Futures Care Homes Limited

Futures

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 21 January 2016 and was unannounced.

The service provides care and support for up to ten people with complex needs who have a learning disability and autistic spectrum disorder.

The service had a registered manager in place. 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 were trained in safeguarding people from abuse and systems were in place to protect people from all forms of abuse including financial. Staff understood their responsibilities to report any safeguarding concerns they may have although most were not clear how to report concerns to external bodies such as the local authority safeguarding team.

Risks to people and staff were assessed and action taken to minimise these risks, although sometimes information was not shared effectively to ensure people were protected. People were encouraged to remain as independent as possible and risks related to this were assessed.

Staffing levels meant that people's needs were met. Recruitment procedures were designed to ensure that staff were suitable for this type of work and checks were carried out before people started work to make sure they were safe to work in this setting. Some recruitment processes had not been robust.

Training was provided for staff to help them carry out their roles and increase their knowledge of the healthcare conditions of the people they were supporting and caring for. Staff were supported by the managers informally although formal supervision and appraisal had not been regular.

People gave their consent before care and treatment was provided. Staff had not been provided with training in the Mental Capacity Act (MCA) 2015 and Deprivation of Liberty Safeguards (DoLS) but demonstrated an awareness of people's capacity to consent. The MCA and DoLS ensure that, where people lack capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. Where people's liberty needs to be restricted for their own safety, this must done in accordance with legal requirements. People's capacity to give consent had been assessed and decisions had been taken in line with their best interests. DoLS applications had been appropriately submitted to the local authority.

People were supported with their eating and drinking needs and they were involved in shopping and cooking. Staff helped people to maintain good health by supporting them with their day to day physical and mental healthcare needs. The service worked well in partnership with other healthcare services, such as the

Intensive Support Team, to ensure people's healthcare needs were met.

Staff were caring and treated people respectfully making sure their dignity was maintained. Staff were positive about the job they did and enjoyed the relationships they had built with the people they were supporting and caring for.

People, and their relatives, were involved in planning and reviewing their care and were encouraged to provide feedback on the service. Care was subject to on-going review and care plans identified people's particular preferences and choices. People were supported to play an active part in their local community and follow their own interests and hobbies.

Formal and informal complaints were responded to appropriately although records were not clearly logged.

Staff understood their roles and were well supported by the management of the service. The service had an open culture and people felt comfortable giving feedback and helping to direct the way the service was run. Staff were positive about their work and about the support and guidance they received from the manager.

Quality assurance systems were in place and audits were carried out to monitor the quality and safety of the service. Audits had not been regular but a new system had been put in place by the manager.

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.

Systems were in place to safeguard people from abuse and staff had received safeguarding awareness training, although some were not clear on reporting procedures. Recruitment processes were not always robust.

Risks were assessed and action taken to minimise them, although identified risks were not always communicated throughout the staff team.

There were enough staff to meet people's needs.

Medicines were managed safely, although some staff were identified as needing training regarding an emergency epilepsy medicine

Is the service effective?

Good

The service was effective.

Staff received an induction and training to support them to carry out their roles. Staff demonstrated skills in supporting people's complex behaviour related to their autistic spectrum disorder.

People consented to their care and treatment. Staff had not received MCA DoLS training to support their practice.

People were well supported with their dietary and healthcare needs.

Is the service caring?

Good

The service was caring.

Staff were patient and compassionate and relationships between staff and the people they were supporting were good.

People were involved in decisions about their care and their choices were respected.

People were treated with respect.

Is the service responsive?

Good

The service was responsive.

People were involved in planning their care. Support was provided in a way which catered for people's individual needs and choices.

People were supported to play an active part in their local community and follow their own interests and hobbies.

Formal and informal complaints were responded to appropriately.

Is the service well-led?

Good

The service was well led.

People who used the service and staff were involved in developing the service.

Staff understood their roles and were well supported by the manager. The manager had a clear strategy for developing and improving the service.

