FitzRoy Support

FitzRoy Supported Living – Trafford

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was unannounced and took place on the 28 September 2016.

We carried out an announced comprehensive inspection of Fitzroy Supported Living – Trafford on 04 and 05 April 2016 when it was found to be meeting all the regulatory requirements which were inspected at that time. After that inspection we received concerns relating to the staffing levels and medication errors at one of the supported living services, Orchard Court. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for FitzRoy Supported Living – Trafford on our website at www.cqc.org.uk

FitzRoy Supported Living – Trafford provides supported living service for 15 people with a learning disability. Five people were receiving this support at Orchard Court at the time of our inspection.

The service had a registered manager. 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.

During this inspection we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to the staffing levels. You can see what action we told the provider to take at the back of the full version of the report.

When we commenced our inspection at 8am we found two people were up and dressed. The other two people were still being supported with their personal care needs. We observed the one care worker on shift rushing between both people to ensure they were ready in time for their daily activities. We received a mixed response from people receiving the service regarding whether or not there were enough staff on duty to meet their needs. People's representatives and staff told us they didn't feel there was enough staff on duty, particularly in the mornings to meet people's needs.

Medicines were ordered, stored, administered and disposed of safely. However we found the registered provider did not record the room temperatures where people's medicines were stored.

We recommend the registered manager reviews the 'NICE guidance' on 'Managing medicines for people receiving social care in the community' as this provides good practice recommendations for the management of medicines.

People's support plans were detailed and person-centred. Support plans contained information about how people liked to communicate and be supported in all aspects of their care. Daily care records evidenced that staff supported people according to their support plans and we observed this during the inspection.

Appropriate plans were in place to guide staff in how to minimise risks to keep people safe. Staff knew what action to take to ensure people were protected if staff suspected they were at risk of harm. They were encouraged to raise and report any concerns they had about people through safeguarding and whistleblowing procedures.

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 not sufficient numbers of staff on duty to keep people safe and meet their needs.

Medicines were managed, administered and documented safely, however we noted room temperature recordings systems were not in place at the time of our inspection

People were protected from abuse and avoidable harm.

FitzRoy Supported Living – Trafford

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.

We undertook an unannounced focused inspection on 28 September 2016 due to concerns that had been raised with us since our last inspection on the 04 and 05 April 2016. The concerns raised were at one of the supported living services, Orchard Court, in relation to low staffing levels in the morning and medication errors. We inspected the service against one of the five questions we ask about services: is the service safe.

The inspection team consisted of one adult social care inspector.

At the time of this inspection there were five people who used the service. During the inspection we spoke with four people who were living at Orchard Court and three relatives by telephone. We also spoke with the registered manager, deputy manager and three care workers.

We looked at a range of records including: four care plans; staff training; minutes of meetings; rotas; safeguarding records; medication records; and audit documents.

Requires Improvement

Is the service safe?

Our findings

We asked people who lived at Orchard Court if they felt safe. People told us: "I have lived here a long time, I feel safe", "Yes I feel happy and safe" and "Yes I always feel safe in my home."

Prior to our inspection we received concerns that people who used the service were placed at risk due to low staffing levels during the morning at one Orchard Court. People who used the service were tenants in their own flats, there was a communal area available where people interacted with each other and staff. One person had their own support hours that were not connected to the support being provided to the other four people. We discussed this person's staffing hours with the person's representative prior to the inspection and they confirmed they were content with the current staffing levels being provided to their family member.

We arrived at Orchard Court at 8am to observe the staffing levels at this time. Each person supported by the service had different needs and required varying levels of care and support. We observed there was one care worker on duty providing support to four people. The care worker on shift told us three of the four people required one-to-one support to assist with transfers and personal care. The other person was able to independently get up and go to bed with prompts from staff, but required assistance with their personal care needs. We observed the morning routine for people to be rushed and at times chaotic. The care worker on shift was working very hard to ensure people were ready to attend daily activities such as day care services and appointments. At 8.30am a taxi arrived for a person to attend a day care service. After this person left, the care worker on duty commented that they had forgotten to make this person their lunch due to the busy morning they had just had. At 9am another taxi arrived for one of the people to attend an appointment. We observed this person had just been supported with their personal care and had to rush to eat their breakfast, to ensure they did not miss the taxi. At 9.10am this person was finally ready.

The care worker on duty confirmed to us that most mornings were similar to the one we had observed and people had their personal care rushed and were in a hurry to eat their breakfast, due to not having a second care worker assisting. This meant there was not sufficient staff to support people with their daily needs.

All the staff we spoke with said there was not enough staff on duty. Comments received included, "We struggle in the mornings here and we need support." Another staff member commented, "It has been extremely stressful working here, supporting four people in the morning on your own is tough." A third staff member commented, "Some mornings we are okay on our own, but on the busy days we need two staff not one."

People we spoke with and their representatives gave mixed views on whether there were enough staff on duty at the service to meet their needs. One person said, "There is enough staff; they know me well" and another told us, "I think we have enough staff." A third person told us, "It's really busy in the mornings, I feel I am being rushed sometimes."

Three of the people's representatives we spoke with told us they did not feel there was enough staff.

Comments included, "There is simply not enough staff on duty, and we have raised this to the provider and commissioners many times." Another person commented, "[Person's name] at times has not been supported with their personal care because staff are too busy." A third person commented, "We have had issues with staffing here for years, it's not a new thing with the provider."

During the inspection we contacted the registered manager and they arrived at Orchard Court. We discussed the problems of the morning support we had just observed. The registered manager agreed the morning routines are extremely busy for one care worker to complete and commented that this was down to the contracting arrangements with the commissioners. The registered manager explained that the provider had recently taken over the support packages at Orchard Court in May 2016. The registered manager said the hours they were commissioned to provide support to the four people seven days a week did not allow for a second care worker to assist in the mornings. The registered manager explained that they had been in talks with the local commissioners to have the hours increased. At the time of our inspection the hours had not been increased.

