan following this inspection that stated support plans would be improved to ensure they were effective, inclusive and reflect the needs of people in the service. At the last inspection in May 2016 we saw that records had been updated but we found that they were still not person centred, or involved the person they concerned.

At the last inspection people were not engaging with the support offered by staff to enable their mental health to improve. At this inspection, we saw clear evidence that people had been provided with opportunities to discuss their support on a weekly basis. These support sessions took place at a time chosen by the person and were with their keyworker. Records were kept after these one to one sessions and information was recorded such as motivation levels, mood levels and goals people were aiming for. For example, one person had said they wanted to attend a social group. Their keyworker had found a group that met weekly and had done a lot of preparation and discussion with the person about attending for the first time. The person had asked the staff member to go with them to support them but to sit separately. Staff would discuss at team meetings how people were getting on and records showed that progress had been made. The importance of the sessions being tailored to individual needs was evidenced. For example, a staff member described how on one occasion the person they were supporting was not keen to sit and discuss how they were. However, they had a chat whilst unloading the dishwasher about the issues they would normally sit and discuss. The person's permission was sought before making some notes of the conversation which the person happily agreed to, read and signed their agreement. This meant staff were finding ways to respond flexibly but also ensuring this information was recorded to evidence progress.

There were also weekly house meetings which discussed more general issues. The group meetings discussed suggestions of activities people would like to try. For example, a Halloween party had been suggested and took place. Photographs showed people enjoying the food and decorations that had been put up. We heard that one person had taken care over their appearance and it was remarked that this was lovely to see. A person had suggested an 'Evening with the Dogs' and this was being planned as their Christmas party. Another event had been suggested and due to the cost, staff had approached the organisers to ask whether any discount would be possible in order for people to attend this. The organisers agreed and the event was in the process of being arranged. These activities meant people were being encouraged to start to engage in more social activities, reducing the risk of social isolation.

At the last inspection, the service was using Rethink's Integrated Support and Safety Planning (ISSP) tool. Staff told us this tool did not allow them to develop a person centred plan which was individual to the person. At this inspection we saw that new paperwork had been produced which meant more personalised planning could be developed. Care plans contained a 'one page profile'. This gave a summary of people's needs and information that enabled staff to know about the person before reading the whole care plan. This was a useful document for new staff that were getting to know people. For example, it detailed 'What is important to me?' One person stated how important music was as a coping mechanism. It also mentioned

their favourite food and aspirations. For example, one person had put 'Want to get back to normal'.

The support plan covered all areas of the person's needs such as medicines and personal care needs. It listed the support people may need to access health appointments. It also gave guidance around supporting people to reduce their smoking. For example, 'Staff to support [person] to smoke safely and off the premises. Support to access smoking cessation'. A signed consent form was on the file in respect of agreement to their care support.

Staff commented that the new paperwork was very helpful as it described people holistically and gave a good overview of a person and their needs. For example, a person was becoming agitated and by looking through the paperwork they identified that bereavement was a trigger. This was then incorporated into the support plan and the person was supported through a difficult period effectively.

People's care had been reviewed by the service and the relevant health professionals to ensure the support was meeting people's needs and aspirations.

Information about how to log a complaint, comment or compliment was displayed in the lounge. No complaints had been received by the service since the last inspection in May 2016.

Requires Improvement

Is the service well-led?

Our findings

At the inspection in December 2015, we found the provider and registered manager had not operated effective systems to monitor and improve the quality of the service. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection in December 2015 when the service was placed in special measures, Rethink sent regular action plans. When we re-inspected in May 2016, systems and processes were still not being operated effectively to ensure compliance with regulations. This meant the provider was still not identifying the issues we found. This was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection in November 2016, there had been significant improvements in the management of the service. A Quality Assurance Manager was in place and involved in supporting all the Swindon Rethink services since June 2016 in the role of an interim operations manager and had been closely involved in supporting the staff team to make the required improvements. The provider told us that the aim of this ongoing support was to continue to provide additional guidance, staff training and assurance that the improvements would be imbedded into working practices. An ongoing interim locality manager was in place and we were told they would continue to cover and provide a full handover to the new Registered Manager once confirmed in post. This would help support existing staff to continue improving the service.

We spoke with staff about the leadership within the service. Staff felt supported by the current management team, commenting, "[Role] has made a huge impact on the service", "All staff are great", "It's good to see everything falling into place" and "I can see the light at the end of the tunnel". A Service Manager is now in place at Cricklade who is responsible for the day to day running of Cricklade Road. Staff commented, "He's fine, making a difference", "He's hands on with good ideas and will help in any way" and "Nice to get feedback that you're doing a good job".

Following Rethink's business-wide restructure, a new post had been created within Rethink for a Head of Care Quality Commission regulated services in the South. This role was specifically designed to provide specialist and consistent high quality management and strategic direction for all CQC regulated services delivered by Rethink Mental Illness. The purpose of this was that new staff joining the service would benefit from additional support from the Quality and Service Improvement team as part of their induction.

The provider monitored the quality of the service. We looked at the systems in place to monitor the quality of the service. Regular audits were taking place in all areas of the service, for example, around medication, risk assessments, health and safety and quality and effectiveness of the support plans. These enabled the service to monitor and improve the quality of the service and know when action was needed. Since the last inspection, visits had been made by the Clinical Commissioning Group (CCG) who checked progress and had reported improvements.

Weekly staff meetings were being held regularly. One member of staff told us, "We have regular meetings as a team, where we discuss the people in the service and their needs". We saw team meeting notes where an

action was to discuss Wi-Fi for people in the service and develop guidelines for internet safety. We asked how this was going and the staff member confirmed they were currently working on this as a result of someone's request to have internet access. Team minutes also focused on improvement actions with the staff team working through an action plan to address all aspects of care, support, risk and the physical environment at Cricklade. Staff felt communication between them and management had improved. One staff member said "The service is better organised and systems in place help".

The home had policies and procedures in place, which covered all aspects of the service including safeguarding, whistleblowing, complaints and medication. Staff had access to the all the policies should they need to refer to them.

People gave feedback in their weekly meetings but also an annual survey was completed each year so people could comment on their experience in the service. The survey had not been completed at the time of the inspection but was planned.

We asked the local authority commissioners for their opinion of the service. We were told they had noticed significant improvements in the service.