Futures Care Homes Limited

Futures Care Home

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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The service provides accommodation and personal care for up to nine people with a learning disability and autism. At the time of our inspection, there were five people using the service, one of whom was on a week's respite.

A Registered Manager was in post. 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.

Our previous inspection undertaken on 29 and 30 December 2016 identified serious concerns regarding the management and leadership of the service and the quality of the care delivery. We asked the registered provider to make improvements to ensure staff were suitably trained and supported to respond to people's complex needs, make the environment safe and ensure infection control risks were managed.

At this inspection, we found improvements had been made to the quality and safety of the service provided. Where staff had lacked supervision, appraisal and basic training, action had been taken to rectify this. Improvements had been made to ensure the premises were safe and the interior had been completely refurbished. However, we remained concerned about the registered persons overall management and leadership of the service. We identified that further work was needed to increase the service's overall rating and ensure that people are provided with good quality, safe care at all times.

There continued to be insufficient staff available to ensure people's safety and provide additional care support hours, provided as part of their care packages, to access activities. The addition of people for respite care, with no additional staff, further impacted on staff's ability to provide one to one support. Staff expressed frustration about the lack of staff and at times felt this placed them and people using the service at risk of harm. The service manager was in the process of recruiting new staff for when a new person was admitted to the service at the end of August 2017, increasing occupancy to five. However, neither the registered manager nor service manager were able to show or tell us how the staffing ratio had been calculated to ensure there was always sufficient staff available.

Consultants had been used to provide advice and guidance to staff with regards to managing people's behaviours in a positive way. Individualised support plans had been developed providing staff with strategies for managing challenging behaviours and distress. These included step by step guidance on physical intervention and verbal de-escalation techniques to be used. Staff had received conflict management training and demonstrated how these techniques would be used. Debriefing sessions were held following incidents of challenging behaviour to discuss and agree what could be done differently to avoid incidents from reoccurring.

People's care records and information shared with us from relatives confirmed people were receiving

personalised care. Individual risks to people had been assessed and actions for staff to address these were clear and coordinated. Systems were in place, which showed staff managed people's medicines consistently and safely.

Staff understood their responsibility to report any concerns to the manager, but were not familiar with the local safeguarding protocols and access to local authority safeguarding team. However, both the registered manager and service manager were aware of their responsibility to liaise with the police and local authority if safeguarding concerns were raised. Such incidents had been managed well. A robust recruitment and selection process was in place. This ensured prospective new staff had the right skills and were suitable to work with people using the service. A formal supervision process had been implemented and records showed these were taking place on a regular basis, where staff's achievements, challenges and personal development were being discussed and actioned.

Staff confirmed they had received a range of training, which had given them the skills they needed to carry out their roles and keep people safe. Staff who had shown a specific interest in particular areas such as medication and first aid had been provided with additional training and had been appointed champions. These staff shared their learning and acted as role models for other staff. However, where training had been completed via eLearning; we found staff had not always fully understood the content of the course and how to put their learning into practice. For example, not all staff were able to describe how they would recognise when there was a potential deprivation of a person's liberty. They were unable to explain the legislation and why this should be applied.

We saw good evidence that the principles of the Mental Capacity Act were being applied. Applications had been made to the local authority to lawfully deprive people of their liberty because their safety would be at risk if they left the service unescorted. These had been submitted in 2015, but had not been authorised. The registered manager was unable to show that they had made any further contact with the local authority to chase these. Neither had they considered making applications for people staying at the home for respite and by virtue depriving them of their liberty.

People received enough to eat and drink, however staff had no menu to work from and prepared whatever food was in the fridge and freezer. This ad hoc approach to meals did not always take into account people's preferences or ensure that they had a balanced and healthy diet. People's health needs were being assessed and monitored and where required, referrals had been made to appropriate health professionals. Staff responded promptly to people's health needs when issues were identified, however records showed monitoring of bowl movements was inconsistent. A four day gap was identified in one person's records, which had the potential for the person to become constipated or unwell, but this had not been identified as a risk.

Staff were kind and caring and had developed good relationships with people using the service. People were comfortable in the presence of staff. Relatives confirmed the staff were caring and looked after people very well. However, staff felt current staffing levels did not enable them to keep people safe and ensure their funded one to one care support time was provided. Feedback from relatives confirmed people had lost one to one care support hours they had originally been assessed for because they weren't being provided. A review of the rosters indicated that people are not currently provided with all their hours a week. This risks a further reduction in funding and one to one support to access the community.