Quality assurance systems were in place to monitor the delivery and safety of the service.

Futures

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 21 January 2016 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert was a family carer for a person with a learning disability.

Before we carried out our inspection we reviewed the information we held on 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. Before the inspection the provider completed a Provider Information Return (PIR). This is a form which asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with two people who used the service and observed the care of four others. We spoke with seven care staff, three relatives, the registered manager and adult social care staff at the local authority. We also gathered written feedback from two other relatives.

We reviewed four care plans, three medication records, six staff recruitment files and staffing rotas covering eight weeks. We also reviewed quality monitoring records and records relating to the maintenance of the service and equipment.

Requires Improvement

Is the service safe?

Our findings

There were systems in place which were designed to reduce the risk of abuse. Staff were able to tell us what they would do if they suspected or witnessed abuse. Staff were clear about how to report concerns within the service but some were not clear about how to report issues to external agencies, such as the local authority or Care Quality Commission, directly. All staff had received training in keeping people safe from abuse and this training was appropriately refreshed. Financial procedures and audit systems were in place where the service was responsible for people's money. These were designed to protect people from financial abuse and balances were checked and audited daily.

We saw that risks had been assessed and actions taken to reduce these risks. Risks associated with day to day activities such as going on day trips, eating and drinking, relationships and using public transport had been assessed. Specific risks associated with people's mental and physical health conditions had also been assessed and strategies put in place to help people manage these.

We saw that one person's plan documented measures to take when the person was going into crowded places in the community. Staff were able to tell us about the measures they needed to take to keep people safe. For example one staff member explained, "I have to stand back from [the person] when we're out, he needs his space". They were also able to explain how supervision of the person was increased when they were in unfamiliar surroundings. We observed staff supporting a person engaged in a craft activity with two care staff. The level of support had been increased as the person had a high risk of self-injury when using scissors but we saw that the additional support was discretely provided and the atmosphere was relaxed and the person was clearly greatly enjoying the activity.

We were aware of a serious safeguarding incident at the service which had taken place before our inspection. The incident had taken place in part due to insufficient risk assessment. We saw that since this time procedures had been tightened up and risk assessments reviewed. We did note one incidence of poor practice where someone had been identified as being at risk of running across a particular road when they attended an activity. A staff member had suggested parking in a specific place to minimise this risk but this information had not been shared with other staff effectively which continued to place this person at potential risk. We raised this with the manager who agreed that the information should have been shared and recorded in the person's care plan.

We found that, in spite of an assurance given to us previously by the Nominated Individual for the service, there was still no business continuity plan in place. Such a plan would document how the service would continue to be delivered in the case of an emergency which meant the service, or part of it, could not be used.

The service was well staffed with permanent members of staff and now rarely used agency staff. The people who used the service, relatives and staff told us that they felt that there were enough staff to keep people safe. One relative confirmed this saying, "I have no complaints". Another relative stated that they appreciated the fact that staff were able to bring their relative to their house for a visit. They said, "I like the

way they are able to put themselves out to bring [my relative] here". A member of staff said, "There are enough staff, yes, for two to one or one to one [staffing]. There are enough to de-escalate [behaviours where people are distressed]".

Support hours were clearly marked on the rota and where people had been funded for additional support we saw that this was provided. During our inspection we observed that people were supported by appropriate staffing to follow their own hobbies at the service or take part in activities such as swimming at a nearby pool. One person had their own staff team and a great deal of thought had been given to the compatibility of staff with the people who they were supporting.

Staffing at night was set at three waking night staff. We noted on the rotas supplied to us that occasionally only two staff were on duty. We also noted that, according to records supplied to us, on eight nights none of the staff on duty had been trained to administer Buccal Midazolam, which is a medicine given to people to prevent recurrent epileptic seizures. This placed people at potential risk of harm. We have spoken with the management of the service about this ad they have given us clear assurances that all relevant staff have now received this training.

