National Schizophrenia Fellowship

Bruddel Grove

Inspection report

4 Bruddel Grove
The Lawns
Swindon, SN3 1PW
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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We inspected Bruddel Grove on 7 and 8 December 2015. This was an unannounced inspection. Bruddel Grove is a care home run by the National Schizophrenia Fellowship, also known as Rethink Mental Illness, where up to five people who have enduring mental health problems are supported. 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 five 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's needs weren't always met because of a lack of staff. Staffing levels were not at full capacity and there was not a full time service manager to ensure the day to day management of the service was effectively carried

Summary of findings

out. There were long delays in recruiting staff. There was a reliance on bank and agency workers and we saw no evidence that agency workers competency had been assessed before managing medicines.

People said they felt safe. Staff had been checked before starting at the service to ensure they were suitable. Staff had an induction when they started at the service which they reported as "good". Staff had received training on recognising and reporting suspected abuse and the importance of reporting any behaviour from colleagues that may concern them. Regular meetings with their managers had not always taken place as per policy. However staff reported feeling supported.

Staff had not received all appropriate training to care for the changing health needs of people in the service, such as incontinence care and pressure areas.

People were supported to enjoy a balanced and healthy diet and were encouraged to prepare some meals for themselves if able. People had access to health professionals when needed.

Staff understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). These provide legal safeguards for people who may be unable to make their own decisions. No person at the service had any restrictions.

People felt cared for and their relatives told us the staff were caring. People's privacy and dignity was maintained when staff accessed their rooms. People were supported to get independent advice from an advocate if required.

People did not always have support that was responsive to their individual needs. There were no structured activities to ensure people were able to enjoy activities they may like to take part in. Staff had attempted to ensure that where people were being considered as ready to move to another service, these were planned. However, communication with other agencies meant these were not always planned effectively and involving all relevant persons.

Improvements were required to ensure the service was well led. Management was not consistent due to responsibilities at other complex services as well as Bruddel Grove.

The service's aims and objectives did not always relate to the people living in the service or reflect their aspirations. Working in partnership with other relevant professionals had not always been achieved to ensure people were enabled to get the best outcomes.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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?

Requires Improvement

The service was not always safe. Staffing levels had not been maintained and there was an absence of effective management in the service.

Staff had undergone thorough recruitment processes before they started working in the service to ensure they were suitable for the role.

Staff understood and practised their responsibilities for keeping people safe and recognising and acting upon signs of abuse.

Is the service effective?

Requires Improvement

The service was not always effective. Staff had not had training relevant to all of the care needs of all people in the service.

There were not enough staff that had the correct knowledge to ensure people were protected from potential health risks.

Staff had not always had regular meetings with their manager to discuss areas of work.

Staff had received training related to the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLs) and understood its principles.

People were supported to access health services.

Is the service caring?

Good

The service was caring. People and their relatives told us staff were caring.

People's privacy and dignity was respected by staff.

People had significant events such as birthdays celebrated with them and staff knew people well.

Is the service responsive?

Requires Improvement

The service was not responsive. People did not receive care that was planned to meet their individual needs and aspirations.

People were not taking part in many activities during the day.

People knew how to raise complaints and were supported by an outside agency if assistance was needed to support them with this.

Is the service well-led?

Requires Improvement

The service was not always well led. At the time of our inspection there was not a full-time service manager in the service. This meant the service did not always have consistent leadership.

The service's vision did not reflect people's actual experiences of the home

Summary of findings

The service had not formed an effective way of working in partnership with all professionals to ensure people were at the centre of the service delivery.

People's views had been sought from staff in relation to aspects of the home.

Bruddel Grove

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 and 8 December 2015 and was unannounced. The inspection team consisted of one inspector.

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 four people who were living at the service and two relatives. We also contacted a healthcare professional for feedback.

We spoke with six staff which included four 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, medicine administration records and risk assessments for two people. We looked at recruitment, supervision and training records for two staff. We looked at information regarding the quality and safety of the service as well as minutes of residents meetings and staff team meetings.