Staff and relatives spoke positively about the service manager and said they were making a positive difference and things were improving. Staff morale had improved, because they felt supported by the service manager. They described them as being helpful and approachable and were able to raise any concerns

without fear of reproach. Relatives were less positive about the registered persons. They felt neither had been open and transparent when it came to issues about how people's funding was being spent. Anomalies were identified in the amounts of money agreed by the local authority and what was actually provided for meals, social activities, transport and holidays. The registered manager had no systems in place to account for how people's funding was allocated and spent.

To sustain the improvements that have been made in the service, further work is needed to ensure all staff, including the registered provider know, fully understand and are committed to embedding the vision and values of the service. These included honesty, integrity, respect and taking quality to its highest level. Whilst some progress had been made further work was needed to develop proper systems to assess, monitor and identify where improvements are needed to improve the safety and quality of the service.

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.

Improved strategies for managing risks to people including challenging behaviours and distress had been implemented. However, there was insufficient staff available to meet people's needs, keep them safe and meet their contracted additional care hours.

Systems were in place to protect people from abuse or avoidable harm. Staff understood how to recognise abuse or potential abuse and how to respond and report these concerns appropriately. Robust systems were in place to check staff were suitable to work in the service.

People's medicines were managed so that they received them safely

Is the service effective?

Requires Improvement

The service was not always effective.

Training for staff had improved. Staff had been provided with a range of training that gave them the knowledge and skills to meet people's specific needs, such as epilepsy. However, staffs understanding of training provided via the computer known as eLearning was not always tested, understood and put into practice.

People's capacity to make decisions about their care and treatment was assessed. Where they lacked capacity to make decisions best interest meetings had taken place with people authorised to make decisions on their behalf.

Where applications had been made to deprive people of their freedom of movement for their own safety, these were not done lawfully. Applications for authorisation had been submitted in 2015, with no follow up and therefore were not legally valid. No DoLS requests had been made for people using the service for respite and by virtue were being deprived of their liberty.

People were provided with enough to eat and drink. People had

access to appropriate services, which ensured they received on-going healthcare support.

Is the service caring?

Good

The service was not always caring.

Due to insufficient staff, people were not always receiving their funded one to one care support hours to access the community. This lack of resources continues to impact on staff's ability to support people to live their lives to the full and in accordance with their assessed needs.

Staff had developed positive relationships with people who used the service. The interaction between staff and people using the service was caring and friendly. People's privacy and dignity respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Insufficient availability of staff continues to impact on people's ability to consistently access activities in the community.

Care planning had improved. Care plans had been rewritten in conjunction with relatives and provided comprehensive information about how staff were to meet people's needs. Staff knew people's needs well and provided personalised care that was responsive to their needs.

Systems were in place to investigate and respond to complaints, but not all complaints had been resolved satisfactorily.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a lack of honesty and transparency at registered manager level and above, with particular focus on replacing the vehicle used to transport people using the service and how people's funding in relation to meals, activities, transport and holidays were allocated and used.

The appointment of a new service manager has led to an improved culture within the service. However, not all staff were clear about the vision and values of the service. To sustain the improvements made, further work is needed to ensure all staff, including the registered provider know, fully understand and are

committed to embedding the vision and values of the service.

Further work was needed by the registered provider to develop proper processes and systems, such as regular audits to assess, monitor and improve the safety and quality of the service.

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 checked 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 08 August 2017 and was unannounced. The inspection was undertaken by two inspectors. On 18 August 2017 we contacted four people's relatives by telephone to ask for their views about the service.

Before the inspection, the provider completed a Provider Information Return (PIR) which we reviewed. The PIR 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 also reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law.

Because the people using the service did not have sufficient capacity to answer our questions, we observed practice around the home including the interactions between staff and people. We spoke with four people's relatives and received feedback from a relative of a person who used the service for respite. We spoke with the registered manager, service manager who was the person in day to day charge of the service, a senior carer and a support worker.

We reviewed four people's care records, looked at three staff files and reviewed records relating to medicines, complaints, training and how the registered persons monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

During our previous inspection in December 2016, we identified a breach of regulation regarding staffing because there was not enough staff available to meet people's needs. At this inspection, we found staffing levels remained insufficient to respond to people's needs and to meet their one to one care support hours contracted by the local authority. This was confirmed in discussion with people's relatives and staff. One relative told us, "There are not normally enough staff, they seem to be quite short. Often there are only three staff on duty, two spend a lot of time writing records, leaving one member of staff to support four people." Another relative commented, "There have been issues around people not receiving their full one to one support hours they were funded for as there is not enough staff. I am also aware that a new person is moving into the home. There are only three staff on shift which is just enough to look after the four people currently residing in the service. This also becomes an issue when people stay at the service for respite, with no additional staff."