Recruitment records showed that staff had followed an application process, been interviewed and had their suitability to work with this client group checked with the Disclosure and Barring Service before taking up their employment. We reviewed six staff files and found that although the service's recruitment policy had been followed in most cases, there were occasions when it had not. We found that one file showed that insufficient investigation had taken place into the professional background of one member of staff and the circumstances related to the end of their last employment. Another file contained only one reference instead of two. The service's own recruitment policy states that at least two satisfactory references should be sought and referees should be spoken with to confirm details in their reference.

We saw that there were robust procedures in place for the obtaining, booking in, storage, administration and safe disposal of medicines, including controlled medicines. A monitored dosage system was in place, with dosages and set times for administration clearly marked. We saw that people's medication administration record (MAR) charts were easy to read and up to date, with staff having signed appropriately when they had administered each medicine. Where medicines had been given on an "as required" basis or had been refused, staff had written the explanation of the circumstances on the back of the MAR chart.

There were clear protocols in place for PRN medicines and those relating to people's epilepsy had been written in co-operation with other healthcare professionals and had been appropriately reviewed. When people left the service for any reason we saw that medicines they might need while they were out were booked out so that there was a clear audit trail.

We saw accurate and up to date records for the return of medicines to the pharmacy. Bottles containing liquid medicines and packets containing loose medication had been dated upon opening, which meant the amounts remaining could be accurately checked against administration records.

Staff had been fully trained in correct medication administration practices and senior staff carried out a formal observation of staff annually to ensure they were continuing to give people their medicines safely. Training records and records of medication competency assessments confirmed this. We saw that medication audits were conducted regularly by a senior member of staff who had been delegated the responsibility for managing medicines.

Good

Is the service effective?

Our findings

We noted that the people who used the service appeared happy with the care and support they received and we observed positive interactions between staff and the people who used the service. One relative told us, "The staff are friendly. [My relative] is happy. I have no complaints at all". We saw that staff met people's needs in a skilled and competent manner which demonstrated that they knew the people well. Staff told us how they were committed to encouraging people's independence and providing them with choices. One relative said, "They are getting [my relative] involved in new things and improving [their] life skills".

When staff first started working at the service they received an induction which covered various aspects of delivering care and support. Although some records relating to people's induction were not available staff were positive about the induction and support they received. They told us they had had the opportunity to shadow more experienced staff and read care plans before they became part of the permanent complement of staff.

Staff told us they felt they had the training they needed to carry out their roles confidently. Training records confirmed that staff received a varied training programme and that the training was updated appropriately. Specific training such as that for physical intervention and breakaway techniques and training relating to specific conditions such as Autistic Spectrum Disorder had been provided.

Staff told us they felt well supported by the manager, although formal supervisions had not always been regular. One staff member said, "There is support from the team leaders and [the manager] is accessible". Other staff echoed this and the general feeling was very positive. The manager had delegated some responsibilities such as medication, to senior members of staff and we saw that staff were encouraged to develop their skills and achieve recognised qualifications.

We noted that staff sought people's consent before they provided people with care and treatment during their day to day interaction with the people they were supporting. However care staff did not demonstrate a good understanding of the Mental Capacity Act (MCA) 2005 and had not received training in this. We saw that people's capacity to make day to day decisions had been assessed and staff were clear that unless people had been assessed as not having capacity to make a specific decision, they needed to assume that they were able to give their consent. Where people's capacity to consent fluctuated on a day to day basis this was clearly recorded in their care plan. Where significant decisions were required in people's best interests, meetings had been hosted to consult openly with relevant people prior to decisions being taken. We saw that such meetings had been held regarding giving people their medicines covertly and the management of a person's weight.

The manager was aware of the need to apply to the local authority if there was a need to restrict someone's liberty for their own safety under the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been submitted appropriately for people living at the service.

We observed staff supporting people to prepare their meals and ensure they had access to food and drink.

