National Schizophrenia Fellowship

Cricklade Road

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Cricklade Road on 4 May 2016. This was an unannounced 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 four people living at the home.

The service has a registered manager, but they were not present during this 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. An interim manager was covering the registered manager's absence and was present during the inspection.

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. There were also concerns relating to the management and leadership of the service. Following the inspection, we received an action plan which set out what actions were to be taken to meet the requirements of the regulations.

During our inspection on 4 May 2016, we looked 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. An issue raised at the last inspection relating to people not having risk assessments in place where the person was managing their own medicines had not been addressed.

There were no staff risk assessments in relation to lone working on staff files. We were told these had been completed but they were not available for us to see. We found risks to people's environment to improve fire safety had been improved but further improvement was needed to meet the actions the service had said it would take after the last inspection. Safety checks on gas and electric and water temperatures had taken place.

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.

People were still not receiving support in a person centred way. People were not always supported to identify and achieve personal goals. Where people had identified activities they wished to participate in they had not been supported to do so.

Staffing levels had not increased but permanent staff were employed by the service. This meant reliance on agency staff had reduced. Training had been booked to improve person centred approaches. Staff said they felt supported but not all staff were having regular supervision.

Staff had an understanding of the Mental Capacity Act 2005 and had received refresher training since the last inspection. However, we saw no evidence of capacity being assessed in relation to people keeping themselves safe around certain risks which could affect them and others in the service.

People had an opportunity to discuss what food they wanted and staff helped to ensure healthy food was prepared for people's meals.

People were supported to access health professionals or appointments. However, support to people who needed prompting about appointments had not always happened. There was an ongoing need to ensure the service and health professionals worked jointly in a timely way to improve the support required for people's recovery.

Staff had attended regular team meetings to enable them to raise concerns and discuss issues collectively.

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

Complaints had not always been evidenced as resolved.

The service had not ensured that the systems and processes in place to assess and monitor the service were of good quality and met regulations. Audits that had taken place since the last inspection had not identified the ongoing issues found in this inspection.

The service was working with commissioners to ensure that clear outcomes for individuals in the service were identified and worked towards.

We found the registered provider was in breach of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and rated as inadequate in responsive and well led. This means the overall rating for this service is 'Inadequate' and the service therefore remains 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.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from

operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

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.

There were ongoing concerns about fire risks and safe management of medicines.

People and staff in the service did not have all relevant risk assessments in place to keep them safe.

Staff had been checked before working the service.

Staff understood how to keep people safe as they understood the safeguarding procedures and how to report any concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

People had not always given their consent about the support they needed.

People were not always supported to attend health appointments if needed.

Staff did not always receive the support needed to enable them to carry out their roles and responsibilities.

People had sufficient food and drink and choice of these.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not given appropriate information and explanations about their support.

Staff spoke warmly of the people they supported and had shown thought around what the person may like.

People were treated with dignity and respect by staff.

Is the service responsive?

Inadequate

The service was not responsive.

People were not receiving individual person centred care that focussed on their preferences.

People's care needs had not been reviewed to ensure they received the right care and support.

Is the service well-led?

Inadequate

The service was not well led. Management had not made the necessary improvements to move the service out of special measures.

The action plan to monitor improvements had not been implemented effectively, as the issues we identified as needing action at the last inspection had not been fully addressed.

Communication between senior management and staff had not been effective to ensure progress had been made to improve the service.

Systems and processes in place had not identified the issues we found in this inspection.

Staff felt that the service was improving and showed a determination to ensure people were supported well.

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 4 May 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 action plan the service had sent us after the last inspection in December 2015 to say how they would make improvements to meet the regulations. 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 four members of staff, and the person managing the service in the registered manager's absence. We looked at four people's care records and two people's medicines records. We reviewed the staffing rotas for the past month and looked at two staff files.

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

After the inspection we asked the registered manager to provide us with additional information.

Requires Improvement

Is the service safe?

Our findings

At the 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 saw at this inspection in May 2016 that some improvements had been made to ensure the premises were safe from the risks of fire. However, issues relating to the management of medicines had not been addressed.