Staff expressed their frustration about the lack of staff. They told us they were constantly being asked to do overtime and got tired. One member of staff told us, "I do extra where I can but I get exhausted and need a rest sometimes but get constant calls to come in and work extra. We have no new staff and someone moving in at the end of the month. One member of staff told us, "Due to the lack of staff it is dangerous here sometimes. For example, this morning a member of staff needed to lock themselves and a person using the service in a room, to protect them from another person whose behaviour had escalated and they were trying to 'attack them. It is too stressful."

Staff described meal times as difficult to manage, as two people required one to one support to eat their meal. Two people also required staff support to receive their nutrition via a Percutaneous Endoscopic Gastrostomy (PEG) tube. During lunch and the evening meal the service manager and registered manager were observed supporting people, however staff told us this was not normally the case and they would be expected to manage with just two staff. One member of staff told us four people using the service were diagnosed as having epilepsy; two of whom have particularly violent seizures, which require urgent attention. Current staffing levels meant if one person had a seizure, or their behaviour became challenging, particularly at meal times there were not enough staff to manage this and keep other people safe.

The registered manager told us the normal staffing ratio was three staff, whilst there were only four people using the service. However, staff told us, a person had been admitted to the service the previous day for a week's respite; but no additional staff had been rostered. The registered manager advised this had been an oversight and made immediate arrangements to roster an additional member of staff during the persons respite stay. Ordinarily the service manager is included in the staffing numbers; however, they stated this means they were unable to complete their managerial duties. Both they and the registered manager had been covering nights due to staff vacancies. The service manager told us they were in the process of recruiting new night staff and an additional member of staff for when a new person was admitted to the service at the end of August 2017. However, neither the registered manager nor service manager were able to show or tell us how staffing numbers had been calculated.

This is a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our previous inspection identified people were being placed at risk of harm, because behaviour which may have impacted negatively upon themselves and /or others was not managed correctly. Staff had not received sufficient training in how to manage people's behaviours effectively. There had been insufficient monitoring and reporting of incidents, which meant poor practices had become embedded into the service. At this inspection, we found the registered provider had employed consultants to guide and give advice to all staff with regards to positive behaviour support. Individualised behaviour support plans had been developed providing staff with strategies for managing challenging behaviours and distress. The plans included, potential triggers and trends, for example, monitoring a person's menstrual cycle to see if this corresponded with incidents of distress. All staff had been provided with conflict management training (referred to as Maybo) and correctly demonstrated to us how these techniques would be used. Supervision records showed staff received debriefing sessions following incidents of challenging behaviour to discuss their wellbeing, what happened and what could be done differently to avoid incidents from reoccurring.

Individual risks to people had been assessed and actions for staff to address these were clear and coordinated. For example, when a person was experiencing a seizure, or during episodes of deliberate or non-deliberate self-harm. Guidance, supported by photographs had been produced to guide staff on how to keep people safe whilst accessing different activities, such as swimming, ice skating and travelling in the minibus.

The previous inspection had identified that the registered provider was failing to adequately maintain the vehicle and premises to keep people safe. At this visit we could see that the required improvements had been made to the environment, however their remained contentious issues with families about the condition of the mini bus. The registered manager assured us that the vehicle had a current MOT and was regularly serviced to ensure it is road worthy and safe to transport people. However, relatives told us, "I question if the minibus is road worthy," and "I do not think [person] is safe when travelling in the vehicle, it is not fit for purpose. The interior is awful and it is falling apart. There are three seats at the front, and for safety reasons [person] cannot sit in front, so they have to travel in back strapped into their wheelchair. They do not like this, as they do not feel safe, but there is no other option. [Person] can sit in a seat, whilst in the vehicle. The minibus used to have seats in the back with arm rests, which were broken and removed."

Following the inspection the registered provider, provided additional information about the safety of the vehicle. They advised the vehicle is fit for purpose and has wheelchair access and safety straps that ensure people are secure when travelling. For safety reasons people identified as a risk when traveling in the vehicle have seating plans in place which have been agreed with the local authority.

Despite issues with the vehicle, relatives felt that overall people were safe living in the service. One relative told us, "When [person] has been for a home visit when we take them back to Futures, they say' bye, bye, if they didn't do that I would think there was a problem, but they always appear to be very happy to return to the service." Another relative commented, "I was hoping when [person] moved in to residential care their quality of life would improve, at first this was the case, however a person with very challenging behaviour was later admitted to the service. This person's behaviour had a negative impact on [person] and others in the service. This person has now moved on and I feel the service is now safer and more stable now."

