Futures Care Homes Limited

# Futures Care Home

## Inspection report

162 Church Road
Brightlingsea
CO7 0QY
Tel: 01206 305835
Website: www.futures-carehomes.co.uk

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## Ratings

| | |
|---|---|
| **Overall rating for this service** | **Requires Improvement** |
| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

## Overall summary

This inspection took place on 12 November 2014 and was unannounced.

The service provides accommodation and support for up to 9 people with learning difficulties and autistic spectrum disorder. Two rooms are set aside to be used as a respite service. These were unoccupied at the time of our inspection and six people were living permanently at the service.

The service had not had a registered manager in place since June 2013 but the newly appointed manager has made an application to become registered with the commission. 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.

Staff knew how to recognise the signs of abuse. Some staff were not clear about raising a concern directly with the appropriate authorities. Risks were assessed and actions taken to reduce them.

We were concerned that staffing levels were not always enough to support people and keep them safe.

# Summary of findings

Sometimes levels dipped below those set by the management of the service. Several relatives expressed their concerns about the staffing levels and one felt this had contributed to their relative suffering a seizure when they should have had one-to-one supervision.

Although systems for administering medicines were in place, medication audits and stocktaking procedures were not robust which could have placed people at risk of receiving too much or not enough of their prescribed medicines.

Staff received the training they needed to carry out their roles and were positive about the quality of the training

The requirements of the Mental Capacity Act 2005 had not been followed in order to assess people's capacity to consent to have a flu vaccination. The service had not yet made any applications to the local authority under the Deprivation of Liberty Safeguards even though an application of this type would be appropriate for some of the people who used the service in order to keep them safe.

People were supported to have a balanced diet and were appropriately referred to dieticians. Other healthcare professionals were involved in people's care but some of their advice had not been followed.

We found that staff were caring and demonstrated that they had built up good relationships with the people they were supporting. Staff knew people well and were patient and treated people with dignity. The people who used the service were supported to follow their hobbies and interests and were introduced to new interests by staff.

We found that comments and feedback raised by relatives did not always bring about change and some concerns had been raised multiple times without them being resolved. Formal complaints were not always responded to promptly and to people's satisfaction.

Record keeping at the service was incomplete and several records could not be located. This had the potential to place people at risk. Quality assurance systems were in place but it was not always clear to whom concerns would be escalated.

At this inspection we found that there were breaches of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**
The service was not safe.

There were not always enough staff to keep people safe.

Staff were trained to recognise the signs of abuse.

Risks were assessed and measures put in place to reduce them.

People received their medication as prescribed but systems to audit medication could be strengthened.

**Requires Improvement**

**Is the service effective?**
The service was not always effective.

Staff received the training they needed to carry out their roles effectively.

The requirements of the Mental Capacity Act 2005 had not been met as people's consent had not always been sought in line with legal requirements. No applications had been made to deprive people of their liberty in order to keep them safe, as is required under the Deprivation of Liberty Safeguards.

Although people were supported to maintain good health we found the advice of some healthcare professionals was not always followed.

**Requires Improvement**

**Is the service caring?**
The service was not always caring.

Relatives were mostly happy with the way staff provided care and support, although the preferences of people who used the service had not always been identified.

People's privacy was not always respected.

**Requires Improvement**

**Is the service responsive?**
The service was not always responsive.

Concerns and complaints from people's relatives were not always responded to promptly and resolved to their satisfaction. Some relatives felt that their views were not taken into account.

People who used the service were supported to follow a large range of hobbies and interests. They were encouraged to take an active part in their local community.

**Requires Improvement**

**Is the service well-led?**
The service was not well led.

**Requires Improvement**

# Summary of findings

Relatives of people who used the service did not feel that the management communicated well or acted on the feedback they gave.

The service has been without a registered manager since 2013. The new manager has begun the process to become registered with the commission.

Quality assurance systems were not always robust and record keeping was poor.

# Futures Care Home

**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.

The inspection took place on 12 November 2014 and was unannounced.

The inspection team consisted of two inspectors.

Before we carried out our inspection we reviewed the information we held about the service. This included statutory notifications that had been sent to us in the last year. A notification is information about important events which the service is required to send us by law. Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used the information provided to us in statutory notifications and the PIR to help focus our inspection.

The people who used the service were not able to tell us about their experiences but we observed staff supporting and caring for them and spoke with six of their relatives, two care staff, the newly appointed manager, the manager who had been in day to day charge of the service in recent months of the service and one of the directors of the business. We reviewed four care plans, three medication records, two staff recruitment files, staffing rotas for the last three months and records relating to the maintenance of the service and equipment. Following the inspection we contacted the local authority contracts department for additional feedback about the service.

