Future Health And Social Care Association C.I.C.

Sandon Road

Inspection report

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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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 26 September 2016 and was unannounced. This is the first time we have inspected this service since it was registered in May 2016.

Sandon Road is a respite service offering accommodation, care and support for a maximum of four adults with mental health needs. At the time of our inspection, there were two people using the service. There was 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.

People were not always protected by effective risk management or processes at the service. Although people using the service felt safe and staff demonstrated an awareness of how to report safeguarding concerns, people were not always supported by staff who were aware of their needs.

People were not always supported to take their medicines safely or as prescribed. Records showed that one person had missed medicines on several occasions and this has not been identified by staff or the registered manager.

People were often supported by staff who worked alone at the service. Recruitment processes at the service had been improved to ensure people were supported by staff that were suitable.

People were not always supported by staff who had received sufficient guidance and training for their roles. Staff had some understanding of the MCA and people felt that they had freedom at the service and were supported to make their own decisions about their care.

People were not always encouraged to eat sufficient or healthy foods to stay well. People were supported to access healthcare support, however their day to day needs and symptoms were not always effectively monitored by staff.

People appeared at ease and enjoyed positive interactions with staff. Care had not been taken to ensure that people resided in a safe and comfortable environment and staff failed to demonstrate that they consistently promoted people's dignity in practice. People had the privacy they needed and were encouraged to maintain their independence.

People had the opportunity to discuss some of their support needs with staff when they first joined the service. We saw that staff supported people with aspects of their needs and people told us that they were satisfied with the service they received.

People and staff spoke positively about the management at the service, however processes to monitor and

maintain the quality and safety of the service were not effective. People could not be confident that their feedback and concerns would always be acted upon and resolved. The registered manager had not established systems or processes to ensure that regulations were met and that people received safe care that met their needs.

You can see what action we told the provider to take at the back of the full version of the report.

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 safe.

People were not always protected by effective risk management to help keep them safe and well.

People were not always protected by safe medicines management at the service.

People told us they felt safe using the service.

Is the service effective?

Requires Improvement

The service was not effective.

Staff were not equipped with guidance and training to support them in their roles.

People were supported to make their own choices.

Staff did not consistently support people to ensure that they had eaten sufficient and healthy foods to stay well.

People were supported to make use of community healthcare services.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with respect and dignity, and care had not been taken to ensure that people resided in a safe and comfortable environment.

People using the service and a relative told us staff were caring and we observed some positive interactions between people and staff.

People had the privacy they needed.

Is the service responsive?

Good

The service was mostly responsive.

People told us that they were satisfied with the service they received.

People were comfortable raising concerns, however people's feedback was not always acted on.

Is the service well-led?

Requires Improvement

The service was not well-led.

Systems and processes to monitor the quality and safety of the service were ineffective.

Staff were not provided with the information and guidance they required for their roles.

People and staff spoke positively about the service management.

Sandon Road

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.

This inspection took place on 26 September 2016 and was unannounced. The inspection was conducted by two inspectors.

As part of our inspection, we reviewed the information we already held about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur, including serious injuries to people receiving care and any safeguarding matters. These help us to plan our inspection.

During our inspection, we spoke with two people who used the service and one relative. We spoke with two members of staff, the service project lead and the registered manager. We also reviewed two people's care records, three staff files and records maintained by the service about risk management, care planning, staffing and quality assurance.

Requires Improvement

Is the service safe?

Our findings

People were not protected by effective risk management or processes at the service. There were no processes in place to ensure that staff were always aware of people's support needs and risks. People's risk assessments and care plans were provided by community healthcare professionals when people first joined the service. We found however that this information was not shared with staff to inform staff of people's risks and support that would help people to stay safe and well.

For example, one person using the service required specific equipment to help them to safely manage their breathing. This instruction and other details of the person's needs were provided to the registered manager and staff in their health records at the time of their admission. However the registered manager and staff had not read this information and had not supported the person to use this equipment during the time they had stayed at the service. We requested that the registered manager urgently sought this equipment to keep this person well, the registered manager assured us this had been done following our inspection.