Requires Improvement

Is the service safe?

Our findings

People's needs were not always met in a timely way because of insufficient levels of staff. The planned staffing levels were a service manager, two staff per day shift and one staff sleeping in overnight. This arrangement was flexible to the needs of people using the service, for example, if a person required additional support at night two sleep in staff would be available.

Staffing levels were not at full capacity as the service was recruiting for a service manager and two mental health recovery workers posts. Staff did not feel there were enough staff. If a staff member had to support another person out of the house, this left only one staff member to support the other people. This meant alongside the absence of a service manager, people were at risk of not having enough staff to meet their needs. We spoke with a member of staff who commented on the long delays in staff commencing work in the service once they had been recruited. We spoke with the registered manager who confirmed this.

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

People told us they felt safe. One person commented "Yes" when asked if they felt safe in the home. They said if they had any problems they would "Talk to a member of staff". They also said they like to go the shops with a member of staff as "It makes me feels safe".

People's needs were assessed and risks associated with these needs were identified. Clear guidance was in place for staff to follow to mitigate the assessed risks. For example, one person we reviewed could present with behaviour that may challenge. Staff understood the guidance in place to identify triggers to these behaviours and de-escalate them if they presented. Another person was at risk of choking. Staff clearly knew and understood the risks and we saw a staff member sat with the person during lunch. Another member of staff, when asked about monitoring risks, said they would "Read through the care plan, risk assessment, goals and review and would see what is still working and what has changed". They went on to say they would "document any changes as this may show a pattern". With regard to challenging behaviour they said "Prevention is better than cure. First know your service user; know their trigger points and use diversion techniques if it helps".

People benefitted from a staff team that understood what actions to take in the event of an emergency. We saw emergency plans in place for people. For example, if there was a fire there was a clear procedure in place for each person and staff were able to give examples of these plans to us.

People were protected from the risk of being cared for by unsuitable staff because robust recruitment processes were in place. The provider had carried out checks to ensure staff were suitable to work with vulnerable people. Staff files contained checks such as references and Disclosure and Barring Service (DBS) checks.

Permanent staff had received training and were clear on their responsibilities and procedures in respect of safeguarding and whistleblowing. A staff member said "in regard to whistleblowing or emotional, financial or physical abuse we are the eyes and ears of our residents and transparency is important". We spoke with another newer member of staff who said they understood safeguarding and risk and would report through appropriate channels if they witnessed an incident or had concerns. The service had policies and procedures in place to report safeguarding incidents and concerns. There were no current safeguarding issues in the service at the time of the inspection.

People had their medication administered safely. We saw one staff member dispensing and the other staff completing the medication administration record (MAR). This was crosschecked on completion of administration. The person understood what their medicines were for and why they were taking it. We saw staff dispose of a dropped medication appropriately by placing it in a bag and labelling it. If medicines were refused staff contacted the Community Psychiatric Nurse, GP or out of hours surgery. There was a homely remedies policy and procedures had been followed. The only homely remedy in the service was paracetamol and we saw a note on records that a person had taken two of these the night before. One person had a risk assessment to self-administer their own medication. We saw their medicines were kept in a locked cupboard in their room.

Requires Improvement

Is the service safe?

The service used an online system of recording accidents and incidents. These were then assessed to identify patterns and trends. The nature of the incident, the dates and the people involved were included on the online report. A member of staff said the incident reports were checked by the area manager and registered manager which they analysed. However, not all staff had access to this system which meant there was a risk not all incidents and accidents were recorded in an appropriate timescale.

There was the annual PAT test for all electrical items during the time of the inspection.

Requires Improvement

Is the service effective?