Both the registered manager and service manager were aware of their responsibility to liaise with the police and local authority if safeguarding concerns were raised with them to ensure the safety and welfare of the people involved. Staff confirmed they had completed training, which provided them with the knowledge

about how to recognise, respond to and report abuse. They understood their responsibility to report any concerns to senior managers, but not all staff were aware of local safeguarding protocols and access to local authority safeguarding team. However, information in the form of 'Ask SAL' posters were displayed around the service. SAL stands for Safeguarding Adults Line, which is a helpline linked to Essex County Council Adult Safeguarding Board for people to contact if they suspect an adult is being treated badly, taken advantage of, or injured. There was also a Whistleblowing leaflet on display for staff to access the NHS and Social Care whistleblowing helpline; however, this contained an incorrect contact number. The registered manager told us they would amend this immediately.

Three staff files examined confirmed a robust recruitment and selection process was in place. All relevant checks and references had been carried out to ensure prospective new staff had the right skills and were suitable to work with people using the service.

Systems were in place, which showed staff managed people's medicines consistently and safely. Medicines, including controlled drugs were being obtained, stored, administered and disposed of appropriately. Random sampling of people's medicines, against their medicine records confirmed they were receiving their medicines as prescribed by their GP. Where people had been prescribed medicines on an 'as required' basis, such as medication to prevent and control further seizures, protocols were in place with detailed guidance for staff on when these should be administered.

Requires Improvement

Is the service effective?

Our findings

Our previous inspection identified failings in staff training, supervision and support and a failure to ensure people's healthcare needs were being met. There had also been deterioration in the maintenance of the environment. During this inspection we found improvements had been made, however further work was needed to ensure staffs understanding of computer based training, known as eLearning.

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 authorisation 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, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw the registered manager had made appropriate DoLS authorisation requests for the people using the service to lawfully deprive them of their liberty because their safety would be at risk if they left the service unescorted. However, these had been submitted in 2015 and were still awaiting authorisation. At the previous inspection, the registered manager told us they were meeting with an independent assessor on 04 January 2017 to review everyone's MCA and DoLS assessment; however, we found no evidence to show they had made further contact with the local authority to chase these. Neither had they considered making applications for people staying at the home for respite and by virtue were being deprived of their liberty to leave the service unescorted.

This shortfall was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The PIR states staff have been given the opportunity to take part in training related to the needs of people using the service to ensure they meet the required standard. Staff told us and certificates in their recruitment files confirmed they had received a range of training designed to give them the knowledge and skills to carry out their roles and responsibilities. Face to face training had been provided for practical subjects, such as moving and handling, administration of medicines, including Buccal Midazolam, PEG and physical intervention and verbal de-escalation techniques. However, the majority of training had been completed via eLearning. Although the registered manager told us this training had been accredited by Skills for Care (Skills for Care is the strategic body for workforce development in adult social care in England) we had concerns that where staff had completed training via eLearning; they had not always fully understood the content of the course and how to put this into practice. For example, one member of staff did not remember having received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The service manager confirmed they had received this training. However, when the member of staff was asked to describe how they would recognise when there was a potential deprivation of a person's liberty. They were unable to explain the legislation and why this should be applied.

People's relatives told us they were aware of the issues raised in the report following our last visit, and were reassured that staff had since received a range of training, including specific training on how to manage people's behaviours. One relative commented, "Staff are aware of the challenges for people with learning disabilities. [Person's] previous key worker was absolutely brilliant, unfortunately, they have recently left, but

I feel all the staff have [person's] best interests at heart. Newer staff appear to be very good; I like what I have seen so far, they show a keen interest in the people using the service."

Staff who had shown a specific interest in particular areas such as maybo, medication and first aid had been provided with additional training and had been appointed champions. These staff shared their learning, acted as role models for other staff, and supported them to ensure people received good care and treatment. New staff were expected to complete the Care Certificate. To achieve the certificate staff need to complete a set of standards that social care and health workers must apply in their daily working life. It is the minimum standards that should be covered as part of their induction training as a new care worker. Staff told us they completed these standards via eLearning. The service manager confirmed that they checked staffs competency and understanding after completion of each module during supervision.

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. We found good evidence of MCA assessments in people's care plans and staff were observed asking people for their consent before providing care and support. There was good evidence to show that relatives were being included in best interest decisions regarding care and treatment. For example, where a person refused their medicines, a best interest decision had been made following a meeting with a person's family, GP, service manager and key worker to administer their medicines (covertly) disguised in food. Additionally, we saw good evidence of capacity assessments being completed for people where they were unable to make day to day decisions in areas such as finances, communication, personal care, medicines and activities.

