Richmond Fellowship(The)

Windsor Road

Inspection report

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Date of inspection visit:
18 March 2016

Date of publication:
20 April 2016

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 16 and 30 November 2015. At which a breach of legal requirements was found. This was because there were no sufficient measures to ensure when people had placed themselves at risk of self-harm or self-injury they could be safeguarded. Staff had not always made safeguarding referrals to local safeguarding authorities and the provider had not implemented proper and robust systems to make sure that care and treatment was provided in a safe way for people. This was with regards to the way medicines were managed, ordered and administered.

After the comprehensive inspection, we issued the provider with a Warning Notice requesting that they resolve the issues above and to ensure that they complied with regulations by 15 February 2016. The provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook a focused inspection on 18 March 2016 to check that they had followed their plan and to confirm that they now met legal requirements.

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Windsor Road' on our website at www.cqc.org.uk'.

Windsor Road provides care and accommodation for up to eleven adults who have enduring mental health needs. The home is a purpose built establishment with facilities on two levels, the upper floor being served by a passenger lift. All accommodation is offered on a single room basis including self-contained bedsit type facilities with private kitchen areas. The home is located on a quiet road in Lytham St Anne's close to local amenities and bus routes. There were eight people who lived at the service at the time of the inspection. People told us that they felt safe living at Windsor Road. One person told us, "I feel safe, things have improved here".

The home's registered manager has worked in this role since October 2015. 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 and associated Regulations about how the service is run.

At our focused inspection on 18 March 2016, we found that the provider had followed their plan which they had told us would be completed by the 15 February 2016 and legal requirements had been met.

People told us that they felt safe and that their risks were being managed appropriately.
We found incidents were reported in a timely manner and support plans were updated. Risk management information was evidenced and shared between staff and management team.
Documentation had been improved to guide staff in understanding people who used the service, this included records of early warning signs, triggers, management techniques and clear instruction on how to seek support if people's needs deteriorated. Protection plans included clear and concise information for the

most effective support to be offered to people who used the service.

We saw staff had undergone training to support people who put themselves at risk. Staff we spoke to told us they felt confident after the training. We witnessed staff reacting to an incident confidently.
Staff on duty had sufficient knowledge of risks around individuals who use the service and what plans they had in place to manage the risks.

We found the service had put in place robust systems for ordering medicines. We did not find evidence of anyone running out of medication or being given medication a day later. We found medication was being administered safely and stock audits had improved significantly.
We found medication support plans contained sufficient detail.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

We found that action had been taken to improve the safe delivery of care and treatment.

Peoples who were at risk of self-harming had been assessed and risks assessments with clear and concise risk management plans were in place.

Training had been delivered to staff on supporting people who attempt suicide and self-harm.

Robust medicine management system had been put in place. Medicine stocks and administration audits had improved significantly.

This meant that the provider was now meeting legal requirements.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for safe at the next comprehensive inspection.

Windsor Road

Detailed findings

Background to this inspection

We carried out an unannounced comprehensive inspection of this service on 16 and 30 November 2015. At which a breach of legal requirements was found. This was because the provider had not implemented robust systems to adequately safeguard people from risk of self-harm or injury. Staff had not always made safeguarding referrals to local safeguarding authorities and the provider had not implemented proper and robust systems to make sure that care and treatment was provided in a safe way for people. This was with regards to the way medicines were managed, ordered and administered.

After the comprehensive inspection, we issued the provider with a Warning Notice requesting that they resolve the issues above and to ensure that they complied with regulations by 15 February 2016. The provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook a focused inspection on 18 March 2016 to check that they had followed their plan and to confirm that they now met legal requirements.

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The home's registered manager has worked in this role since October 2015. 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 and associated Regulations about how the service is run.

At our focused inspection on 18 March 2016, we found that the provider had followed their plan which they had told us would be completed by the 15 February 2016 and legal requirements had been met.

People told us that they felt safe and that their risks were being managed appropriately.
We found incidents were reported in a timely manner and support plans were updated. Risk management information was evidenced and shared between staff and management team.
Documentation had been improved to guide staff in understanding people who used the service, this included records of early warning signs, triggers, management techniques and clear instruction on how to seek support if people's needs deteriorated. Protection plans included clear and concise information for the most effective support to be offered to people who used the service.