Our findings

Staff mostly received relevant training to enable them to undertake most aspects of their role. This included basic mental health awareness, conflict management and personal safety, managing medicines, fire safety and safeguarding vulnerable adults. However, as people's needs increased the staff had not had training to learn and maintain the necessary skills to meet the needs of the people they care for and support, for example in personal care. There was a person in the service whose needs required a lot of personal care and support around eating and monitoring their weight. The staff had not received training in these areas and had identified that they did not feel equipped to support and manage personal care needs such as care of pressure areas, continence care, falls, nutrition and hydration. Staff expressed concern about providing adequate care for this person and said the mental health team were looking at options for this person's ongoing care.

There was a large reliance on bank and agency workers and we did not see any evidence that their competency had been assessed in respect of managing medicines or lone working. The impact of this on people in the service meant they were not always supported by staff that had the skills to ensure they were kept safe.

Staff had meetings with the manager to discuss their work. However, due to the manager's commitments elsewhere, these were not always held monthly in line with the policy. However staff we spoke with felt supported. A staff member said "Someone is always at the end of the phone if needed". Staff confirmed, and records demonstrated, that people had yearly reviews with their manager.

The service was reviewing staff training across all three services and an action plan had been developed.

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

New staff underwent an induction period in which they undertook training and shadowing duties with more experienced staff members. One staff member spoke highly of the person who had carried out their induction and felt they were given clear explanations about their role. A person we spoke with told of their experience working in mental health services and felt confident in their role in the service. New staff were undertaking the Care Certificate. This certificate has been implemented nationally to ensure that all staff are equipped with the knowledge and skills they need to provide safe and compassionate care.

People were able to enjoy a balanced and healthy diet if they chose to. People were encouraged to make their own breakfast and lunch. Staff said they tried to get people to eat together at supper time for a meal cooked by a member of staff. People got up at different times during the morning and prepared their own breakfast, mostly cereal and toast. People who required a specific diet were supported to follow it and were also being monitored in line with professional recommendations regarding their weight and fluid intake.

Staff we spoke with showed an understanding 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. People had their capacity assessed where appropriate and their consent was sought as required. We saw notes about a person who had recently refused a specific health test and the GP had assessed them as 'fully alert mentally'. This person had also signed an agreement to take prescribed medicines and to look after their personal care.

There was a no locked door policy to the front door at the home so people were free to come and go all day. There was a board beside the front door which people signed to say when they were out and expected back. People can only be deprived of their liberty 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). There were no DOLS in the home at the time of the inspection.

People had access to health professionals such as GP's, dietitian and hospital appointments. A podiatrist was booked to attend to three people's feet as they were unable to do these themselves.

Requires Improvement

Is the service effective?

People's enjoyment of the garden could be reduced because of its condition. The garden was very overgrown and uncared for at the back of the property. Also a healthcare professional had commented on the unkempt appearance of the garden prior to the inspection visit. It is important that people are supported in an environment which is maintained to be suitable for the purpose for which it is meant.

Is the service caring?

Our findings

People felt that staff were caring. One person told us "Staff here will always listen" and "They are caring". Another person we spoke with said they felt "well cared for". People also commented: "The (staff) are a good bunch". We spoke with a person's relative and they said "The care has been very good. They (persons relative) have been very happy there". Another relative stated that "The team are second to none" and said they "would be the first to say if I thought differently ".

People's needs were met with care and attention by the staff. We observed a person being provided with their morning coffee and biscuits in their chair as they were reluctant to move. They also ensured the person had soup and other refreshments during the day. We saw staff respecting people's choices around food and going out.

A person had recently moved to Bruddel Grove after being in another service run by Rethink. They went on to say they liked their placement "Much better in Bruddel as its much quieter here".

Staff cared for people in a kind manner and were present throughout the day for people to talk to. We spoke with a staff member who had worked at the service for many years. They said they "Love the work". They know the people in the service well and were clearly popular with them. They were clear about their professional role and boundaries whilst at the same time being friendly and caring.