Relatives were confident that people using the service received adequate food and drink. One relative commented, "[Person] has nice meals, they are able to choose what they want to eat, there is no menu as such, I see them eating things they like, such as jacket potatoes. The other day when I visited they had fish in cheese sauce with new potatoes, followed by rice pudding." Another relative told us, "I don't always see what [person] eats, but from what I have seen they have a balanced diet. [Person] can be very fussy and likes food such as, croissants, bread, crisps and biscuits. The staff are on the ball when it comes to [person's] nutrition and do encourage them to have healthy alternatives."

We saw people had access to the kitchen and were able to help themselves to snacks, such as crisps and fresh fruit. For people physically unable to access snacks for themselves we saw staff offered them drinks and snacks on a regular basis. Because staff knew people's needs well they were also able to respond to non-verbal cues, which told them the person was hungry. However, staff told us they did not stick to a menu and prepared whatever food was in the fridge and freezer. When asked what was for tea staff did not know and said, "We will look in the freezer." This ad hoc approach to meals did not always take into account people's preferences or ensure that they received a balanced and healthy diet.

Following the inspection the service manager informed us that there is now a two week rolling menu in place and being followed, with people's preferences and dislikes taken into account.

Relatives told us they were kept informed and were included in making decisions about people's health care and when they required treatment. One relative told us, "Before [person] had a Peg fitted, they had eating problems. I had fears about what they were eating, and if they were hungry. Now, I do not worry and staff keep me informed about their health. They are well looked after. If there are any changes in their care, I am notified, for example if the dietician is visiting, staff let me know. I can't praise the staff enough."

Information in care plans showed that overall people's health and dietary needs were being assessed and monitored. Where required, referrals had been made to appropriate health professionals, including the GP, physiotherapist, dietician, speech and language therapist and the intensive behavioural team. There was good evidence throughout people's care plans to reflect they were being supported to access regular check-ups, including the dentist, opticians, annual health reviews and routine blood tests. However, although records showed staff were monitoring people's gastronomy care well; bowel monitoring was inconsistent. This had the potential for people to become constipated or unwell. For example, one person was found to have had a four day gap, since they had previously opened their bowels but this had not been identified as a risk. The service manager agreed to investigate these concerns and put measures in place to ensure staff were properly monitoring and responding to people's health needs.

Since our last inspection significant improvements had been made to ensure the premises were safe and to improve the environment. A legionella risk assessment had been carried out and records showed regular water temperatures were being undertaken. Gas and electrical equipment had been serviced and a recent fire risk assessment had been completed. All fire checks were up to date. Environmental health had visited and had given the service a five star rating for food hygiene. All windows had been fitted with window restrictors to prevent people falling from height through the window openings on the first floor or being able to leave the premises unescorted through the ground floor windows. The premises had been completely refurbished and now provided people with a clean and comfortable place to live. Relatives told us, "I think they (registered provider) has made a lot of improvements. The service has been decorated throughout, new furnishings provided, the outside is more accessible and there are more garden chairs.

Good

Is the service caring?

Our findings

Our previous inspection identified staff were working under conditions which made it difficult to promote a caring and person centred service. This was due to a high turnover of staff and increased use of agency, which meant people were not always receiving care and support from consistent staff who knew and understood their needs.

At this inspection the service manager acknowledged the physical aspects of the job around managing challenging behaviour had been draining on staff, they had been depressed and fed up with little guidance and support. Staff told us, morale had improved since the service manager had been in post. However, the pressures of working long shifts, managing difficult behaviours and the high turnover of staff in the last year, with experienced staff leaving had placed more responsibility on regular staff. This had added to their stress levels and they described feeling constantly under pressure to ensure people's complex health needs were being met and to keep them safe.

Staff told us the majority of their time was focussed on completing routine tasks and they were not always able to provide one to one care support to people to access activities in the community as agreed in their care packages funded by their local placing authority. The addition of people for respite care, with no additional staff, further impacted on their ability to provide this support. This was confirmed in conversation with a relative who told us, "I have questioned the number of times [person] has gone out; they are often curled up on the settee if everyone is busy. If they don't go out, they get bored. They end up watching a lot of DVD's and gets fed up." During the inspection, we observed this person lying on the sofa curled up in a blanket, as described by their relative. One relative commented, "My [person] was initially allocated 36 hours of one to one support per week as part of their care package, but were actually using about eight. This was discussed at their annual meeting, where the hours were cut because they weren't being used, we finally settled on 18 hours per week. Things are improving, [person] is going out more, but not as often as I would like." This situation arose because the 36 hours of one to one support were not being provided; that this was not addressed by the registered persons has resulted in the person loosing 20 hours per week of one to one care support that they were originally assessed as needing. A review of the rosters indicated that they are currently provided with between 13 – 14 hours a week. This risks a further reduction in funding, which will further impact on staff's ability to provide meaningful time with people to access the community.

