Francis House

Quality Report

Dennington, Swimbridge, Barnstaple EX32 0QG
Tel:01271 830030
Website:www.francishouse.com

Date of inspection visit: 18 April 2017
Date of publication: 14/06/2017

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

In our comprehensive inspection in November 2016, we were concerned that as clients were becoming older there were increasing potential safety risks for people using this service. There were no staff after 10pm at night and some clients smoked in their rooms, which meant there were fire risks. Clients could contact on call staff in a neighbouring building but some had mobility issues, which meant there was a risk of falls and staff not being available to help.

We raised our concerns with Devon and Somerset Fire and Rescue Service who carried out an audit in February 2017 and issued an enforcement notice. The fire service required staffing to be in place during the night until fire safety had been signed off by Devon and Somerset Fire and Rescue Service, including a new fire alarm system.

The purpose of this unannounced inspection was to check if staffing was provided at night for the safety of the clients. We did not assess any improvements made to the environment during this visit.

On this inspection (18 April 2017), we found night staff in place. Staff on the late shift worked until 10pm, and additional sleep-in staffing (10pm to 8am) had been provided during the night in the residential building since February 2017. This was shared between four staff on a rota and was reported as working well. Staff had been provided with sleeping quarters in the same building as the client's rooms (residential building), Staff used this from 10pm to 8am. This meant there was a member of staff available if there was an emergency. Additional staff could be called via an on call phone or radio to other staff that lived elsewhere on site.

We spoke with the staff member on duty and looked at the fire evacuation plan and the residential building (known as Clare House). The staff member showed us the progress that had been made with the new fire alarm systems. The evacuation plan was up to date and identified client's rooms. The staff member on duty knew which clients had mobility problems and explained how they were sited on the ground floor.

Summary of findings

Contents

Francis House

Services we looked at
Substance misuse services

Summary of this inspection

Our inspection team

The team that inspected Francis House comprised of Sarah Lyle, lead inspector and a mental health inspection manager.

Why we carried out this inspection

We inspected Francis House as part of a focussed, follow up inspection. The purpose of the inspection was to follow up on the concerns raised at the comprehensive inspection on 7 – 8 November 2016 about lack of staff at night. The Fire Enforcement Notice of 15 February from Devon and Somerset Fire and Rescue Service required the service to provide staff during the night until a new fire alarm system was in place.

How we carried out this inspection

During the inspection visit, the inspection team:

- visited Francis House accommodation block (known as Clare House)
- checked the staffing arrangements at night
- spoke with the member of care staff on duty that night
- looked at the fire evacuation plan
- spoke with the assistant manager the following day.

Information about Francis House

Assisi Community Care Limited consists of one registered location, Francis House that provides rehabilitation to people recovering from substance misuse. The service includes the accommodation facility known as Clare House.

There were 11 clients at the time of our inspection.

The service is registered by the CQC to provide the following services:

- Accommodation for persons who require nursing or personal care
- Accommodation for persons who require treatment for substance misuse

The service has a registered a manager and a nominated individual.

We carried out a comprehensive inspection on 7 – 8 November 2017 and found the following issues where the service provider needed to improve:-

- There was not a clear model of care that ensured client needs were fully met and that care was delivered in line with best practice.
- Staffing levels were not safe at night and the physical environment was not suitable for the risks of the client group, such as reduced mobility, memory problems and other factors associated with the ageing client group.
- Medicines given to did not have the legally required prescribing and dispensing information, including dose instructions and patient name. The provider took immediate action to improve this.

However we found the following areas of good practice:

- Clients were treated with kindness and staff were caring.
- Morale was high amongst the staff team and staff were enthusiastic about their roles. Clients were supported with their education and learning.
- Clients had up to date care plans and clients felt involved in their care.

Summary of this inspection

- Systems were in place to ensure regular mandatory training and supervision.

We made the following requirement notices:-

1. The lack of clear model of care meant that client needs were not met and that care was not delivered in line with best practice. This was a breach of regulation 9. (1)(a)(b)
2. Care and treatment of service users was not appropriate to meet individual needs and did not reflect the increasing needs of the client group associated with ageing. This was a breach of regulation 9. (1)(a)(b)
3. The provider was not correctly carrying out safe administration of medication. This was a breach of Regulation 12 (1)(2) (g).

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

This key question was not inspected as part of our follow up visit.

Are services effective?

This key question was not inspected as part of our follow up visit.

Are services caring?

This key question was not inspected as part of our follow up visit.

Are services responsive?

This key question was not inspected as part of our follow up visit.

Are services well-led?

This key question was not inspected as part of our follow up visit.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review the responsibilities under the Mental Capacity Act during this unannounced safety check inspection.