Requires Improvement

# Is the service safe?

## Our findings

The manager told us that staffing levels were set at four staff in the daytime and two night staff from 20.00. Additional staff were needed when respite clients were at the service. We looked at rotas for the last three months and found that on several occasions staffing levels dipped below the set level. We found that not all the staffing records were accurate and so it was not possible to establish how often the service was short staffed. It was not clear from the staffing record how the additional one-to-one hours were being used.

Staff told us that they felt that there were usually enough staff. One member of staff told us staffing can be low when people go off sick but said that, "Management join in. Everyone knows what they are doing". One person had one to one staffing all the time.

Three relatives of people who used the service told us that they felt that there were not always enough staff on duty. One person said, "There are just not enough". We saw that a safeguarding concern had been raised because of what occurred when a person had been left unattended for a period of 15 minutes when they should have had one to one supervision. Records showed that there were only four people on duty at the time of this incident instead of five, as the service was supporting a respite client in addition to the people who live permanently at the service. This was below what we had been told was the minimum required to meet people's needs and therefore was a potential factor in not keeping people safe.

Staff had received training in keeping people safe and reporting concerns about possible abuse. We found that staff were knowledgeable about the signs and symptoms a person might display if they were being harmed, although they were not clear about how to report concerns directly to the local safeguarding team. Safeguarding concerns were escalated promptly and the service made referrals when needed. We noted that the local safeguarding team had asked the new manager to conduct an investigation and we saw that it had been carried out thoroughly and the findings were made available to us. We saw that the matter had been raised with the particular member of staff and an action plan aimed to ensure that the situation did not happen again.

We saw that risks associated with people maintaining their independence and using the leisure facilities in their local community, such as horse-riding and sailing, were assessed. Risks were regularly reviewed. We saw that specific risks such as using the trampoline, road awareness and touching electrical sockets were assessed. Measures to reduce the risk posed by electrical sockets included using socket covers on all unused plugs. We noted that throughout the service plugs were covered in this way. We also saw that window restrictors were present on the upstairs windows to keep people safe.

We were concerned that one person had suffered an epileptic seizure in a swimming pool but their risk assessment and care records had not been reviewed in the light of this incident. We raised this issue with the new manager and these records have now been updated.

Records relating to the maintenance and servicing of equipment and regular health and safety checks showed that the manager took steps to maintain a safe environment. We noted that the carpet was worn in one area of the living room and felt that this could present a possible trip hazard. The director told us that this was due to be replaced and had already got samples for people to choose a new floor covering.

Staff employed had been through a recruitment process before they started work. Staff had criminal records checks in place to establish if they had any criminal record which would exclude them from working in this setting. All appropriate pre-employment checks had taken place before people started working. Staff received the training they needed to carry out their roles and worked alongside permanent staff until they became familiar with people's needs and the routines of the service.

Staff received training before they administered medicines and those we spoke with were knowledgeable about the medicines they were giving to people. There were protocols for staff to follow when giving people medicines which they only needed occasionally or in response to a specific health need such as recurring epileptic seizures. These protocols were comprehensive and staff were able to tell us, in detail, how they would support a person to take their medicine in this circumstance.

We saw that there were effective systems in place for the ordering, booking in, storing and disposing of medicines,

Requires Improvement

# Is the service safe?

including controlled drugs. However the stocktaking and auditing systems for medicines were not robust which meant we could not be assured that people were receiving their correct medication.

Requires Improvement

# Is the service effective?

## Our findings

We found that the staff did not demonstrate a consistently good understanding to the Mental Capacity Act 2005 (MCA) or the Deprivation of Liberty Safeguards (DoLS). The MCA ensures that, where people lack capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation.

We saw that some MCA processes, such as one for the administration of emergency medication when a person had a series of seizures, had been carried out correctly. Where people did not have the capacity to consent to receive this type of medicine Best Interests meetings had been held with the local GP or consultant. People's relatives had been appropriately involved in the decision making process. However we had some concerns. One person's relative was very unhappy that their relative, and others who used the service and who did not have the capacity to consent to a medical procedure, had received an influenza vaccination. The MCA process had not been followed and the vaccination had not been identified as being in their best interests. We were aware that this was an issue which also concerned the local GP surgery but the management of the service had a responsibility to ensure that the rights of the people who used their service were protected.