People's privacy and dignity was respected. All people had keys to their rooms. We observed all staff knocking before entering people's rooms and if a question was asked they waited for the answer. Staff said that prior to entering a person's room they would "Always knock and ask permission before attempting any personal care with a person". They stated "Dignity must be respected at all times if giving any personal care". They expressed empathy by wondering how it would be if they were having help. We asked a staff member who had done a sleep in the previous night if they had been woken during the night. They commented that they had by a person singing and said "They sounded happy so I did not disturb them".

Staff knew who to contact if a person in the service required an advocate, for example, to ensure people were supported appropriately by an independent person. This is important if people do not have close relatives to support them through situations such as alternative care being considered or to support people make complaints if they need to. One person had accessed an advocate for this purpose.

People in the service had a monthly meeting. Three of the five people in the service attended the last meeting. Items discussed were meals, activities, house improvements, concerns and dissatisfactions. Changes had been made in the menu to reflect these meetings.

The service recognised the importance of people being able to celebrate occasions and ensured these were recognised for each person. Gifts were considered for each person depending on their likes and we were told all people's birthdays were celebrated with them. People were supported to keep in touch with relatives where appropriate.

Is the service responsive?

Our findings

People did not receive a service that was responsive to their individual needs. The support planning was meant to consider people's individual's aspirations. The provider stated that 'All our homes have the ultimate aim of enabling residents to move on to more independent accommodation and sustaining their independence by providing access to flexible staff support that meets their changing needs'. We found this conflicted with the client group supported at Bruddel Grove, some of whom had been there many years and had received support for most of their adult lives. Their care needs and plans were being integrated into a recovery model instead of their needs being assessed in a holistic and person centred way. It was not clear that people shared the aim of moving on from the service. We spoke with people in the home and no-one described their goal as moving into more independent living and described feeling settled in the service.

People's needs were assessed and were used to develop individual support plans (ISSP). These plans included goals and aspirations for each person whilst defining the point at which each person was at mentally and physically and where they wanted to be in the future. People were responsible for self-assessing in order to monitor progress within this process. Staff we spoke with felt that this tool was not suitable for every person as not all people had enough insight required to understand their own needs. For example, a person had assessed themselves 10/10 in all areas of their life but they were clearly needing support with their mental health and health needs.

The care plans were arranged in a way that made it difficult to get a full overview of a person's life history and support needs and their personal likes and dislikes. There was little information on what was important to people and what they wanted from being in the placement and what they were ultimately aiming for. We saw a document entitled 'First Look at my Situation' which contained information on self-care, living skills, social networks, work, relationships, addictive behaviour, responsibilities, identity and self-esteem, trust and hope and managing mental health. However, this was mainly used to set goals which were not all relevant to each person. We spoke with a person who said "They know me now but they didn't know anything about my background".

People had reviews which they were invited to attend and were involved in the process. A person commented: "I sign the paperwork when I have a review". However, during the inspection a person came into the office and asked to see their care plan. When they looked it was out of date and had last been updated in 2013. The person commented on this and the staff member said they would contact the mental health team to try and organise a review.

People did not have opportunities to engage in activities to keep them occupied. A person told us that another service they visit which is managed by the same provider had new activity boxes and said they had asked if Bruddel Grove could have the same. The person was keen to paint some cups in the boxes that "Can be painted". It was not obvious during the two days of inspection that any planned activities took place. One person sat in a chair for much of the day and other people wandered around the building. They came out for drinks but we did not observe any staff member doing any activity with them at any time. One member of staff remained in the office for the majority of the day. A professional we spoke with said "People would benefit from some more one to one time or group work". This meant people were at risk of social isolation and loneliness due to lack of social contact with the community. We did evidence some involvement such as accompanying a person on a walk and some Christmas activities, such as taking a person to a Christmas Fair and making a Christmas cake. However, there was no evidence that structured activities that may have supported people's hobbies and interests had been considered.

The provider had taken immediate action following an inspection of another of their local services inspected at the same time. We were assured the action plan for that service would encompass Bruddel Grove.