We viewed the staff rotas which confirmed there was not sufficient staff to support people with their daily needs. People were attending activities five days a week, Monday to Friday, with most of the activities starting early and requiring people to be ready before 9am. We noted on the rota staffing hours for Monday to Friday were; one care worker on duty from 7am to 11am, at 2pm a care worker arrived and worked until 11pm, this person also stayed overnight. On the weekends staffing hours were 7am to 3pm and 3pm to 11pm, with this person also staying overnight.

The registered manager confirmed the provider was responsible for supporting people to health appointments, but at times appointments had been re-arranged to ensure sufficient staffing was made available. The registered manager told us the deputy manager supported people when they had health appointments. We asked to view the records of missed health appointments, but this had not been recorded. The registered manager confirmed they would record future cancelled or rearranged health appointments. The registered manager commented that they did not feel many appointments had been cancelled, if anything they had been rearranged for a more suitable time.

The registered manager did not have a dependency tool to assess the staffing levels for the support people required. The registered manager confirmed the staffing levels needed to be increased for the morning support. Short term absences were managed through the use of bank staff or staff from other areas of the service; the provider used the same bank staff to ensure continuity of care. The registered manager and deputy manager were also available to provide support when required. We noted on the rota and discussions with the registered manager that there was only three permanent staff, one staff member had recently left the service. The registered manager explained that the provider had recently recruited a new staff member that was soon to join the team in October 2016 and the provider was looking to recruit at least one more care worker.

During the inspection the registered manager confirmed that the deputy manager would begin their shifts at Orchard Court at 7am, Monday to Friday, starting immediately to assist with people's morning routines until the staffing hours had been reviewed. Since the inspection we have received a new rota from the provider that confirms the deputy manager will be working at Orchard Court Monday to Friday, starting at 7am.

This was a breach of Regulation 18 (1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staffing. The provider did not ensure that there were always enough staff to meet people's needs.

Prior to the inspection the provider notified the commission of three errors relating to the medicines at

Orchard Court. The three medicines error were all relating to people missing their prescribed medicines, due to an error by the care workers on duty. Discussion with the registered manager confirmed the care workers in question sought medical advice once they realised an error had occurred, no side effects to the people were noted as a result of their missed medicines. We saw evidence that medicines errors were reported, investigated and action taken to reduce the chance of re-occurrence. We saw evidence that the registered manager had held meetings with all staff who administered medicines to raise the issues with the medication administration records (MAR) sheets, and completed additional supervisions when staff had made any medicines errors.

As part of the inspection we looked at the systems in place for the receipt, storage and administration of medicines.

People's medicines were stored individually in their flats in a lockable cupboard. We noted no room temperatures had been recorded by the staff responsible for medicines. We discussed this area with the registered manager who acknowledged this observation and told us the provider was looking to store people's medicines in one location within Orchard Court, and in the meantime temperatures would now be recorded daily to ensure the room temperatures were not exceeding current guidance.

We recommend the registered manager reviews the 'NICE guidance' on 'Managing medicines for people receiving social care in the community' as this provides good practice recommendations for the management of medicines.

A list of staff responsible for administering medicines, together with sample signatures was available for reference and photographs of the people using the service had been attached to medication administration records to help staff correctly identify people who required medicines.

All of the support staff who administered medicines had received appropriate training, which involved an observation of their competency. We saw that medicines were stored and administered safely. The four people's MAR sheets we saw were fully completed with no gaps in recording. Records were kept of medicines received and disposed of. There were also medicine protocols for 'as required' medicines. 'As required' medicines are those administered when a person feels like they feel they need them, rather than on a regular basis. People were receiving their medicines safely and as prescribed.

The provider's internal quality assurance officer completed a medicines audit on 21 June 2016 that looked at the following areas; storage; MAR sheets; required medicines; and balance checks. This audit also commented on the lack of room temperature recordings. The registered manager confirmed weekly checks of medicines had been completed by both the registered manager and deputy manager but this had not been recorded. The staff on duty completed daily handover checks of the medicines to ensure people's medicines had been safely administered, this was evidenced on the handover sheets.

At the time of our inspection none of the people using the service self-administered their medicines. No controlled drugs were at Orchard Court.

We viewed four care files for people living at Orchard Court. People's care files contained risk assessments for various aspects of their care and support. These included being out in the community, showering, using the garden and travelling by car. Risk assessments differed according to people's needs and behaviours and included detailed information on control measures when risks were identified. This meant that the service actively sought to identify and manage risk to the people it supported.

Care workers we spoke with could give examples of the types of abuse people using the service might be vulnerable to. They told us that they would report any concerns to the registered manager; one care worker said they would escalate their concerns to the registered manager's line manager, the local authority safeguarding team or to the Care Quality Commission if they felt their concerns were not dealt with properly. Care workers also said they had received training in safeguarding adults and we saw that an up to date safeguarding policy was in place at the home. This meant that staff were aware of the different forms of abuse to look out for and knew how to report any concerns correctly.

We looked around the home and found all communal areas, toilets and bedrooms to be clean, tidy and free from offensive odours. All areas were bright and well decorated and furnishings were in good condition. After gaining permission we looked in people's bedrooms and found these were clean, tidy and personalised. We saw personal protective equipment (PPE) such as gloves were available for staff to use as required.

We saw Personal Emergency Evacuation Plans (PEEPS) had been written for people. These gave guidelines on how a person could be evacuated from the building in an emergency.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider did not ensure that there were always enough staff to meet people's needs.