We also noted that some people had listening devices and/or cameras in their rooms. The manager was not able to show us that the need for this had been assessed and agreed as being in people's best interests in line with the MCA. It was not clear to us how staff were both keeping people safe and ensuring their privacy and dignity.

This was a breach of Regulation 18 of the Health and Social care Act 20118 (Regulated Activities) 2010.

We observed staff members skilfully supporting the people who used the service and demonstrating a detailed knowledge of people's specific health conditions such as epilepsy. One relative of a person who used the service told us, "The staff are really lovely. [My relative] was ill recently and they were really good to [them]".

Staff received an induction before working with people who used the service. One member of staff explained to us that they had received lots of training even though they had worked in another care home previously. They had spent some time shadowing permanent staff, reading the care plans and getting to know the people who used the service.

Staff told us that they received the training they needed to carry out their roles and felt supported by the management of the service. They met with their manager regularly as part of a formal supervision process. Records confirmed that staff received training and supervision and that all staff except two had received an appraisal within the last year.

The front door to the service was locked and we saw that all the people who used the service were effectively deprived of their liberty. The outgoing manager told us that this was being done for people's own safety (the service was located on a busy road). The new manager told us that they had not yet completed the required applications to the local authority regarding DoLS but had begun the process for all the people who used the service

People who used the service were involved in planning their meals and staff knew about people's specific dietary needs. The member of staff on duty was able to tell us how they support one person to try and gain weight. We saw that there were high calorie snacks available for this person and plentiful stocks of fresh fruit and vegetables were in the kitchen. People were encouraged to drink and we observed staff offering drinks to people. Care plans identified people's food preferences and staff on duty were able to tell us about them in some detail. One person was unable to eat bread and related products and staff explained how they encouraged them to try other foods. We saw that specialist advice from a dietician had been sought for some people and one person's weight was being monitored but had not yet increased to an acceptable level.

Staff supported people with their health needs related to their epilepsy. One relative was unhappy with the way this was being managed for their relative. We noted that staff were recording this person's seizures in different sections of the care plan and the seizure record which was reviewed every six months by the consultant managing this person's epilepsy was not accurate. We noted that five seizures which occurred between 24 October and 3 November 2014 had not been recorded on the seizure chart. Recording in this area needs to be strengthened to allow medical professionals to accurately review the treatment.

Requires Improvement

# Is the service effective?

Although there was very detailed information in some care plans about how to support people who were having or were about to have an epileptic seizure, relatives told us about two recent occasions when their relatives had not received the support they needed. Both incidents have been referred to the local safeguarding authority for investigation.

We saw that people had access to regular health appointments. One relative of a person who used the service told us that they were not always informed about health appointments even though they wished to attend these with their relative. They told us, "We're parents. We would like to be informed before the appointment rather than afterwards. Otherwise we are reasonably happy with how they look after [my relative's] health".

One relative told us they were concerned that their relative was not receiving the daily healthcare treatment they needed even though this had been discussed with staff and the management of the service. A healthcare professional had devised a daily plan for this person's relative in order to keep them as mobile and independent as possible.

We noted that records which the service held on each person were extensive, sometimes extending to several files. Staff were not clear where important information, which people would need to take to hospital in an emergency, was located.

Requires Improvement

# Is the service caring?

## Our findings

A relative of one of the people who used the service told us that staff were good and felt that, "They sincerely care for [my relative]. It's a lot off my mind as I know they are looking after [them]". Another person commented that their relative was always very keen to return to the service after time away stating, "[My relative] is always raring to go back in!". They told us that they found staff were, "Always available to talk to and are really lovely".

Throughout our inspection we observed staff treating people respectfully and patiently. Staff were observed to use Makaton signing with one person and took time to ensure they understood what the person wanted. One member of staff told us, "They are the same as me – the same age and interests. I like to come in on my day off and do [activities] with people sometimes". It was clear to us that the staff knew the people who used the service well and communicated easily with them as they decided what people wanted to do that afternoon.

Although relatives of people who used the service were involved in decisions about their relative's care and welfare and had signed care plans, we received mixed feedback about how they were routinely involved in their relative's care. One relative told us that they had recently attended meetings with the manager who had been in day to day charge in recent months. The meeting had been called to review their relative's care and they told us they were 'very pleased' at how it went. We saw that relatives were invited to review meetings two or three times a year. Other relatives were not so positive and commented that sometimes the service does not communicate well with them or keep them updated about important matters concerning their relative.

