FitzRoy Support

# FitzRoy Supported Living – Trafford

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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| 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** |

# Summary of findings

## Overall summary

We inspected FitzRoy Supported Living –Trafford on 15 and 16 November 2017. The first day of the inspection was announced. The provider was given 48 hours' notice of the inspection because the location provides a community based service and we needed to be sure someone would be available.

At the time of this inspection the service was providing support to 19 people in four 'supported living' accommodations for adults over 18 years, older people, people living with learning disabilities, physical disabilities and/or autistic spectrum disorder and people with sensory impairments. Supported living describes the arrangement whereby people with learning disabilities are supported to live independently in their own tenancies.

At the last inspection on 04 and 05 April 2016, we rated the service as overall "Good". Four months 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 on 28 September 2016. During this inspection we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to the staffing levels.

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.

We found the provider did not have a clear overview of the staffing hours being provided at Highfield Avenue. We noted a number of discrepancies in relation to the evening support of four hours that had not been provided consistently for a number of months.

Staff had limited understanding of the Mental Capacity Act (MCA) and followed the principles on a day to day basis. However, people's ability to make a decision had not been assessed before decisions were made on their behalf. There was a risk decisions could be made for people who were in fact able to decide for themselves.

Staff were knowledgeable about the different types of abuse people might be vulnerable to and knew what action to take to safeguard people from harm. Staff looked after money for people and there were effective systems to protect people from financial abuse.

Medicines were managed safely and people were encouraged to be as involved as possible with their medicines. Protocols around the use of 'as and when needed' medicines were in place for people who required this.

People had good relationships with the staff who supported them. Staff knew people well and treated them

with dignity and respect. People had some opportunities to express themselves and have a say about their care on a day to day basis, but we found an inconsistent approach by the provider to evidence people's involvement when planning and reviewing their care.

New employees were required to go through an induction which included training identified as necessary for the service and familiarisation with the service and the organisation's policies and procedures. There was also a period of working alongside more experienced staff until such a time as the worker felt confident to work alone.

Some people attended local day services, or completed voluntary work. People were supported to be part of their local community and follow their interests or hobbies. However, we found social outings during the weekends did not take place, due to no flexibility in the staffing structure to allow additional staff to work the weekends. The registered manager felt this was the case due to a lack of commissioned hours to use during the weekends.

People had support to eat healthily and planned their own menus. Some people were supported to complete batch cooking for their meals, while others used microwavable foods due to the lack of cooking facilities in their flats. We were informed by the registered manager this had always been the case previously for people.

People's care plans and risk assessments provided staff with all the information they required to keep people safe and meet their needs. Care plans we looked at were person centred and showed the care needed to promote people's health and independence. This included any environmental risks in people's homes and any risks in relation to the care and support needs of the person. For example, each person had a Personal Evacuation Emergency plan (PEEP) which provided information to people what to do in the event of a fire. The PEEP was presented in a visual
and written format. This meant that people received information that was meaningful to them.

At this inspection we found the quality and safety monitoring of the service was ineffective at identifying where the quality and the safety of the service was being compromised. Some quality audits were not effective and were not being checked by the registered and deputy manager as frequently set out by the provider's policy. There was a lack of systems in place to ensure the service was monitored in a meaningful way. The service did not have clear records to show that people had been given the opportunity to provide feedback about the quality of their care.

The CQC had been informed of any important events that occurred at the service, in line with current legislation. However, we found the provider had failed to notify us of one incident that occurred at Highfield Avenue.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

## 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 at Highfield Avenue on duty to keep people safe and meet their needs.

Medicines were managed, administered and documented safely. However, we noted room temperature recording systems had not yet been established at Highfield Avenue at the time of our inspection.

Staff were knowledgeable about the different types of abuse people may be vulnerable to and knew how to respond to allegations of abuse.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff followed the principles of the Mental Capacity Act on a day to day basis, but people's capacity to make certain decisions had not always been assessed.

Training was available in a variety of topics to meet people's needs. Staff were supported through supervision, appraisal and team meetings. However, supervisions did not take place as often as described in the provider's policy.

Staff supported people to receive sufficient nutrition and hydration. There was good communication with health care professionals.

### Is the service caring?

**Good**

The service was caring.

People and relatives told us that staff were caring and friendly. Staff understood people's needs and responded well to these.