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

People did not always receive planned and coordinated care and support when they needed to move to a different service. When people's needs changed, such as the person whose care needs had increased greatly, staff had tried to be involved in their transition. Staff had requested that a person have access to an Independent Mental Capacity Advocate to assist them with decisions about their future. However, they were told the person "Has capacity". Staff were keen to support the person but were given no information about what plans were being considered. We

Is the service responsive?

witnessed staff ringing the person's Community Psychiatric Nurse (CPN) but they had no reply. On the second day of inspection they rang again and were told the CPN would return the call but this did not happen. The lack of communication between services that have joint responsibility for individuals means people do not always receive an effective transition.

Staff said they tried to arrange a review with a psychiatrist once a year and said they could call the psychiatric service for support if needed. All residents had a medical review with a GP at least once a year.

Complaints were logged on the database which staff knew how to record and the process of reporting. No complaints had been received about the service since the last inspection.

Requires Improvement

Is the service well-led?

Our findings

The deployment of managers meant staff did not benefit from consistent leadership. The registered manager was responsible for three services in Swindon including Bruddel Grove. This meant the service wasn't always effectively managed because the registered manager also had national responsibilities as locality manager. This meant their time focusing on the three services was often limited to three days a week. The registered manager told us that their duties and responsibilities did impact on the amount of time spent at each service including Bruddel Grove.

The service did not have a manager on site at the time of the inspection. The service manager had responsibility for the day to day management of the home as well as covering vacancies at two nearby services that supported people with complex mental health needs. Although this meant there was not the consistent presence of management and leadership in the service, staff told us that these issues had not impacted on the people who lived in the home. This was reflected by people's feelings about the service.

Staff did not always get feedback from the management team after reporting incidents. This indicated that communication between staff and the wider organisation could be improved to ensure staff feel their views are sought and valued.

The aims and objectives of the service stated it was to support people towards recovery and for them to potentially move on to semi-independent or independent living. Although the service had a clear aim and vision of what it was aiming to achieve, this was not being met. The service promoted 'recovery'. The provider stated that 'All our homes have the ultimate aim of enabling residents to move on to more independent accommodation and sustaining their independence by providing access to flexible staff support that meets their changing needs'. The files we looked at did not evidence progress towards this aim. A healthcare professional who supported someone in the service said "The staff are not person centred – they do what they have to do and no more". They went on to say that they felt "The staff could do more to encourage people to engage and make progress". They also stated that communication with the service was "Not good" and said they struggled to "Get information out of the service manager". We saw a care plan which the mental health team had reviewed in May 2014. It stated 'Recovery was to be promoted'. We did not see any evidence of any improvements since this review.

It was unclear what outcomes the service was aiming to achieve and whether people in the service had the same aspirations of moving to independent living. We spoke with a relative who felt that the person would not be able to live independently at any time

People were given the opportunity to share their views on the service being provided. We saw records of regular meetings with people living in the home having taken place. All residents were offered the Satisfaction Survey once per annum but we did not see any follow up to the responses.

We found that the provider had an effective system to regularly assess and monitor the quality of service that people received. The home received an unannounced visit by the manager of another of the provider's services, every three months. This involved them completing a detailed check list which covered all areas of the service. They made judgements about whether the home had met the required standards. We saw the detailed report and action plan from the last visit in August 2015 was fully compliant.

Communication with stakeholders was not always effective. This meant that decision making, responsibility and partnership working were not being effectively achieved. For example, details of people's 'aims' had not been confirmed by the provider with the commissioner. This meant that staff were unclear of what areas they should be working with people to improve their independence. The lack of a contract with the local commissioning team also meant outcomes could not be easily evidenced to reflect effective partnership working to achieve joined-up care.

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, was appropriate or reflected their preferences. Regulation 9(1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the requirements of people in the service. Regulation18(1) Staff had not received appropriate training or support to enable them to carry out the roles they were employed to perform. Regulation 18(2)(a)