The referrals process at the service had failed to identify that the environment was unsafe and unsuitable for this person. A staff member told us, "[We] would not have had [person's name] stay if we were aware of [their] needs." This person had been put at risk of harm and had been involved in a near-miss incident at the service. Although actions had been agreed for staff to take to monitor this person's safety at the service, we found that these were not being followed, for example staff did not consistently monitor this person using the stairs to help keep them safe. The actions that had been verbally shared with some staff had not been added to the person's risk assessments to guide all staff to consistently support the person.

The registered manager agreed that support plans that staff had developed with people at the service did not provide full or correct details of people's risks and failed to fully reflect people's conditions, needs and risks to guide staff. Risk assessments were generic and did not offer staff clear guidance as to how to help people manage their risks whilst they stayed at the service. For example, one risk assessment instruction stated read, 'To find out triggers' and suggested the desired outcome for the person was for them to remain calm, however there was no guidance for staff as to how to support people to achieve this.

Failure to provide care and treatment in a safe way and to assess the risks to the health and safety of people using the service, and failing to do all that is reasonably practicable to mitigate such risks is a breach of Regulation 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People required support with taking their medicines, however they were not always protected by safe medicines management at the service. Although one person told us, "Staff remind me to take my own medicines… sometimes I would forget," we could not be confident that this person was supported to take their medicines safely and as prescribed. Staff agreed with our finding that medicines records indicated that this person had missed several medicines they required to stay well and to help manage a health condition. Staff we spoke with could not confirm whether this person had taken their medicines on these occasions, and the person's medicines records did not reflect whether this person had taken their medicines when they spent time away from the service. The registered manager confirmed that medicines records were not

audited and we found that gaps in people's medicines records used to indicate that they had received their prescribed medication had not been investigated or addressed. There was no indication if the staff had failed to remind the person as they had expected of if the person had declined to take the medication themselves.

Staff were not always provided with clear information about medicines that people required and when to support people to take their prescribed medicines. Staff had failed to recognise that one person required a specific prescribed medicine to stay well and records showed that this person had only received one dosage during their stay at the service rather than two doses per day. Supplies of the medication the person needed were on the premises but staff told us that they had not known this medicine was available to administer. Although some medicines were monitored and reordered for people by community healthcare professionals, there were no systems in place to ensure that supplies of other medication required by people were available and requested in a timely manner. This had prevented people from consistently accessing and taking some of their medicines safely and as prescribed.

One staff member told us, "I've had medicines training but a few years ago, [the service project lead] observed me." Another staff member we spoke with confirmed that they had received medicines training during their induction, however no competency assessments had been completed to ensure staff knew how to support people safely in practice. We observed on one occasion during our visit that a staff member failed to encourage one person to correctly prepare their medicine, to help reduce the person's risk of discomfort when this was administered. The registered manager told us they would take action to address concerns with medicines management at the service.

Failure to ensure the proper and safe management of medicines is a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service told us they felt safe. A relative we spoke with confirmed that they felt that people were safe. Although most staff had not received safeguarding training, staff we spoke with could describe some signs of abuse and demonstrated that they knew how to respond to safeguarding concerns. Guidance was on display at the service to help make people who used the service aware of how to report any concerns.

People had access to a safe in their bedrooms at the service to keep their belongings and monies secure. Staff we spoke could identify the location of the fire assembly point at the service and told us they would contact emergency services when necessary, this instruction was outlined in people's care plans. Records showed that whilst staff who supported people during the day were routinely reminded of fire procedures at the home, arrangements had not been made to ensure that night staff remained aware of how to keep people safe in the event of a fire. The registered manager assured us that this would be addressed.

People were often supported by staff who worked alone at the service. We observed that people went out to the community for most of the day, and staff were available if people required support whilst they spent time at the service. Staff were responsible for leading the shift as lone workers and were able to seek guidance from the service project lead through the on-call system at the service as necessary. A relative told us, "I assume there are enough staff at the service." The service project lead commented that there were not always enough staff available and the registered manager confirmed that staffing levels did not change when the number of people using the service increased. We could not be assured therefore that staff were always deployed effectively. The registered manager told us that they wanted to review staffing and the possibility of preventing lone working at the service.