We saw staff had undergone training to support people who put themselves at risk. Staff we spoke to told us they felt confident after the training. We witnessed staff reacting to an incident confidently.
Staff on duty had sufficient knowledge of risks around individuals who use the service and what plans they had in place to manage the risks.

We found the service had put in place robust systems for ordering medicines. We did not find evidence of anyone running out of medication or being given medication a day later. We found medication was being administered safely and stock audits had improved significantly.
We found medication support plans contained sufficient detail.

Inspected but not rated

Is the service safe?

Our findings

At our comprehensive inspection of Windsor Road on 16 and 30 November 2015 we found the provider had not implemented proper and robust systems to make sure that care and treatment was provided in a safe way for people who used the service. People's medicines were not always managed safely. Ordering systems were chaotic and the service did not have a sufficient ordering schedule that meant people's medicines were in line with monthly medicine administration records. We found examples of people's medicines running out and an emergency prescriptions being requested frequently. A lack of stock control placed people at high risk of not receiving their medicines as prescribed.

We found that two people had not been effectively risk assessed or protected against self-injury and attempt to take their lives. Significant incidents had occurred on a frequent basis and the service had failed to undertake comprehensive risk assessments to formally assess monitor and prevent self-injury and suicide attempts.
This was a breach of Regulation 12 (1) (2) (a) (b) (c) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection 18 March 2016 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 12 described above.

We looked at medicine management and found the provider had established a robust system for ordering medication. For example, all medication was ordered from one pharmacy and people's medication cycles had been arranged so that they got majority of their medication delivered on a monthly basis.

We looked at how the service ensured that people did not run out of medication and found there were no concerns around medication stocks running out. Stock audit checks had significantly improved. There was system in place to establish medication stock levels. We spoke to the registered manager who informed us they had undertaken daily and weekly audits of medication records and stock. We checked the records and audited the stock and found this to be correct. This ensured that the service had put measures in place to monitor and detect medication errors and areas of concern and identify actions to reduce errors.

We looked at guidance provided to staff for people using "as and when medication" (PRN). We found PRN care plans provided sufficient detail for staff to use when deciding when to give medication. People told us they felt confident with the way their medication was being managed and where changes to medication were required, they told us they were involved in making the changes. Records we saw confirmed that people had been included in the implementation of the medication improvement plan and people were informed before the service changed the pharmacy. We spoke to the Pharmacist who informed us they had worked with the service and the manager and medicine practice had improved.

We looked at people's medication records and found information on people's allergies was recorded in front of each person's medicines file. Staff had discussed this in their staff meeting. The provider had sought medication management training from the Local pharmacy who had trained registered nurses on safe

management of medications.

We looked at how the service was managing the safety of people who put themselves at risk due to self-harming and suicide attempts. We found staff had undergone training around supporting people who self-harmed, ligature training and support for people who attempt suicide. We spoke to staff who felt they were confident and equipped to understand risks around individuals and felt confident to put their knowledge into practice. Two members of staff we spoke to were able to give detailed information on each individual they thought were at risk and how they were managing them. This matched with the details we found in care records. An incident happened while we were there and we observed staff putting safety plans into practice. We asked staff about safeguarding procedures and local protocols and staff showed awareness of safeguarding procedures and protocols that they would follow to ensure people they supported were safe.

One resident we spoke to told us "Sometimes I feel safe" And "Staff are good at spotting when you are unwell, they know the signs and they drop everything to come and help you, its reassuring".

We looked at people's protection plans and risk assessments and found these had been completed and provided clear and concise information for the most effective support to be offered to people who used the service. Documentation we looked at showed improvements with regards to guidance to staff in understanding people who use the service. For example we found records included early warning signs, triggers, ways of managing risks and clear instructions on what to do if people continued to put themselves at risk of harm. This meant staff had been supported to have a better understanding of people's needs.

We looked at whether the service had followed safeguarding protocols. We found incidents had been reported to the local authority safeguarding department in a timely manner. Support plans and risk assessments had been updated to reflect this and information on incidents had been evidenced and shared in staff handovers. We observed management had audited and analysed incidents and trends. In two instances we observed management had made recommendations on how staff had acted and offered further advice on how the identified risk could be further managed. This meant that management were providing oversight on what staff were doing and ensuring the service learnt from incidents.