People told us they were treated with dignity and respect. They also told us staff respected their home, their family and their belongings.

People and relatives were involved in decisions about care and support and people were given choice and control over their lives. However, three people's relative said they would like to be more involved in planning their care and support.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Complaints had not been clearly recorded at Orchard Court. There was no auditing system in place for monitoring complaints to identify trends and patterns.

People took part in activities they enjoyed and were increasing their independence. However, activities in the community during weekends were not scheduled. Due to staffing hours not being included on the rota.

People received support in the way they wanted and needed because staff had clear accessible guidance about how to deliver their care.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

Audits had identified issues with the quality of the service but these had not always been addressed in an effective way.

There were not effective systems for seeking feedback on the quality of the service from people and their relatives.

People and staff told us that the registered manager was approachable and supportive.

# 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.

This inspection took place on 15 and 16 November 2017. The inspection team consisted of one adult social care inspector. On the first day of the inspection, an expert by experience member of staff contacted the families of people who used the service to seek their views of FitzRoy Supported Living – Trafford. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience working in nursing settings.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

We liaised with Trafford and Stockport local authority contract monitoring teams and adult safeguarding teams to obtain their feedback about the service. We also contacted Healthwatch Trafford. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

To find out how staff supported the people, we visited people in their flats when staff were there (with people's permission). We visited three supported living accommodations which included Orchard Court, Lorraine Road and Highfiled Avenue. We spoke with 13 of the people using the service, the registered manager, two deputy managers and six support workers. During the inspection, we spoke with nine people's relatives by telephone.

As part of the inspection we reviewed six people's care files, four staff personnel records, various policies and procedures, staff training records, four people's medicines administration records, audit and monitoring records and other documents relating to the management of the service.

Requires Improvement

# Is the service safe?

## Our findings

We asked people if they felt safe with the support they received from FitzRoy Supported Living – Trafford and they said that they did. One person told us, "The staff are always available, this keeps me and the other people safe." We asked people's relatives if they thought the people using the service were safe, they also said they felt people were safe. Comments from people's relatives included, "I am happy with the service given, it suits us, and our [person's name] is safe", "[Person's name] is very safe. I never have concerns in respect of [person's name] safety" and "I have a piece of mind that [person's name] is safe and being well cared for."

At the last inspection in September 2016 we found a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the registered provider had not ensured that there was always enough staff to meet people's needs at Orchard Court, predominantly during the morning support. At this inspection we found the provider had made improvements to the staffing levels at Orchard Court, however we found the staffing levels at Highfield Avenue were not managed safely.

We viewed the staffing rotas at Lorraine Road and Orchard Court and found people were supported to manage their weekly activities with the support of two support workers during the mornings. Our observations of the support people received, the feedback from the people and their relatives and the staff at the service, showed that there were sufficient staff employed to meet people's needs at both services. Through our discussions with the registered manager, we established three people were living at Daresbury Close and they were support by one support worker at all times.

During the second day of our inspection we visited Highfield Avenue which supports six people. Each person supported by the service had different needs and required varying levels of care and support. We viewed the staffing rotas from 11 August to 6 November 2017. We found a number of occurrences where the additional evening 'four hour' support had not been covered to provide assistance to the support worker who was carrying out the sleep in shift. We discussed this area with the deputy manager and calculated from their rotas a total of 152 hours of support had not been provided. The deputy manager acknowledged Highfield Avenue has had a number of difficulties with the staffing levels and required the frequent use of agency staff until they recruited new staff. However, we found these missed hours had not been addressed by the provider which meant people had not received their commissioned hours of support.

Shortly after the inspection we were contacted by the registered manager who disputed the number of hours missed. The registered manager said they reviewed the rota stored on their computerised system which indicated the rota at Highfield Avenue was not accurate with the correct total of hours missed being 104 and not 152. Although this may be the case, the provider had not identified or reacted to these missed hours of support, nor had they notified people/ their families and Stockport commissioners that the provider was unable to safely accommodate these hours. The registered manager said they would use the missed hours at the weekends to allow people to access the community.

Staff we spoke with said there was not enough staff on duty during the weekends to support people with

social activities in the community. Comments received included, "During the week people are very active, but weekends are a different matter. We just have enough staff to cover people's basic needs of personal care, medication and meals", "I believe weekends have always been an issue here [Orchard Court] but we do our best", "I have never had the staff to support with the evening support here [Highfield Avenue]. I do my best, but evenings are a struggle as all six people need your assistance" and "I think it is sad we cannot have additional staff over the weekends to take people out [Lorraine Road]."