The registered manager informed us that they had taken action to improve recruitment processes to assess the suitability of staff for their roles. A staff member who had started working at the service within the last year told us that their pre-employment checks had been completed appropriately and records we sampled confirmed this. The staff member had completed a check through the Disclosure and Barring Service (DBS) to ensure that they were suitable for their role. We saw that the registered provider had conducted ongoing DBS checks for staff members to protect people using the service.

Requires Improvement

Is the service effective?

Our findings

One person told us, "Staff know what they are doing." A relative we spoke with commented, "Staff are good at their jobs, they're fine." While it was positive that people felt that staff were able to support them well, our findings showed that people could not be confident that staff always understood people's needs. Staff had not received clear guidance through regular training and supervision or staff handovers, to ensure that they were always equipped to understand and meet people's needs.

Although staff told us they felt supported in their roles, the service project lead confirmed that staff had not received supervisions or had the opportunity to participate in staff meetings as regularly as had been intended and required by the registered provider. A bank staff member who had been working at the service for nine months at the time of our inspection told us, "I don't have supervision or [records on the] training matrix because I'm not permanent." Staff were not given regular opportunities to reflect on their practice and receive guidance to aid their development through supervision.

Not all staff had been supported to complete required training for their roles. The registered manager had not ensured that staff remained aware of basic requirements to keep people safe at the service, for example through up-to-date training in safeguarding, fire awareness, health and safety and infection control training. Staff had not been supported to complete training that had been identified as necessary for their roles, for example, training relating to risk assessments and alcohol awareness. The registered manager told us that they intended to update staff training and informed us that staff had recently completed mental health awareness training. New staff completed an induction process which involved training and shadowing colleagues and a bank staff member told us that their induction involved receiving information about the role and a lot of training. The Care Certificate is a set of minimum care standards that new care staff must cover as part of their induction process. The induction process did not meet these standards to ensure that new staff were equipped with the guidance and skills to provide people with safe and compassionate care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. Although staff had not received MCA training, the registered manager and two staff members we spoke with demonstrated an awareness of the principles. One staff member told us that people had the right to make their own decisions wherever possible and added, "[We must] give [people] the lead to make their own choices."

One person told us, "I go out every day to my [own home]," and a relative told us that they knew that their

relative using the service went out when they wanted to. One staff member told us, "It is important for people to remain as independent as possible because they have to leave and go home [when they are ready]." People using the service made their own choices and decisions throughout the day about what to do and when they went out. A relative told us that staff contacted people to check that they were okay if staff found that people had not returned to the service at the time they had intended. While people expressed that this was a positive aspect of their care, one person had not been supported by staff to consider or manage their risks whilst out in the community to help the person to stay well.

One person using the service had previously been subject to a community treatment order which had prevented them from going into the community without supervision due to their health needs. Our discussions with the registered manager and staff showed that they were unsure of the capacity in which they could support this person, for example, whether the person continued to require such support during their time at the service. The registered manager and staff sought confirmation from healthcare professionals during our visit and were able to confirm that staff had been meeting this person's needs appropriately during their time at the service.

One person told us, "I don't eat here. I have all my food out and at my [own home]. I don't really use facilities here, I do make myself a drink." Another person told us, "I do all my own meals, I've had toast this morning and a drink." The service project lead told us that people using the service fulfilled their own daily living tasks such as doing the laundry, shopping and preparing meals, and that staff supported them with these tasks. We found however that staff did not ensure that people at risk had eaten sufficient food to maintain good health. One person had expressed to staff that they had difficulty with preparing their meals and the service project lead had identified that another person required support with preparing healthy meals to stay well and to manage a specific health condition. However, no arrangements had been made for staff to provide this support. We saw that whilst one person was encouraged by a staff member to prepare their lunchtime meal some hours later during the early evening, when the staff member asked the person if they had eaten and found that they had not, no action was taken.

People were supported to access healthcare services. One staff member told us, "We encourage people to book their own appointments; opticians, the chiropodist, the dentist." Staff told us that they sought the guidance of community healthcare professionals involved in people's care when they found this necessary. People's care reviews and meetings with their community healthcare professionals were held at the service with the support of staff.