During this inspection, we looked at systems and processes in place for managing medicines. We spoke to staff involved in the management and administration of medicines. The medicines management processes in the care home did not assure us that people were always safe from preventable harm. The Rethink medicine management policy stated a local policy should be in place to support people to self-administer medicines. Staff could not show us a local policy. People purchased medicines in the community to promote independence; however, there was no risk assessment in place to determine whether people were able to manage their own medicines safely.

A person's monitored dosage system (MDS) contained a medicine that had been discontinued in August 2015. Each day staff removed this medicine from the MDS. Staff did not have the training to do this safely and although the service had tried to have this medication stopped by the prescriber this had not been successful. There would be a risk to the person if the tablet was changed by the pharmaceutical company and became difficult to recognise when removing it. This could result in the wrong medication being removed which could impact upon the person's safety.

When people went on social leave, medicines were secondary dispensed in to an unlabelled container. While secondary dispensing may be appropriate in exceptional circumstances, this increases the risk of errors. Therefore a labelled supply should be obtained from a pharmacy to make sure people take their medicines as prescribed.

While there was a medicine administration record (MAR) in place for all service users, the details on the MAR were not always complete. The MAR did not always state the form of medicines. For example, staff handwrote 'sodium valproate 300mg' on one MAR. Sodium valproate is available in tablet and liquid form. It is therefore possible that staff could administer the wrong type of medicine. Staff wrote paracetamol on one person's MAR without instructions on how it should be administered. There was not always enough information on the MAR to make sure people received the right medicines at the right time.

Staff told us they had medication training and were observed three times before being allowed to administer medication on their own. However, we saw no evidence of these checks on staff files.

At the last inspection in December 2015, we found that risks to people had not been fully assessed and safety management plans had not been completed for all people. At this inspection risk assessments, safety management plans and safety alerts had been completed but some areas of risk had not been considered. For example, a person who had epilepsy had no risk assessment or safety alert completed to mitigate the

risk and manage their care if they had a seizure.

At the last inspection in December 2015, people were smoking in their rooms which contained substances that could be combustible. Furnishings were not flame resistant. These issues increased the risk of fire. Following this inspection, the provider arranged for an urgent health and safety audit and the local fire service visited to assess the risks. These concluded that risk management in the service was 'adequate'. However, there were advisory notes from the fire service about staff continuing to challenge people about smoking in their rooms on an ongoing basis. Staff told us they were having conversations with people about this when it happened but people continued to smoke. We were told that a fire proof bin had been provided to allow one person to dispose of cigarettes safely and for it to be emptied regularly. However, we saw a plastic bin in the person's room. There was no risk assessment in place to identify how the risk should be managed.

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

People's care plans contained a summary of prescribed medicines. Staff told us they sent a copy of this information with people when they transferred to another care setting; this made sure they received the right medicines. At the last inspection in December 2015, people attending GP appointments, drug rehabilitation services, mental health services and pharmacies were receive medicines the service did not know about. This had the potential to be harmful if they interacted with medication the service was managing for people. The provider sent a letter in March 2016 asking service users to tell staff about medicines received from other healthcare providers or that they purchased. We saw this had happened. One person had purchased two boxes of paracetamol and the medicine was stored in the medicine cupboard and recorded on the MAR.

The home had a safe process for the disposal of unwanted medicines. While the medicines administered by the staff were stored securely and at the correct temperatures, people did not store medicines securely in their rooms. On the floor of an unlocked bedroom, we saw prescription only inhalers; therefore, other people could access the medicines. Staff told us they regularly reminded people to lock bedroom doors but they found it difficult to enforce the policy. The provider was buying bedroom furniture with a lockable drawer for the storage of medicines.

Daily room checks were taking place to ensure that risks were minimised in respect of fire hazards due to people still smoking. Plans were in place to replace the furniture including flammable protective mattresses. The fire service had also advised Rethink to consider installing less sensitive smoke alarms. The action plan said that Rethink were in discussion with the landlords regarding the options for the property.

At the last inspection in December 2015, we found there were not sufficient staff to keep people safe or to enable them to receive appropriate care and support. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection staffing had not increased. However, only four people were in the service at the time of this inspection which meant there were adequate staff to support people. Staff we spoke with said staffing had improved. They felt this had 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. For example, we saw a referral had been made over concerns that a person in the service was being financially abused. Staff understood how to recognise and report abuse. This ensured people were protected from the risks of abuse as staff understood how to manage concerns.