Menus were decided in collaboration with the people who used the service and people were free to have alternatives to the menu if they wanted. People chose to eat where they felt most comfortable. We saw that one person had baked a cake with staff the previous day and people were encouraged to increase their independent living skills. One person was supported to shop for their own food and then prepare their own meals. Two people occasionally cooked for each other.

We saw that some people had specific dietary needs and these were recorded in their care plan and the service used the learning disability dietician's food and drink chart to monitor and record people's diets. Staff were skilled in supporting people's specific needs related to their diet.

People's access to healthcare, including specialist healthcare, was good. People were supported to attend routine healthcare appointments with opticians and dentists. Staff worked in partnership with other healthcare professionals such as district nurses, GPs and hospital consultants to meet people's need promptly. The service also worked with healthcare professionals regarding people's epilepsy and mental health needs. Staff told us they were well briefed by the manager before supporting people to attend any healthcare appointment. Grab sheets were in place which contained important information for healthcare professionals to know when someone was admitted to hospital in an emergency.

Good

Is the service caring?

Our findings

People appeared happy with the way staff provided care and support. One relative said, "I have found the staff pretty good. They work well with [my relative]". Staff, including newly employed staff, demonstrated that they knew people well and we saw that they had built good relationships with the people who used the service. Staff were able to give us in-depth explanations of what worked well for people and how care had to be delivered flexibly according to people's needs and moods.

We saw that systems were in place to support people to communicate their feelings and wishes. People were encouraged to use mood books where they wrote in different colours according to their particular mood. We observed that the atmosphere was relaxed and staff managed people's early signs of agitation to diffuse potentially disruptive and distressing incidents. People who used the service had the opportunity to use a local advocacy service if they needed to and this tended to be used for specific purposes, such as annual reviews of their care.

Staff were observed explaining to people what would be happening and taking the time needed to do so effectively. One person was seen to communicate with staff using Makaton signing, although Makaton training had not been provided to staff.

We saw that people, and where appropriate their relatives, were involved in decisions about their care. Regular meetings were held with staff and the manager had begun to take a more structured approach to meeting regularly with relatives. The manager and staff told us how much they valued the input of families and recognised that they have expertise and knowledge which can be very helpful to staff. People were supported to maintain their relationships with their family. One person had a chart in their room which detailed how many 'sleeps' there were until the next time they would go to visit their relative.

Staff practice promoted people's dignity and privacy and provided the support people needed whilst encouraging them to be as independent as possible. Staff were clear about people's rights and care plans reflected that people, and their relatives, had been consulted about aspects of their care and their views recorded.

We observed staff knocking at people's doors and waiting to be invited in which showed respect. All the interactions we observed confirmed to us that relationships between staff and those they were supporting were respectful and friendly. Support was provided discretely where necessary and the general atmosphere was of an inclusive service where care was centred on the people who lived there.

Good

Is the service responsive?

Our findings

People received care that met their needs and took into account their individual choices and preferences. Staff knew the people they were supporting and caring for well and were familiar with the contents of each person's care plan. Care plans documented people's choices and preferences and made clear how to provide care and support in ways that would not prove unsettling for people. For example we saw that a lot of consideration had been given to establish how one person's particular personal care need could be met in a professional manner by the staff. The service had worked in partnership with the person's relatives and the Intensive support Team and had managed to resolve a difficult situation and provide a way forward for staff.

A staff member explained to us how one person would be supported to undertake an unpopular activity, such as having their hair cut, by preceding and following this with favoured activities. Another member of staff told us how important routines were for one person. They said, "It's really important to [them]. [They] get thrown out if the sequence is wrong". This importance was evidenced by charts in this person's room which, through symbols, set out the person's daily routines, particularly around personal care.

We saw that throughout the service, staff had a detailed knowledge of the most important elements of people's care plans. For example one person's plan documented that they did not like people sitting next to them or standing behind them. We observed staff respecting this and being very careful about how they interacted with this person to minimise their distress. We noted that another person was known to be anxious about new car journeys. When they began attending a new daytime activity this needed them to undertake a new journey. Staff had worked with the person to reduce their distress and had taken them by bus on the route the car would take so that they could get used to the new journey beforehand.