People's day to day health needs were not consistently managed to help keep them well, for example through effectively monitoring their symptoms or helping them to manage their medicines. We observed that a staff member was advised during a staff handover to contact a person's doctor if they showed signs of specific symptoms relating to their condition. We found however that where other staff had identified these symptoms at an earlier time during our visit, they had not taken any action to monitor this person or assess whether they required further healthcare support. This person was at risk of not being supported to access further healthcare support as required to stay well.

Requires Improvement

Is the service caring?

Our findings

People using the service told us that staff were caring and one person told us, "It's really nice here… staff are lovely." A relative commented that staff were kind and caring and told us they felt that staff were approachable. One staff member told us, "It's good to get [people] involved," and provided us with examples of how they spent time with people using the service such as playing card games together. We observed some positive interactions between people using the service and staff and found that staff had developed a good rapport with them. People appeared at ease and relaxed in the communal areas of the service. One person showed us around the service and told us that they had developed a positive relationship with another person using the service.

Care had not been taken to ensure that people resided in a safe and comfortable environment. The registered manager confirmed that a light in the communal area had required replacing for four weeks and no action had been taken to address this. We identified that another communal area of the service was poorly lit and the home was not always kept warm and comfortable for people using the service. People could not be confident that their views would always be listened to and acted on when they raised such concerns. Records from a residents' meeting showed that one person had raised concerns about the temperature of the water at the service, twelve weeks prior to the time of our inspection. No action had yet been taken to address this concern to enable people to bathe in suitable conditions as they wished during their stay at the service. We brought this to the attention of the registered manager who confirmed that these issues would be addressed.

A relative told us that staff treated people using the service with respect. A staff member we spoke with told us about the importance of respecting and treating people as individuals and added, "I support people as I would want to be treated." Although we observed that people were addressed respectfully by staff, we observed occasions where staff practice at the service failed to consistently promote people's dignity.

For example, one staff member told us that a person using the service had "Kicked off," whilst describing an occasion where this person had become distressed. Another staff member referred to a person's personal circumstances with a lack of care and sensitivity and in the earshot of others, without regard of the risk of this person or others overhearing them. Although this occurred in the presence of the registered manager, they did not intervene or display any concern about this staff member's conduct. We needed to ask the staff member to stop speaking in this manner on this occasion.

People using the service were encouraged to maintain their independence and were able to come and go freely from the service and do as they wished. One person told us, "There are no rules here, I can go to bed when I want to, if I want a drink in the night I just get up and make one."

People using the service had the privacy they needed. One person told us that they had the privacy they needed when they were spending time with visitors at the service. They told us, "I see [my visitor] in the lounge, it's nice and quiet." A person using the service had made a request about having more privacy while they stayed at the service and this was respected and followed by staff.

Good

Is the service responsive?

Our findings

One person told us, "I've been here [for a short while], I feel better in myself… I've settled." This person showed that they valued using the service whilst they made improvements to their own home environment. This helped to support the person's independence and progress towards plans they had for when they left the service.
The registered manager told us, "We support people to get back into the community." Staff we spoke with demonstrated awareness as to why people were using the service on a temporary basis. Staff provided examples of how they had supported people with practical aspects of their plans for returning to the community. A relative told us that they were pleased with the service and added, "[Staff are] pleasant. They help as much as they can."

One person told us, "Staff are nice here and listen to me… They ask me if I'm okay, [they're a] nice bunch." People had opportunities to discuss some of their support needs with staff when they first joined the service. People were supported to complete 'recovery star' templates which involved discussing their needs with staff and goals they wished to fulfil. People's recovery action plans and goals were not completed fully with the support of staff however, to reflect people's needs or how people wanted to monitor and progress towards their goals over time. Although this meant that the registered provider's process for promoting people's recovery were not always applied by staff, the service project lead assured us that the recovery star templates had initiated useful discussions with people using the service about their wellbeing.

People appeared to be relaxed in the communal areas of the service and went into the community during the day. A staff member told us that activities at the service varied based on the interests of people using the service and added, "We do what they want, offer them company, spending time together and we do activities at any time." We saw that one person using the service often watched television which they enjoyed and a staff member sat and spoke with them for a short time.

One person told us if they had any complaints, "[I would] just tell the staff." A relative told us, "I'd be comfortable raising concerns, definitely." A staff member told us, "If a person using the service wanted to make a complaint I would support them, I'd make a record of the complaint and report it to the manager." The service project lead told us that there had been no complaints and most feedback we sampled showed that people had a positive experience of using the service.