Requires Improvement

Is the service effective?

Our findings

At our inspection in December 2015 we found that people were not supported in line with the principles of the Mental Capacity Act 2005. 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 staff told us they had received refresher e-learning training in the Mental Capacity Act 2005 (MCA). 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. Assessments around people's capacity about understanding the implications of risks such as fire, medication and self-neglect on both themselves and others in the service had not taken place at the time of the inspection. We were told these were still outstanding as were to be done in partnership with the mental health team and these had not been arranged. We were told by the mental health team after the inspection that these would be organised as a priority.

People's consent had not always been sought. For example, we saw a Safety Assessment form completed on 8 January 2016 which had been signed by a staff member but not the person. The form stated "Please sign below to confirm that the information on this form is accurate and you consent to the guidance explained above". As this had not been signed, it was therefore unclear whether the person had consented to the information contained in the form or not.

People can only be deprived of their liberty so that they can 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). 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 were being met. No DoLS were in place in the service.

People accessed their own routine health care appointments and sought medical advice when needed. However, we saw on one person's records that prompting was needed to ensure they did not miss important blood tests, with a note saying, 'Staff to remind me to have bloods taken'. We saw a record dated 20 April 2016 stating "I have messed up with my last couple of blood tests I have an appointment on Saturday". There was no record about whether staff had reminded the person to attend these appointments.

Staff were not always effectively supported to carry out their roles and responsibilities. Most staff had taken part in one supervision session with the interim manager since the last inspection in December 2015. However, one member of staff had not had supervision since June 2015. The staff member said supervision was 'Hit and miss'. However, they said they did feel supported by the current management.

Staff completed an induction period where they undertook training and shadowed more experienced staff. One member of staff said they felt confident to start working more independently after their induction and felt supported. We spoke with two staff who described working with other staff when they first joined the service.

Staff had received training including safeguarding, emergency first aid, basic mental health skills, managing conflict and personal safety, risk assessment, professional boundaries and fire safety procedures. Further training was planned around person centred care. A staff member said they felt specialist training around substance abuse would be helpful.

Staff had met monthly since the last inspection in December 2015. They felt this gave them 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.

Requires Improvement

Is the service caring?

Our findings

People had not been involved in decisions about the general running of the home. There was no evidence that opinions had been sought or acted upon. This meant people's voices were not always heard and their opinions could not shape how their care was delivered. We asked the manager if resident meetings were held and we were told there had been one since the last inspection but only with one person.

People were not engaged with their local community. This would help ensure people felt less socially isolated. An information pack was still not finalised which would have contained some information about local activities and useful contacts.

We asked if anyone had been assisted by the local advocacy service to help them to express their wishes or in making decisions. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We were told no-one in the service had accessed this but staff knew of a mental health advocacy service if people needed independent advice.

Staff went out of their way to ensure people got presents that were appropriate for them for birthdays and Christmas. For example, one person in the service liked a particular type of animal and the staff ordered a book on this. Staff said they had also discussed with the person about going to visit a place where they may be able to see this particular animal. Another person liked a well-known musical. Staff had been looking for this DVD in various shops but had been unsuccessful. A member of staff ordered this on the internet so the person had a copy. The person was delighted when it arrived.

We saw positive interactions between staff and people using the service. Interactions were friendly and demonstrated good relationships had been developed. Humour was used appropriately. 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. Some of this information had been noted so that people's preferences were known. However, more information could have been recorded to inform care planning and support and to reflect the staff's knowledge of the people they supported, their preferences and what relationships were important to them.

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.

Inadequate

Is the service responsive?

Our findings

At the last 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 this inspection we saw that records had been updated but we found that they were still not person centred, or involved the person they concerned.

We saw no evidence that people had been provided with opportunities to be involved in making decisions about their care or treatment, such as one to one meetings or actions from conversations. The staff said that discussions did take place on an ongoing basis. However, there was no record to show that people's views had been actively sought about how their needs should be met.