Before coming to live at the service each person had received a full assessment of their needs and abilities. The assessment covered important areas of support such as personal care, medication, communication and likely behaviour patterns. The findings of the assessment formed the basis of their care plan. Care plans documented people's life histories as well as identifying their particular support needs. We reviewed the care plan for the most recent resident and saw that, although due for review, it contained very detailed and specific information to help and guide staff. We noted that the person had settled in well.

We saw that there was a strong commitment from staff to enabling people to make choices about how they spent their time. People were supported to attend a range of outside interests. During our inspection we noted some people went swimming, some for a walk, one went shopping, one had a meeting with their keyworkers and one attended a local school. We saw weekly activity planners were used and these used words and pictures to remind people what would be happening on a particular day and who would be supporting them. Some people had sensory rooms attached to their bedrooms which provided a quiet space for them to relax if they became distressed.

There was a complaints procedure in place and we saw that complaints were responded to and matters investigated. Relatives told us that they had confidence in the manager to address any concerns they might

have. Records related to complaints were not well organised and the manager assured us that they were in the process of introducing new systems to log any issues in a more structured manner.

People who used the service were enabled to raise any issues about their care at the regular meetings they held with their keyworkers. Surveys were sent out to relatives and we saw that issues made in the most recent surveys were being addressed by the manager.

Good

Is the service well-led?

Our findings

The service had a positive and open culture. The manager was well known to staff and residents and relationships were comfortable and friendly. The manager had been overseeing the management of another of the provider's services for many months and sometimes spent time there, although this was set to reduce. Staff told us that, despite this, the manager was often at the service and was always accessible to them on the phone. All the staff we spoke with felt well supported. Staff told us that staff meetings gave them the chance to raise any concerns they might have or to share ideas. Formal supervision and annual appraisal for staff had not been regular which may have added to the need for staff to seek informal support from the manager. Now that the provider had reduced the requirement of the manager to attend the other service so frequently we were assured that formal supervision sessions and appraisal meetings would take place in a more structured manner.

Staff told us that the manager provided advice and guidance when they needed it and they looked to him for their lead. Relatives were also very positive about the way the manager interacted with them. One told us, "The manager is firm but fair and the management style is very open. The site is well run. It is a good service". Some relatives had had cause to occasionally raise concerns about aspects of their relative's care but all were complimentary about the manager.

The directors also took an active role in the service. We saw that this sometimes created some confusion about lines of responsibility and we discussed this with the manager. They felt that they and the directors had now established a good working relationship and they were clear which person was accountable for which aspect of the service. The provider has not always kept the commission informed of significant events at the service and statutory notifications have not always been sent to us as required. This was thought to be partly due to the past confusion over lines of accountability and we were assured that this would not be the case in the future.

The manager had clear ideas about how they would develop the service and were working with relatives and staff to identify improvements which would benefit the people who used the service. All the staff we spoke with told us they would be happy to place a relative at the service and were proud of the work they did.

The culture of the service was based on a set of values which related to promoting people's independence and achieving personal goals. Staff we spoke with were clear about how they provided support which met people's needs and maintained their independence and we observed this during our inspection. There was a real commitment from the managers and staff to ensure that the people who used the service lived independent lives as part of their local community. Community involvement was clear in all parts of the service from routine shopping trips to accessing local leisure facilities.

There were systems in place to monitor the quality and safety of the service. A training matrix gave an overview of the training provision at the service and this was closely monitored by the manager. Other records for the people who used the service and staff were well organised, which meant that important

information could be located easily. Audits were carried out by senior staff as well as by the Nominated Individual. These had not been taking place regularly in 2015 but we saw that the manager now had a system in place and we viewed the audits that he had carried out in January and February 2016. He told us that these would be monthly from now on and we saw that each time issues had been highlighted an action plan had been drawn up to address these.