There were opportunities available for people to share their feedback through residents' meetings and use of the service's suggestion box and complaints process. People were invited to share feedback at the end of their stay, although we were not assured that people's concerns were always listened to or acted upon to drive improvement at the service. For example, one person's feedback stated that they had not felt safe or comfortable during their stay at the service and we found that this had not been explored by staff or the registered manager. Feedback forms we sampled from two people showed that they felt that staff had been respectful and understanding. One comment stated, 'The staff were there when I needed someone to talk to.'

Requires Improvement

Is the service well-led?

Our findings

A staff member told us that the ethos of the service was to, "Get people well to go home," however people's recovery was not consistently supported by staff who had an informed, consistent understanding of people's needs. Although staff told us that the registered manager regularly visited the service, we found during our visit that the registered manager had failed to maintain oversight of the quality of care people received. The registered manager had not ensured that systems in place were effective to always meet people's needs and to support people to manage their risks.

The systems in place for monitoring and checking that the service was delivering good quality care were not wholly effective. Whilst people made positive comments about the support they received, the registered provider had not identified that the management of safety, risk management processes and aspects of the day to day support provided at the service were on occasions failing to meet the needs of people using the service. Issues identified at the inspection such as risk management, safe medication administration and poor sharing of information between staff had not been identified by the registered provider's quality monitoring processes.

There was a poor approach to risk assessment and management at the service and the registered manager was unaware of concerns relating to the safety of people using the service and staff. Although some daily notes reflected that staff had become aware of risks to a person using the service, the registered manager and service project lead had not overseen people's care notes to identify or address this. We brought examples of how people had been put at risk of harm to the attention of the service project lead and registered manager, who had been unaware of these concerns. The registered manager did not have oversight over risk management or concerns at the service and did not ensure that internal investigations were conducted appropriately and safeguarding concerns were raised where required.

The registered manager and service project lead failed to inform staff of the needs and risks of people they were supporting. We queried this with the service project lead who told us, "I don't want staff to act differently around people." Our discussions with the registered manager and service project lead showed that they also lacked awareness of people's specific risks and behaviours. People's risks were not communicated clearly between staff within an open culture to help ensure that people were always safe and well.

The registered manager had failed to identify and resolve ongoing maintenance issues at the service, in relation to the lighting in communal areas and unsuitable water temperatures. They assured us that these issues would be resolved. The registered manager told us that they found it difficult to maintain oversight of the service due to their management of additional services, and informed us that they maintained an awareness of updates about the service through regular visits, monthly meetings and reports. The registered manager told us that they would address concerns they had about the quality of communication at the service.

Failure to have effective systems in place to assess, monitor and improve the quality and safety of the

service and to manage risks relating to the health, safety and welfare of people using the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person we spoke with was aware of who the service project lead was and told us, "They are friendly enough." Staff told that they felt well supported. A staff member told us, "[The service project lead] is a good manager, they look after their staff… we feel 100% supported." Another staff member told us, "The [service project lead] is friendly and approachable, I feel supported." One staff member told us that the registered manager visited the service three times a month and that they were, "Always a phone call away."

Staff meetings were held and a record relating to an upcoming meeting showed that staff were due to discuss the fundamental standards of care and support that must be met. We found however that staff supervisions had not taken place as regularly as required by the registered provider and this had not been identified as a concern by the registered manager. Staff were not provided with the information they required to assist them to effectively support people and they had not received all mandatory or refresher training for their roles. The registered manager and service project lead had not introduced formal competency assessments to aid staff development, however the registered manager told us that they intended to do so.

A staff member told us, "I'm asked for my opinions of how we can improve here," and told us that they would be happy for their relative to use the service. Staff we spoke with told us ways that they would improve the service which included helping people to develop basic life skills and to make the service, "More warmly and homely," we found that improvement was required in these areas.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to provide care and treatment in a safe way and to assess the risks to the health and safety of people using the service, and failed to do all that is reasonably practicable to mitigate such risks. The registered provider had failed to ensure the proper and safe management of medicines for people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to assess, monitor and improve the quality and safety and risks relating to the health, safety and welfare of people using the service.