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 receiving a service said, "I have a personal assistant, thankfully [person's name] takes me out, but the staff here [Orchard Court] haven't got time to take me places" and "I think the staff do a good job, I do go out with them sometimes [Orchard Court]." A third person told us, "I like to keep busy, I can go out myself, but the others [people at Highfield Avenue] can't get out as much as me due to there only being one staff on."

Six of the people's representatives we spoke with told us they did not feel there was enough staff, especially at weekends. Comments included, "Thankfully staffing levels have improved, but we have had to fight for these hours through the Ombudsman so that the local commissioners", "Additional cover during the weekends would be great, but we are never going to get that", "The staffing at Orchard Court has improved, I am much happier. Weekend cover would be a luxury to get people out, but I don't think FitzRoy have the commissioned hours for this", "I have always felt the staffing at Highfield Avenue are not adequate. People don't seem to get out enough for me", "The staffing at Highfield Avenue are fine at the moment, of course we would always like more staff" and "The weekends at Lorraine Road would benefit with an additional support worker to take people out."

During our visits of the three supported living accommodations we found weekend cover was staffed by one member of staff. This meant people who required staff assistance could not access the community, which impacted on people's social needs. We discussed this area with both the registered and deputy managers who commented that the commissioned hours do not allow for additional cover during the weekends. We were also provided with an email from the registered manager which evidenced they had raised concerns to Stockport commissioners in respect of additional staff hours during weekends. The response the provider received from Stockport commissioners in October 2017 said the hours commissioned are sufficient and no further commissioned hours would be provided.

Within a supported living setting people should receive bespoke packages of care designed around their preferences and assessed care needs. During this inspection we found that people shared their commissioned care hours with the other people living in their home and could not be assured that they would receive their individual commissioned one to one care hours consistently. We discussed this with the registered manager who told us that they were aware of the hours people received. The registered manager did not have a dependency tool to assess the staffing levels for the support people required to ensure the deployment of staff safely covered the needs of the people. Short term absences were managed through the use of bank staff or agency staff. The provider had recently recruited one support worker, who was waiting for their safe recruitment checks to be completed before they could work at Highfield Avenue.

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

Although the provider was not the landlord, each of the households were well maintained and staff kept a record of repairs and safety issues which they supported people to report onto the relevant housing

association. Staff assisted people to regularly test smoke alarms, check firefighting equipment and monitor water temperatures. Staff maintained logs of other health and safety checks and ensured generic premises risk assessments were completed and reviewed. Each person had a personal emergency evacuation plan in place (PEEPs). These plans provided details for staff about how much support a person may need if they had to leave the premises in an emergency. For example, verbal prompts or physical interventions such as the use of moving and handling equipment. This information could also be used to assist the emergency services in any rescue attempts.

During our tour of Orchard Court we noted two people's bedroom doors were being wedged open. We discussed the potential fire safety risk and door closure systems with the deputy manager who had reported this to the housing association for the flooring to be adapted to allow the door closures to fully work. The deputy manager provided evidence this work had been reported. The deputy manager said staff were aware to remove the door wedges during the night and this had been included in the two people's PEEPs.

We found assessments were undertaken to assess possible risks to people using the service. We saw risk assessment documentation had been completed and was present on the six care files we considered and the deputy manager told us that they were completed for each person using the service. The assessments included individual risks to people who used the service and others, medicines, road safety when accessing the community and pressure sores (if applicable). The risk assessments included information for staff about action to be taken to minimise the chance of the risk occurring such as spotting the signs of deterioration in behaviour and which health care professional to speak to for guidance. The assessments we looked at were reviewed regularly or when there was a change in people's needs.

As part of the inspection we looked at the systems in place for the receipt, storage and administration of 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. Medication administration records were up to date with no gaps in recording and people were encouraged to countersign their medicine administration records if they wished. People had detailed medicine risk assessments and care plans in place, which included potential side effects for support workers to look out for. 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. This meant that people were receiving their medicines safely and as prescribed.