We saw a 'New Service User Assessment' form had been completed for each person in the service. This provided an overview of the person for each area of their life and relevant history to help staff understand the person better. When people first moved to the service a 'First look at my Situation' document was completed. This document provides an opportunity to understand the person's situation and their support needs and is completed when they first move into the service. These detailed people's views on what support they may need and also listed aspirations. For example, we saw on one person's file they 'Used to do a lot of fishing'. However there was no record in the person's care plan to identify any personal goals relating to this interest. The same person had a support timetable in their file which only had 'Room check and clean' on it. There were no details of any activities or key working support to discuss activities with the person.

People's care records included a document called 'My Support Plan'. These were individual support plans identifying goals for individuals. Goals were not always clear. For example, one person's goal linked to 'Stay Safe' which stated 'Combustible material in the bedroom being caught alight by smoking materials'. It went on to say 'Since the blanket smoking ban has come into place, there is a higher health and safety risk as staff are noticing that residents are hiding their smoking materials in extremely flammable places, such as wooden chest of drawers filled with paper. Residents are stubbing out their cigarettes onto plastic surfaces such as window frames'. Under the heading, 'Plan to achieve my goal' it stated 'To be aware of the need of smoking in room/bed; falling asleep while smoking; build-up of combustible material; bad weather (resistance to smoke outside). Smoking ban has increased residents hiding their smoking paraphernalia in/on flammable places'. There was no plan about achieving the goal. The final part of the form was 'Support I need'. There was a list of tasks for staff to keep the place safe but no details of support to the individual. For example, it had 'Evacuate' and 'Check the building externally for signs of fire' but there was no guidance about prompting the person and having discussions about the risks of smoking. The 'Support Plan' signature for the person was blank so it was not clear whether the support plan had been carried out in partnership with the person to evidence their agreement with this goal.

People's care records contained a form called 'My physical health and wellbeing'. One person had a copy of

this on file which detailed the support they needed which included 'Staff to check that I have my inhalers when I am breathless'. A question asking what support the person may need to manage this was answered with a comment stating 'Stay in for depot injection'. This was clearly not linked to the use of inhalers and what support was required to ensure the person used these effectively and safely. Another person had epilepsy but there was no description of how the epilepsy may present and any risks or management needed to support the person. Therefore, it was not clear if staff had fully understood the purpose of this form.

People were not always supported to take part in activities identified in their support plans. For example, one person had set a goal on 25 February 2016 to go for a pub meal with staff and other people in the service. The timescale was set at three weeks. We asked if this had happened and were told it had not happened so far. This meant the goal had not been reviewed or checked to see if still relevant or any opportunities or steps taken to try to achieve the goal. People were not supported to engage in their local community or to take part in activities that would limit the risk of social isolation.

People in the service had not been provided with information so that they could understand their condition and the support they needed to assist their recovery. There was no information provided about the risk and benefits of any support considered so that people could consider the implications of not undertaking any of the care and treatment. There was no evidence of any discussion about what people should expect from the support provided to them in the service and any outcomes they were working towards.

Some staff told us that Rethink's Integrated Support and Safety Planning (ISSP) tool meant it was a challenge to ensure support planning was holistic and to interpret 'at a glance' what support the person required.

Some people's support plans had still not been reviewed with the appropriate health professionals to ensure people were getting the appropriate support to meet their needs. The management said these had been requested from the health professionals but they had still not been completed at the time of this inspection in May 2016.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, we reported that there had not been initial assessments completed on people when they moved to the service. At this inspection, we saw the service had completed these for people already in the service. Staff commented that the assessment information was very helpful as it described people holistically and gave a good overview of a person and their personality and relevant history which enabled them to see the whole person with positive aspects of their life rather than a collection of 'risks'. Going forward a contract was in the process of being finalised with the Swindon Mental Health Clinical Commissioning Group to specify referral and acceptance criteria and include quality and performance indicators to monitor people's care delivery.

We looked at the complaints received by the service. We saw two complaints had been logged since our last inspection. However, we saw a complaint about a member of staff had no resolution recorded. The other complaint had been resolved.

Inadequate

Is the service well-led?