Following the inspection the service manager provided additional information informing us that they had worked out from the fees set up by Essex County Council and Future Care Homes Brightlingsea, new establishment hours and the staffing ratio. They had taken into account people using the service for respite and had worked out the exact staffing levels needed on a weekly basis. These hours had been added to the staff rota to ensure these hours were being met. The calculations showed people were currently receiving support hours over what they had been funded for by the local authorities. The service manager advised they would be sharing this information with families to ensure they were aware of what staffing levels and additional support hours should be. They also informed us they were in the process of reviewing hours with the local authorities who had suggested that some extra funding may be needed.

A common theme when speaking with relatives was since the previous inspection there was now a more stable staff team, which had led to improved relationships between people using the service and staff. One relative commented, "I have known most of the staff for quite a while now, I am happy with the staff who do a very difficult job, I think they are all caring." The relative of a person who used the service for respite also told us, "I have no concerns about my [person] going to the service. The caring side is fine, they do care very well; it's the management side of things that are not so good. [Person] absolutely loves going there; staff are good and very caring."

We observed the interactions between staff and people using the service and saw for ourselves that people were comfortable in the presence of staff. We saw lovely interactions, for example, one person lying on the sofa threw a cushion at a member staff, as they passed by. The member of staff stopped and threw the cushion back. This carried on for a few minutes and created spontaneous fun and laughter between the person and the member of staff. People were seen to be at ease going up to staff and cuddling them. There were a lot of smiles from people when staff approached them. From these observations and speaking with staff it was evident that they had a really caring attitude towards the people using the service. This was confirmed in discussion with relatives. One relative told us, "The staff are very caring, they look after people very well. One person using the service can be quite demanding but I have observed the staff and they are very tolerant of their behaviour." Other comments included, "The care provided at the service is very good, they really do support [person] to have a good quality of life. I would happily recommend the service" and "I don't have any worries about leaving [person] at the service; I have a lot of faith in the staff, who do a brilliant job. Overall, I feel happy that [person] is being looked after."

Throughout the inspection, we saw staff communicated effectively with people using the service. Staff understood what people could do for themselves, how they communicated and where they needed help and encouragement. Communication passports provided good guidance for staff on how to communicate with people who were non-verbal. Descriptors were given so that staff would know, for example when people were happy; excited and how they were able to make decisions. We saw picture cards or objects of reference were being used by staff to support people to make choices. For example, one person will hand a member of staff their shoes, which indicates they want to go out. Similarly, staff recognised a person pushing their food away as refusal, and offered an alternative. Staff were patient allowing people the time they needed to communicate their views and to make day to day decisions.

At our previous inspection, relatives had raised concerns about the lack of communication from the registered manager and staff about any changes in their loved ones needs. People's relatives told us since the new manager had been in post communication had improved. One relative said, "I have been fully involved in reviewing [person's] care plan. The service manager emailed me following changes made to their care plan to obtain my views." Another relative told us, "I have been asked to go through my [person's] care plan with the manager and their key worker. The documentation is really good, and they have assessed the risks to person before they go out, and take part in activities."

The PIR stated people using the service had regular review meetings to discuss their care, treatment and support options. Records of recent review meetings confirmed this and showed the person, their family, health / care professionals, key worker and service manager had attended where decisions about their care and treatment had been discussed and agreed. We also saw evidence in people's care records where staff had supported people to make decisions by explaining the benefits and risks of accessing routine health appointments, such as the dentist.

Care plans described in great detail how to respect people's choices and protect their dignity when providing personal care. People looked comfortable in the staff's presence and appeared happy for staff to

support them. We saw staff spoke discreetly about their personal care needs and managed a situation well where a person had been incontinent. They discretely guided the person to their room to attend to personal hygiene and change their clothing.

Requires Improvement

Is the service responsive?

Our findings

Our previous inspection identified that people's care plans were not sufficiently person-centred or up to date to allow staff to deliver consistent and effective care. The four people's care records reviewed at this inspection had been completely re written and now provided a comprehensive overview of their needs, including how they wanted their care provided. For example, morning and night routines contained a high level of detail with step by step guidance for staff on how this was to be carried out. Information had been included to reflect people's preferred method of communication, their likes and dislikes. For example, under the heading 'Things I don't like', listed being cold, rushed, seizures and people being in my personal space. There was intricate detail to guide staff on how to meet people's specific health needs, including enteral feeding regimes for people who received their nutrition via PEG, epilepsy and seizure management. We saw evidence that these plans were being reviewed on a regular basis by appropriate health professionals, including the dietician and epilepsy nurse.