People's medicines were stored individually in their flats in a lockable cupboard. We noted at the last inspection in September 2016 no room temperatures had been recorded by the staff responsible for medicines at Orchard Court. At this inspection we found room temperature recordings had been introduced at Orchard Court and Lorraine Road to ensure safe practice. However, we found room temperatures were not being recorded at Highfield Avenue. We discussed this with the deputy manager who confirmed room temperature checks would be introduced to ensure the room temperatures were not exceeding current guidance.

Where people were prescribed topical creams and lotions we found there was no body maps to inform staff where the creams needed to be applied. This meant we could not determine if people had received theses medicines as prescribed. The deputy manager confirmed this area would be reviewed. We will review this at our next inspection.

Safe recruitment processes were in place to ensure that only suitable persons were recruited to work with within the service. We saw that references had been obtained for staff prior to them working in the service as well as checks with the Disclosure Barring Service (DBS). The registered manager told us that she operated a

thorough recruitment process and would only employ staff that she felt would be competent to work in the service.

The managers and staff understood about types and signs of abuse and could explain the action they would take if they suspected or witnessed abuse. We saw records that showed staff had received safeguarding training and were aware of the whistleblowing policy. Whistleblowing is where people can disclose concerns they have about any part of the service where they feel dangerous, illegal or improper activity is happening.

We noted that accident and incidents that occurred at people's houses were appropriately recorded and reviewed by the manager and any trends and patterns were investigated and acted upon to prevent reoccurrence.

Requires Improvement

# Is the service effective?

## Our findings

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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in community settings are called the Deprivation of Liberty Safeguards in Domestic Settings (DiDS). In supported living, the care provider must request that the local authority applies to the Court of Protection for DiDS authorisation if they think the person's liberty must be deprived to keep them safe. The service had made applications to the Court of Protection through the local authority. However, we were informed by the registered manager that social care professionals from the local authority had not been out to complete mental capacity assessments and best interest to assist with people's applications. The registered manager commented that they would be making further inquiries to how long this will take the local authority.

At the inspection in April 2016 we made a recommendation that the service arranges training for staff on how the Mental Capacity Act (2005) applies to people in supported living. At this inspection, we found training had been provided to staff, but staff knowledge of the MCA and DoLS was limited.

Staff had limited understanding of the key requirements of MCA and how it impacted on the people they supported. Staff had completed MCA training and most put this into practice effectively, and ensured that people's human and legal rights were protected on a day to day basis. In discussion with the registered manager they provided evidence of a meeting where the MCA and people's restrictions had been discussed with staff at Lorraine Road, but the registered manager acknowledged this needed to be completed at the other support living accommodations.

We found the provider's approach to assessing people's mental capacity was inconsistent. At Orchard Court we found formal capacity assessments had not been completed for four people to assess if they could make a specific decision. For example, having bed rails in place. The first principle of the MCA is to assume people have capacity. Without capacity assessments there is a risk decisions were made for people who have the capacity to make them for themselves. The provider completed their own 'mental capacity toolkit' when assessing people's capacity. However, we found this documentation did not accurately assess people's capacity, but was completed by the deputy manager in respect of what they thought the person's capacity was like, in areas such as medication, care and treatment and finances. Furthermore, we found the deputy manager had also completed best interest documentation without involving the person or their family members. We did find instances when the 'mental capacity toolkit' had been completed in line with the MCA at Lorraine Road. However, the inconsistent approach the provider followed did not assure us they understood the principles of the MCA.

Care files contained a number of consent forms, including consent for information to be shared with other professionals, consent for photographs and for medicines to be held on people's behalf. In five care files we viewed we noted people who were deemed to lack a mental capacity were signing that they consent to the above. This meant the service had not fully applied the principles of the MCA across all decisions being made in people's lives.

The registered manager and provider failed to comply with the requirements of the Mental Capacity Act 2005 in respect of assessing people's capacity. This was a breach of Regulations 11 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had health care passports in place, which showed the support they would need if they attended hospital. The passports had been completed with people and were detailed about how people would like to be supported. People's health needs were also recorded in their care plans, with some information about how they preferred to be supported. Some people needed support to attend health appointments and to understand information given by health professionals. We saw staff supported people to attend these appointments and discussed any outcomes with them. Staff made records of any consultations or decisions made so that everyone was aware of the outcomes. Some people were at risk from health conditions including epilepsy. The risks had been assessed but guidance for staff could be improved for example, some risk assessments gave staff no guidance about when they should call for advice from a medical professional. In addition during the inspection one family member we contacted at Orchard Court was concerned that their family member's health passport contained limited information about the person's health conditions and also found instances where the information contained information about another person's healthcare needs. The registered manager apologised to the family member for this error and ensured the hospital passport was reviewed fully.