Our findings

At our last 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. In addition, communication in the home was poor and people, their relatives and staff did not feel listened to. The service did not have a clear vision of the outcomes for people using 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 an action plan. This detailed what they would do to ensure the areas of concern found during the inspection were put right.

At this inspection in May 2016, systems and processes were still not being operated effectively to ensure compliance with regulations. The lack of appropriate management oversight and leadership identified at the December 2015 inspection meant the provider had failed to identify the issues we found. This resulted in people not having their care needs met. At this inspection in May 2016, a manager was in post to cover the absence of the registered manager and they were being supported to make improvements by a senior manager in the organisation. The change of management had meant there had not been the continuity to ensure ongoing progress had been made with the action plan.

During this inspection we found a number of areas that had been stated as completed on the action plan had not been assessed to see if the required improvements had been met. For example, the action plan sent on 29 April 2016 stated that a 'Full independent service audit replicating inspection methodology to review progress of action plan in site visits'. It was stated the current status was that two managers visited the service on 7th April and week of 11 April had occurred to carry out this audit. We did not see this audit on the day of the inspection or after the inspection when requested so it is unclear whether the audit had been carried out which may have highlighted the inadequacy of the person centred plans. Our findings from this inspection found the person centred plans were not effective or met the regulations. The action plan also said that an overall review of support planning practice had been undertaken and that there would be a schedule of contacts with CCG's regarding reviews available by 2 May 2016. We saw no evidence of these reviews and the manager confirmed these reviews had not yet been completed. We also identified ongoing issues in medicine management. We did not see any audits completed by Rethink which may have identified these issues.

At the last inspection in December 2015 we saw a policy stating that all staff should have a risk assessment for lone working which should be reviewed regularly. The action plan stated these had been done. We asked to see these at this inspection, but again management were unable to provide these for us to review. Therefore, it was not evidenced that staff had undergone any risk assessments to review their safety when working alone in the service.

Due to the lack of leadership, and partly due to lack of joint working and support from professionals, people were still not being supported to enable progression to meet their personal goals. People were not being supported to engage with the community which placed them at risk of becoming more socially isolated which could have an impact on their mental health. The action plan had said a range of involvement

strategies to get people's views would be developed. We were not given any information about what strategies had been tried.

Complaints had not been fully resolved. The delivery plan had stated that 'All complaints have clear feedback process recorded and agency and management are able to provide evidence on enquiry'. A service guide pack providing information to people in the service had still not been developed. This meant the provider did not have effective systems in place to ensure issues were identified and action taken to improve the service.

We asked the local authority commissioners for their opinion of the service. We were told they had ongoing concerns, including reviews which still needed to be organised.

Following this inspection, we met with senior managers to discuss the findings in this report. They stated a commitment to make the improvements identified. However, they had not identified the issues we found in this inspection. The delivery plan stated audits and actions had been completed, however we saw that audits had not identified issues and where actions had been identified they had not always been completed.

Communication between management and staff was not always effective. Staff said the support and expectations from more senior management in the organisation relating to actions needed to improve the service had not always been clear. Staff felt there was a lot of indecision. For example, redesign of risk assessments were on the fifth or sixth version. Staff told us this had resulted in additional workload which impacted on the time available to support people.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager at the time of the inspection in December 2015 was not currently in the service. Staff felt supported by their immediate management and felt the service was starting to improve. We had comments such as, "I feel optimistic" and "I feel able to be honest" and "Definitely on the up".

Regular staff meetings were taking place. One staff member told us they had attended a recent staff meeting where the manager had praised them for their hard work. The member of staff told us this had meant a lot to them.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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 support that was personalised specifically for them. Providers were not working in partnership with people to provide support to help them understand and make informed decisions about their support options. Regulations 9(1)(a-c) (3)(a-g)

The enforcement action we took:

Impose condition to submit monthly report of audits undertaken on care plans

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA (Regulated Activities) Regulations 2014 Safe Care and Treatment Care and treatment must be provided in a safe way for service users. Regulation 12(1)(2)(a)(b)(c)(e)(g)

The enforcement action we took:

Impose condition to submit monthly report of audits undertaken to ensure people's safety.

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)(2)(a-f)

The enforcement action we took:

Impose condition to submit monthly report of audits undertaken to ensure people's safety.