Staff were knowledgeable about people's needs and preferences. This was confirmed in conversation with relatives. One relative told us, "Every day is different for [person], the staff know their needs really well, for example, if [person] is quite, staff know it is because they have their period. Their knowledge of [person] makes me feel better, because I know if they are having a down day; the staff will take time to make them feel better. I can't honestly fault the staff, they go way and above what I expected, they are brilliant. I think the world of the staff, they are so accommodating." Other comments included, "I have no concerns about [person's] well-being." I believe the staff know people in the service well enough, they respond very well to my [person] needs. They know when to step in and offer help and support. I have never seen any evidence of staff being unkind" and "Everything is alright, I can't fault the staff. [Person] has come on in leaps and bounds since moving into the service; they are always cheerful when I see them. It is lovely; [person] appears to be really enjoying them self."

Each person using the service had been allocated a key worker to enable a higher level of consistency in the care and support they received. [A key worker is a named member of staff who works with the person and acts as a link with their family]. This role ensured staff working with the people understood their needs, their life history and were aware of things that may define them such as their cultural background, gender and personal preferences. They also had a key role in supporting people to keep in contact with their family, including sending cards and gifts.

People's care records and information shared with us from relatives confirmed people were receiving personalised care. One relative told us how staff had taken immediate action where marks had been identified on [persons] legs. They said, "There is not anything that I am not kept up to date with. As soon as the marks were noticed, this was investigated and the cause identified as the shower chair. Within a week [person] had been assessed for and provided with a new shower chair. Their wheelchair was also upgraded to make it more comfortable."

We saw that staff responded promptly to people's health needs. During our inspection, a nurse visited a person to check their PEG. They informed staff of a potential ulcer developing around the PEG site. Staff

immediately made arrangements for an appointment with their GP later that afternoon. We also saw lovely examples where staff responded to people's needs in a kind and caring manner. For example, following the midday meal we observed a person became distressed. Staff told us this was due to a build-up of wind whilst eating and that this occurred after most meals. Staff supported them to walk around the service until the symptoms had alleviated reducing the person's distress. On another occasion, we saw staff responded well to a person who was standing at the door to the garden pointing to the rain outside. Staff told us they liked the rain and encouraged them to get their coat so that they could go out in the garden and enjoy the rain. They came back in shortly after but from the smiles on their face, we could see they had enjoyed the activity.

Our previous inspection identified that people were not always able to enjoy activities outside of the home because of limitations with transport and staffing. Although at this inspection we have identified there continues to be issues around staffing and facilitating one to one activities. Changes whereby a person who had high levels of challenging behaviour, requiring a lot of staff attention has moved from the service. This has freed up some time for staff to facilitate people's access to activities outside of the service more often. This was confirmed in conversation with relatives. Comments included, "I tend to ring before I visit, just to check [person] will be there, as sometimes I have arrived and they have been out and not come back for ages, they like being out all of time, shopping etc. I would rather them be out than in." and "My [person] goes out a lot more. I actually bumped into them out in the community with staff. When I saw them they were having a really good time and enjoying them self, and they told me to go away Mum, I love you but I am out. The staff are right on it, and you could see by their faces that they were having a good time out with [person]."

We observed how people spent their day. People were able to spend their time as they chose in their rooms, watching television in the lounge or outside in the garden. We observed one person enjoy a leg massage and foot spa. Another person enjoyed time in their room watching DVD's of their choice, whilst we saw another person was enjoying sensory activities. People also had access to external activities for example, one person returned part way through the morning having been horse riding. They were really happy and had clearly enjoyed the activity. People's care records showed other activities of choice were facilitated, such as bowling, shopping, swimming, ice skating, spa, visiting the zoo and trips to the pub.

Several documents were available to people, relatives and visitors on how to make a complaint. These included a complaints policy and procedure, easy read version for people using the service and a leaflet with information on how to report concerns. Our previous inspection identified that although there was procedures in place, recording and responding to complaints needed to be more robust. The complaints file showed further work was needed to ensure people's views were listened too, thoroughly investigated and a full explanation provided of the outcome and action taken. Although, one compliant had been fully investigated, responded to and closed, complaints from relatives about the mini bus had not been fully addressed. Relatives told us they did not feel the vehicle issue had been resolved satisfactorily and that transport remained a big issue. One relative commented, "There used to be two vehicles, but now there is only one, this has been an on going issue since 2010 where families were promised that a new vehicle would be provided, however this has not happened."

Requires Improvement

Is the service well-led?