People had access to yearly health checks, flu jabs and other health screening programmes. Staff explained what these appointments were for and people were able to choose to attend or not. Referrals were made to health professionals by staff when needed. However, during the inspection we were notified by two people's families that health appointments have not always been well managed by the service with some health appointments being missed. We discussed this with both the registered and deputy managers who acknowledged health appointments in the past have sometimes been missed but commented that this was not a regular occurrence. The registered manager felt the overview of health appointments had improved and was now better organised. For example, after each person's health appointments the information was recorded in the daily handover, diary and in the front of people's care plans. We will review the progress of this at our next inspection.

All staff had undertaken essential training in areas such as safeguarding, mental capacity act, and medicines, as well as further training in specific areas. New staff completed an induction period where they spent time shadowing more senior staff and completing essential training. Once their induction was complete, they worked as part of a team. All new care staff were undertaking the Care Certificate. The Care Certificate is the standards which all health and social care workers who are new to care need to complete during their induction to ensure they are meeting the fundamental standards of care.

Staff received supervision and an annual appraisal but we found these were not as often as set out in the provider's 'Support and Development' policy dated January 2017. This indicated staff will receive a minimum of six support and development sessions per year. On average we found people were receiving between two and three per year with an annual appraisal. Supervision provides an opportunity for management to meet with staff to feedback on their performance, to identify any concerns, or to offer support, assurances and learning opportunities to help them develop.

The six people living at Highfield Avenue were involved in weekly meetings where a menu plan was developed. The staff on duty would cook the meal with support from some of the people who enjoyed cooking.  We observed people being supported by staff with their evening meal, and saw people had been provided with different meals dependent on their preferences. We found people living at Orchard Court received assistance with their meals, which included batch cooking that was frozen for the week ahead or support to use the microwave. In discussion with the registered manager they acknowledged people's flats were not equipped fully to assist with cooking fresh meals. However, we found the communal area of Orchard Court had a cooker which staff could use. People's family members commented that the provider had not taken the opportunity to get people together at least once a week to cook a meal of their choice with people's support. The deputy manager confirmed this would be something they would be introducing in the near future. We will review this at out next inspection.

Before people moved into the supported living flats/home the service completed a comprehensive assessment of their needs and preferences in collaboration with the person, their family and relevant healthcare professionals. Records showed the assessments considered people's needs and risks in relation to relationships, medicines, communications, personal care needs, domestic tasks, accessing the community, financial support and emotional and behaviour needs. Relatives confirmed they were involved in the assessment and care planning process.

Good

# Is the service caring?

## Our findings

We asked people if they thought the care staff were caring and the feedback was positive. People told us, "The staff are very caring, I get on with them all", "We sometimes have different staff, but they do treat us right" and "The staff are all caring in my opinion." Feedback from people's relatives was also positive, "The staff approach is very caring, I have no concerns", "I cannot fault the care [person's name] receives" and "Importantly the staff team understand people's needs."

We observed interactions between the support workers and people using the service were warm and friendly. There was also good humoured banter at times and we heard the people laughing and joking with staff. Support workers we spoke with could describe each person very well, including individual's likes, dislikes and preferences. During the first day of our inspection at Orchard Court we observed one person becoming upset. A staff member was quickly on hand and provided reassurance to this person; within a couple of minutes the person who was upset was laughing and clearly appreciated the staff member intervening. Two staff members who worked at Orchard Court commented, "I have worked here previously and know the people's needs very well. I am very happy to be back" and "I love working with them all."

Staff we observed understood the importance of showing dignity and respect. For example, we saw a member of staff knocked on a person's door before they entered the person's flat and they asked their permission before undertaking a task. A person we spoke with said, "The staff never barge in on me, they are respectful." A relative stated, "I have no doubts the staff support [person's name] and the other clients with the upmost respect and dignity."

The service enabled people to do as much for themselves as possible. People we spoke with told us, "They [support workers] are always encouraging me to keep active and take up new projects." Another said, "I have a job at a local charity shop two days a week, the staff encourage me with this." A member of staff told us, "I believe people's independence is essential, at the end of the day it is support living and we always try to support people to do as much as possible for themselves to encourage their independence."