People who used the service were treated respectfully by staff throughout our visit. We saw staff respecting people's choices and encouraging people to be independent. One person was encouraged to go and find their bag before they went out for the afternoon. Staff showed patience and worked at the pace of the person they were supporting and gently encouraged without rushing. Staff told us about a piece of work with one person to encourage them to collect the things they needed for a particular outing or activity by using one object to represent the activity as a whole. For example if staff held up a swimming towel the person was encouraged to fetch their swimming costume.

People's privacy was respected by staff and we observed someone who wished to spend some time alone and this was understood and respected. We noted that care plans did not document whether people, or their relatives, had been asked to express a preference about whether they preferred a man or a woman to provide them with their personal care. We also found that care plans did not document people's preferences with regard to their daily routines. The new manager told us that one of their first actions was going to be to ensure that this kind of information was captured within a care plan and that the service would then provide people with the care they needed in the manner they preferred.

We noted that throughout the majority of our inspection a resident from another service, which is managed by the same provider, was at the service. This was because the manager of that service, who had also been in day to day charge of this service in recent months, wanted to stay on to assist our inspection. We did not see that any of the people who use the service were consulted about this person being in their home.

Requires Improvement

# Is the service responsive?

## Our findings

Although the service had a pictorial complaints procedure it was not clear how people who used the service would be enabled to raise a complaint themselves. Two relatives expressed frustration as they had raised issues but had seen little change as a result of this. One person had repeatedly raised concerns about their relative's clothes going missing but this issue had not been resolved to their satisfaction. Another relative had raised the issue of staff not following a treatment plan for a for their relative's specific healthcare needs with the manager. They told us they were still concerned that staff were not meeting this person's daily healthcare needs.

Two relatives who had made complaints told us that they had not been responded to in writing and one had been waiting for over a month for a response to a complaint they had raised. Three relatives made comments about how they found that after issues were raised either formally or informally action did not always follow to improve the situation. We asked one of the directors how they had responded to the two recent complaints. They said that the local safeguarding team had asked the service to carry out their own investigation and this had not yet concluded. There was no paperwork related to the second complaint and the director confirmed that they had not yet responded to this in writing. Therefore, because there was no effective system in place to listen and respond to complaints, learning in order to reduce and prevent future inappropriate care and treatment could not take place.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

We saw that although the people who used the service may have very limited capacity to be involved in making decisions about their care, their relatives were invited to be involved if they wanted to be. The manager who had been in day to day charge in recent months told us that meetings were held four times a year with relatives and we saw that they had signed some care plans and risk assessments

Care plans showed that people had a large variety of hobbies and interests, such as sailing, horse riding and trampolining and had the opportunity to do these regularly. On the day of our inspection everyone had been out during the morning and in the afternoon people decided they wanted to go to the zoo. A relative told us that they felt some activities were not available as often as they used to be but were not sure why this was. We saw that some people who used the service had funding in place for additional staff hours but it was not clear from the records how this additional staffing was being used to benefit people.

Staff were aware that one person required maximum stimulation and to be occupied as much as possible to meet their individual needs. Staff spoke knowledgeably about techniques that would be used to distract this person and provide them with enjoyable things to do.

People who used the service had their needs assessed and care plans included some specific detail which aimed to ensure staff met people's needs in a way people were most likely to accept the support offered. One care plan described the various stages a person goes through before they had an epileptic seizure to help staff recognize the signs and then gave them clear information how to support the person during a seizure.

People's preferences were documented and we saw that they were enabled to take part in events taking place in their local community such as theatre trips. We noted that people took regular trips to the library, local shops and cinemas.

We saw that each person who used the service met once a month with their keyworker to set a goal for the following month. One person's recent goal had been to go bowling and the next meeting documented that this had taken place and then moved on to consider the next goal. The manager told us that relatives were invited to attend these meetings every three months so they could have some input. Resident meetings were not carried out as it was felt that this would not be a format which the people who used the service would be able to respond to.

The outgoing manager told us that surveys with families and other stakeholder had not been carried out recently and was unable to find the most recent ones for us to look at.

Requires Improvement

# Is the service well-led?

## Our findings

Record keeping throughout the service was not effective and some information we asked to see could not be provided. Records relating to the people who used the service were housed in several large files and the most recent information was not easy to locate as old information had not been archived.

