# Cornerstone Aberdeen South Housing Support Service

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**Type of inspection:**
Unannounced

**Completed on:**
13 August 2024

**Service provided by:**
Cornerstone Community Care

**Service provider number:**
SP2003000013

**Service no:**
CS2015343108

## About the service

Cornerstone Aberdeen South is a housing support and care at home service providing care to adults with a learning disability. The provider is Cornerstone Community Care, a large voluntary organisation and registered charity, which provides care services across much of Scotland. The people they support live in their own homes, sharing with a small group of people. At the time of inspection the service was supporting six people living in two different properties in Aberdeen city.

## About the inspection

This was an unannounced, follow up inspection, which took place on 8 August 2024. The inspection was carried out by two inspectors from the Care Inspectorate. To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we:
- Spoke with two people using the service and one of their family
- Spoke with two staff and management
- Observed practice and daily life
- Reviewed documents.

## Key messages

• The manager and lead practitioner were working hard to support the staff and service users.

• Staff were not following all of the procedures in relation to eating, medication and staff deployment, which meant people were not receiving safe and effective support.

• People were happy in some respects, such as choosing their menu, but they were not happy with the lack of staff.

• Previous requirements had not been met and the service needed to take immediate action to improve the quality of people's care.

## From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

| | |
|---|---|
| How well do we support people's wellbeing? | 2 - Weak |

Further details on the particular areas inspected are provided at the end of this report.

## How well do we support people's wellbeing? 2 - Weak

People's health and wellbeing was supported at a weak level. There were some strengths and also areas of weakness that could lead to poor outcomes for people. We have therefore regraded this question to an evaluation of weak.

Staff did not understand and carry out their responsibilities in relation to supporting people with medication. Medication errors had occurred with potentially serious consequences.

The management team carried out medication audits in relation to the stock levels and the most recent one found unexplained shortages of some tablets, and extra for other tablets, and one unlabelled tablet in a Rescue Medication bag. The staff in the service have had observations of their practice, retraining sessions, discussions at team meetings and medication errors continued to occur. The management team are considering their next set of measures to improve medication administration and recording to keep service users safe.

People had access to food and drink that met their needs during the day, but not late in the evening or overnight. One service user was unable to access food and drink between 7pm and 7am. Another was able to eat and drink between these times but not in the safest manner.

There was a menu board written for the week and one service user confirmed that they got to choose what went on it. However, because the food shop had not yet arrived, the menu and the board had to change. The service user was not fully informed and did not know what they would be eating that night.

There were many examples of people doing activities, and these were sometimes in the house and sometimes at events such as attending a disco, going for a walk, doing shopping, arts & crafts. People's long term goals were proving more difficult to achieve despite staff trying to find innovative ways for them to happen. This meant people had some things to do each day but were not being supported with all of their choices.

As well as choices in activities, the service users had other restrictions related to the staffing rota. For example, choice in when to go to bed was limited for some people because they needed to use a hoist, so had to go to bed before the night shift worker was left alone.

People's wellbeing was considered by the service, but choices had to fit with their available staffing rather than being predicated by what people wanted to do **(see 'What has the service done to meet any previous requirements we made at or since our last inspection', Requirement 2')**.

# What the service has done to meet any requirements we made at or since the last inspection

## Requirements

### Requirement 1

By 27 June 2024, the provider must ensure that:

a) All incidents which are detrimental to the health and welfare of service users are thoroughly investigated in a timely manner.

b) Incident reports are completed in a timely manner and where applicable notification reports are sent to the Care Inspectorate.

c) When service users have experienced harm, or are at risk of harm, adult protection processes must be followed in a timely manner, and notifications made to the adult protection team and other appropriate healthcare professionals.

This is in order to comply with:
Health and Social Care Standard 4.18: I benefit from different organisations working together and sharing information about me promptly where appropriate, and I understand how my privacy and confidentiality are respected.

Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011 No. 210 Social Care)

**This requirement was made on 27 May 2024.**

#### Action taken on previous requirement

This was a requirement resulting from the investigation into a complaint.

We saw incident reports, and were satisfied that most of them were reported to the Care Inspectorate, in a timely manner, with two recent notable exceptions. Some, but not all, were investigated sufficiently. We did not see that outcomes for people had improved, for example some people did not receive their medication as prescribed, and some people were left unattended when they should have been supported by staff.

One notable incident recently should have been reported to the police and adult protection, and this was not done until the next morning. An error meant that the member of staff was not able to contact the On Call Manager and they did not independently contact the relevant people.

While some areas could be seen as strengths, the practice was not up to a good standard, and the errors could have very serious consequences for people. This requirement had not been met and we have agreed an extension until 1st September 2024.

#### Not met

### Requirement 2

By 27 June 2024, the provider must demonstrate proper provision for the safety and welfare of services users is made. In order to achieve this the provider must:

a) Ensure that at all times suitably qualified, skilled, and experienced staff are working in the care service in such numbers as are appropriate for the health and welfare of service users.

b) Demonstrate that overnight staffing levels take account of people's right to safely have access to food and fluids when hungry or thirsty.

This is in order to comply with:
Health and Social Care Standard 1.19: My care and support meets my needs and is right for me.

Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011 No. 210 Social Care).

**This requirement was made on 27 May 2024.**

#### Action taken on previous requirement

This was a requirement resulting from the investigation into a complaint.

The manager and lead practitioner developed a staffing tool, which had been further adapted by the branch manager and this was starting to look in depth at people's individual support needs and how the staffing levels affected other people in the house.

The numbers of staff on duty in the house did not always allow for two staff to undertake personal care or medication duties, while one other member of staff was available to supervise people and ensure they were safe.

There was one member of staff working overnight, and there was no contingency plan to be able to access another one. This meant one person could not have food or drink between 7pm and 7.30 am. Another person could have medication and drink in their bed but that did not follow "safest" guidelines, and was not affording choice for the person.

The evacuation plans in case of a fire overnight did not advise safe, or best practice and the manager agreed to revise these immediately.

The service did not demonstrate proper provision for the safety and welfare of services users.

This requirement had not been met and we have agreed an extension until 1st September 2024.

#### Not met

### Requirement 3

This was a requirement resulting from the investigation into a complaint.

By 27 June 2024, the provider must ensure that incidents which are detrimental to the health and welfare of service users are thoroughly investigated in a timely manner.

a) Incident reports must be completed in a timely manner and where applicable notification reports are sent to the Care Inspectorate.

This is in order to comply with:
Health and Social Care Standard 3.17: I am confident that people respond promptly, including when I ask for help.

Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011 No. 210 Social Care).

**This requirement was made on 27 May 2024.**

### Action taken on previous requirement

The action taken in relation to this requirement has been described in Requirement 1. This requirement has not been met and will not be reinstated, because the reinstated requirement will cover this improvement.

### Met - within timescales

## Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

## Detailed evaluations

| How well do we support people's wellbeing? | 2 - Weak |
|---|---|
| 1.2 People get the most out of life | 2 - Weak |

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