Care files contained information about people's lives before they had moved into the supported living service. People's views and preferences were captured in the documentation. Since moving into the service one person had records of 'circle of support' meetings. These were meetings where the person, their relatives and other professionals involved in their care discussed their care plans, goals and preferences. This meant people, their relatives and professionals were able to contribute information that was relevant to developing new goals and ways of supporting progress. This meant the service supported this person to express their views and be involved in making decisions about their care.

We asked people and their relatives if they had been involved in their care planning. We received a varied response to this question. Three people's family member's commented that they don't believe they were involved in a care plan review. Other people's relatives told us they were invited to an annual meeting to discuss their family member's progress and care plans. We discussed this area with the deputy manager who acknowledged it has been difficult pin pointing times when people's family members are available, so

the provider have passed on people's care plans for them to review to consider if the information is correct. In discussion with two people's family member's this process of viewing the care plans has caused them distress due to the information recorded in care plans not being accurate. The registered and deputy managers confirmed this was the case and said the care plans were reviewed as a result. We found the provider adopted an inconsistent approach when reviewing people's care needs.

We recommend the provider reviews this area to ensure there is a clear format of how often care plan reviews take place and who needs to be involved.

Advocacy support was available to people. An advocate is a person who works with people or a group of people who may need support and encouragement to exercise their rights. One person's care records we looked at showed that this had been considered. This meant people can receive support to express their needs and wishes, if they are unable to, or have difficulty doing this for themselves.

There were appropriate and up to date policies in place for issues such as dignity, equality and diversity and confidentiality. Staff we spoke with demonstrated a commitment to offering care in a way that respected people's diversity.

None of the people receiving personal care services at the time of our visit had specific needs or preferences arising from their religious or cultural background. The provider's assessment process would identify these needs if necessary. Equality and diversity training was included in the provider's basic training programme.

Requires Improvement

# Is the service responsive?

## Our findings

Care plans were personalised to the individual and recorded details about each person's specific needs and how they liked to be supported. Care plans detailed the support to be given on a daily basis and contained a depth of information to guide staff on how to support people well. For example, there was information about people's routines and what was important to and for them. One care plan stated what the persons abilities were when undertaking their own self-care, and where they needed physical assistance and encouragement to ensure their personal care needs were fully met.

Care files also contained life histories, detailed assessments of need, a list of their likes and dislikes and a document called 'my wish list' which included information about their goals and aspirations. We saw that this information was used to personalise people's support plans.

Records showed staff completed comprehensive records of daily care and support delivered which were shared across the staff team. Staff completed formal handovers at shift changes to ensure that key information about people's behaviours and schedules were shared across staff.

FitzRoy Supported Living – Trafford was being commissioned by the local authority to support people to access the community and avoid being socially isolated. People told us how staff supported them in this way. Although people were encouraged to participate in weekly activities, we found activities and outings for weekends were limited due to the provider not having commissioned hours for this. People could access additional weekend support from the use of their personal budgets.

We saw that all care files contained a section to record people's final wishes. This allowed the person to express what they wanted to happen in their final days. In the five files we viewed we noted this section had started, with some people having clear plans of their future wishes.

The relatives of two people who used the service at Orchard Court told us they had submitted formal complaints and felt they had not been dealt with in line with the provider's complaints policy. For example, timescales for responding to formal complaints had not always been adhered to. During the inspection we asked the deputy manager for their complaints file, at Orchard Court, we were handed a file that contained safeguarding information. The deputy manager commented that they were aware complaints had been received but this information had not been collated yet. Shortly after the inspection the deputy manager emailed us a complaints log which indicated Orchard Court had received 11 complaints since November 2016. We found the complaints log was not clear on actions that had been taken and the date when the complaint was responded to and resolved. We did not see any evidence of the provider analysing and learning from these complaints to address the themes identified.

This meant the provider did not have effective systems in place to respond to complaints. This was a breach of Regulation 16 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

# Is the service well-led?

## Our findings

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems which help providers to assess the safety and quality of their services. The deputy manager of the supported living service's Orchard Court, Highfield Avenue and Daresbury Close conducted a range of checks such as medicines audits, health and safety checks and monthly housekeeping audits. However, we found gaps in the frequency these audits had been completed. For example, monthly medication audits at Orchard Court had not been completed in April, July and October 2017. Monthly housekeeping audits had only been completed in August, September, and October 2017.