We asked one member of staff to show us what information would accompany a person if they were admitted to hospital in an emergency. The manager who had been in charge of the service in recent months told us that there was a hospital passport for each person which contained information about how the person communicated and how best to treat them successfully. A member of staff was unable to locate this. The manager also said that they had a link with the local hospital's learning disability liaison nurse but this was not recorded and not all staff were aware of this. This showed that consistent care could not be supported in records and staff knowledge.

Some care plans were not dated so we could not see how current the information was. Care plans, although very large documents, did not contain information about how to establish if someone was in pain or distress, how to establish a person's mood or how to communicate with them effectively. The new manager told us that they were aware of this lack of information and were planning to develop people's individual communication plans.

Records relating to the management of two people's epilepsy were not complete and had not been appropriately reviewed. One person's emergency treatment plan for their epilepsy was not current and another person's could not be located. The new manager has taken this forward since the inspection and put an action plan in place and has contacted an appropriate health professional for support with this.

We asked to see the records of the induction of the newest members of staff but these could not be located. Staffing rotas were handwritten and the amount of crossing out made them very difficult to read. We found that some records were inaccurate. We noticed gaps in the rota and the former manager told us that she must have worked these shifts but, given the concerns raised by relatives about low staff numbers as times, this was a concern as the record was not accurate.. The staffing record did not make clear how people's one-to-one hours were staffed each day which meant we could not be sure that people were receiving the support they required.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The service has not had a registered manager in place since July 2013. A manager from another of the provider's service had been providing management support to this service. A new manager has started the application process to become the registered manager.

Staff told us that team meetings were held regularly and once a month the whole staff team met together. These meetings gave staff the opportunity to raise issues and give and receive feedback. The manager who had been in day to day charge of the service in recent months told us that they regularly worked shifts to act as a role model for staff. The rota reflected that they worked some shifts but this seemed to take place when the service was short staffed rather than as part of any planned development of the service.

Some of the directors and the Nominated Individual of the service also worked occasional shifts as support workers. The Nominated Individual is the person legally responsible for the provision of the service. One of the directors, who also works as a support worker, had recently asked the newly appointed manager to carry out a disciplinary investigation into an incident which involved a colleague rather than someone for whom they had line management responsibility. We felt that this showed a lack of clear lines of accountability. Given that there has been no registered manager at the service for over a year we were not sure how the Nominated Individual and other directors ensured staff were able to raise issues about colleagues who also happen to be their line managers and legally responsible for the conduct of the service. No consideration had been given as to how this potential conflict of interest should be managed.

Relatives' comments about the management of the service were mixed. Some people found that communication was poor and felt that feedback they gave the service was not acted upon. One relative was unhappy that they had not been formally informed that a new manager had been employed and found this out at a social occasion. The new manager told us that they did not believe a letter had gone

Requires Improvement

# Is the service well-led?

out to relatives outlining the new management arrangements. There was a formal system of gathering feedback but the service could not find the latest surveys to show us and so we were not able to see how the service took people's comments on board.

The manager who had been in charge in recent months carried out a series of audits to monitor the quality of the service and we saw that these were carried out regularly. These audits did not include an overview of recent staffing levels. Additional audits had been carried out by an external auditor in recent months but we noted that some issues raised in these audits were not dealt with promptly. In addition we saw that the local authority had recently been working with the service to improve some areas of practice. Actions identified by the local authority were not always promptly addressed by the service and were carried forward.

Some of the service's systems were not effective. There was no protected handover time between shifts and information was handed over verbally from one shift to the next. A communication book and delegation sheet supported this but staff did not sign these and so we were not assured that staff had always received the information they needed before supporting people on the next shift.

We noted that the medication audit system could be strengthened. Staff were unclear who to escalate issues to. We saw that a medication audit carried out on the 11 November 2014 had identified that controlled drugs had not been checked in by two people, as is required by the service's own policy. It also found that some staff signatures were missing from the medication administration record. This was recorded but staff we spoke with were not clear who this information would be escalated to. We also found some stocktaking discrepancies when we counted some medicines which the audit had not picked up. The new manager was planning to make changes to several elements of the medication system.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment<br><br>**The provider did not have suitable arrangements for obtaining, and acting in accordance with, the consent of the people who use the service. Regulation 18.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints<br><br>**The provider did not provide people who use the service with a suitable complaints system or fully investigate and resolve complaints, as far as reasonably practical. Regulation 19 (2) (a) (c)** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records<br><br>**People who use services were not protected against the risk of unsafe or inappropriate care because accurate records in respect of their care and treatment, and records in respect of persons employed were not maintained or could not be located promptly when required. Regulation 20 (1) (a) and (b) (i).** |