In addition, the provider completed annual quality audits of the service. These considered how the service was performing in line with CQC's key lines of enquiry. The most recent of these audits had been completed in July 2017. These had identified issues such as the frequency and recording of team meetings as well as some issues with medicines and finances records which had been addressed. The audit had also identified the issues found on inspection with the inconsistent use of the MCA assessments. However, as these issues persisted at the time of inspection the action taken to address them had not been effective.

We found the registered manager's audits of the services located at Orchard Court and Highfield Avenue were inconsistent and we found audits in relation to health and safety had been completed in June and September 2017. The registered manager was not aware that complaints at Orchard Court were not being recorded in a way that provided an overview. We found the registered manager did not have systems in place that indicated they sampled people's care plans to ensure if safely recorded people's needs. This meant there was a lack of provider oversight and governance at the Orchard Court which impacted negatively on the care that people received.

We found the missed staffing hours at Highfield Avenue had not been addressed in a timely manner by both the registered and deputy managers. As a result of these missed hours the registered manager agreed to put these hours back in to the service when we brought this to their attention.

Staff did not show an understanding of the Mental Capacity Act 2005, or the lawful and safe use of restraint practices. People did not always consent to their care and treatment. The provider was not consistently following the principles of the MCA and was not ensuring people who lacked capacity to consent were provided with care that was least restrictive and in their best interests. This meant the provider and the registered manager did not understand their responsibilities associated with the Act.

Staff we spoke with were positive and complimentary about their managers. They told us there was good communication between the managers and themselves and that managers responded to any concerns staff raised. Comments included, "The managers are supportive and easy to work for", "[Deputy manager's name] is easy to work with and will support staff with care on occasions" and "[The registered manager's name] is a good leader." This showed us that the staff had confidence in their managers.

However, during the inspection we received a varied response from people's family members in respect of

leadership qualities of both the registered and deputy manager. Comments included, "It's hard to trust management when management are saying one thing, but nothing seems to change", "Overall it's a lovely home [Orchard Court], but with a little bit of change, particularly in leadership, it would be perfect", "They [management team] do try, but they are not always consistent", "I don't believe the managers are good enough, but that's just my opinion", "I have found the managers approachable and supportive", "I have no concerns about the leadership qualities of the registered manager" and "I don't believe the management team have had it easy, but I have found them generally fine."

Feedback systems were in place for people who used the service. However, we were provided with the results of completed questionnaires which we and the registered manager found difficult to analyse. We were provided with a number of sheets which did not clearly detail how many people participated, nor did it analyse what people's opinions of the services was. We discussed this with the registered manager who acknowledged the questionnaire results were difficult to understand and confirmed they would review their feedback systems.

The above concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regular meetings were held to update the staff teams on the needs of the people and managers were available should staff need support. Records we looked at confirmed this.

We asked how the aims and values of the service were communicated to support workers so that they would underpin the support they provided to people. The registered manager pointed out that the service's vision and values were clearly displayed on the wall in the office and said that they were discussed at team meetings and in staff supervision sessions. The provider also produced a regular 'team brief' newsletter, which shared examples of good practice and success stories. This showed us that the staff understood the vision and values of the service and we saw during the inspection that the support they provided was underpinned by them.

The registered provider is required by law to notify the CQC of specific events that have occurred within the service. We compared records that were being maintained by the registered provider with those on our system and found that this was not always being done. For example, we found one safeguarding concern had not been notified to CQC. Highfield Avenue had reported it to the local authority in October 2017 but it had not been reported CQC. In discussion with deputy manager they thought it was the responsibility of the local authority to notify CQC. This meant that the registered provider was not complying with the law and did not understand their responsibility. Furthermore their lack of understanding means that there is the potential that other incidents that should have been notified to CQC have not been.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, because the registered provider had failed to notify where required.

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 11 HSCA RA Regulations 2014 Need for consent<br><br>The registered manager and provider failed to comply with the requirements of the Mental Capacity Act 2005 in respect of assessing people's capacity. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Audits had identified issues with the quality of the service but these had not always been addressed in an effective way. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>We found the registered provider had not ensured that there was always enough staff to meet people's needs. |