Our findings

Our previous inspection found significant failings in the management and leadership of the service. No nominated individual for the service had been appointed by the registered provider. [Providers registered with the CQC are required to nominate an individual responsible for supervising the management of the regulated activity.] The director of the company has now taken on this responsibility. The registered provider had also failed to display their rating on their website as required under the terms of their registration. This has now been rectified. Where previously the registered manager had failed to notify safeguarding authorities and CQC of safeguarding issues, these were now being reported and appropriate action taken.

Concerns had also been identified about the lack of a formal management structure above the registered manager. As a result, the registered manager had lacked effective support to carry out their duties. They had formulated their own role as an operational manager but had no clear indication of the scope of their responsibilities within the organisation. People's relatives had been similarly critical of the registered provider. The absence of clear management hierarchy had led to an unacceptable decline in the overall standards of the service.

Feedback from relatives following this inspection were mixed, but overall more positive. They told us they had been made fully aware of the issues raised following the last inspection. Comments included, "There have been a lot of problems, and they were very short of staff, I think they have made a lot of improvements; the service seems to have had a 'boot up it'. Staffing is improving, it's lovely there now, I wouldn't have my [person] anywhere else" and "It has been reassuring to see that the registered provider did take these issues on board and has made a lot of changes, including a complete refurbishment of the home." However, feedback about the registered manager was less positive. Comments included, "I have had poor experience dealing with registered manager, I do not have trust in them that they will deal with my concerns," and "The registered manager is medically trained, but their people management skills leave a lot to be desired and because of the registered manager some very good staff left." The registered manager acknowledged they had received mixed feedback about their management style and told us they were leaving the organisation. They told us the service manager in charge of the day to day running of the home had been appointed in their place and had applied to CQC to become the registered manager. (They were approved by CQC on 31 August 2017).

Relatives told us since the service manager had been in post the service was much better. One relative told us, "I believe they are making a positive difference, things are improving, and any concerns I have are listened to and responded to." Other comments included, "I have a good relationship with the service manager, if I have any concerns I will ring and my issues are resolved" and "Service manager is okay, they listen and take action to address issues of concerns." However, relatives told us issues remained with the overall management of the service. Comments included, "I don't feel the registered provider has been entirely open and transparent with us, for example, the vehicle remains an issue," and "I do not feel the service is run in the benefit of the residents. I have concerns about how [person's] funding is being spent. They are allocated funds within their contract for holidays, but they have not had a holiday."

We looked at a breakdown of peoples funding provided by the local placing authority. This included a breakdown of funds allocated for meals, social activities, transport and holidays. We found discrepancies in the amounts of money agreed by the local authority to be allocated to individuals and what was actually provided. For example, people were allocated £20 each week within their care package towards funding the cost of a holiday, but not everyone had been on a holiday. Discussion with the registered manager confirmed holidays were not being provided due to the cost of supplying staff to facilitate time away. From the breakdown of the activities budget we could not see how, or if this funding had been reallocated to provide additional activities for people. Similarly, each person was allocated £50 a week for food, which would equate to £7 per person, each day. However, the registered manager, service manager and senior support work told us the food budget allocated for each person was £35 a week, which equated to £5 per day. Receipts in people's money folders showed they were using their own personal allowance to buy their lunch when accessing activities in the community. The management team were unable to explain why people were using their own monies to purchase food when funding was being provided by the local authority. The registered manager was unable to account for the shortfalls in what monies were allocated to people and what was actually being spent.

Following the inspection the service manager informed us they had carried out a check of people's funding provided by the local placing authority and where there were discrepancies these have been rectified to ensure people were now receiving the full amount.

The previous inspection had identified a "poor staff culture" and low staff morale. Staff told us this had improved and spoke highly of the service manager. Comments included, "The manager is very hands on but can't always help on the floor as she needs to do administration tasks. It is so much better with her as the manager," and "We now have staff meetings and if [service manager] says she is going to do something she does it. This was not how it was before. They are helpful and approachable and if you have any worries you can tell her without fear of reproach."

The service manager told us their main objective had been about improving the culture, quality and safety of the service. Staff had lacked direction, hardly anyone was accessing activities and no one had focus or vision of what was best for people using the service. They told us they had implemented a number of changes, including an immediate review of peoples care plans to ensure all staff were providing personalised care rather than the quickest way of doing things. Where staff had lacked supervision, appraisal and basic training they had taken measures to rectify this to ensure staff had the skills they needed to carry out their roles and keep people safe. We saw that a formal supervision process had been implemented which stated staff were to receive a minimum of six supervisions a year. Staff supervision records showed these were taking place on a regular basis, where staff's achievements, challenges and personal development were being discussed and actioned.

To sustain these improvements further work was needed to ensure all staff, including the registered provider knew, fully understood and were committed to embedding the vision and values of the service. Futures website states their values are to support people to make their own choices and place responsibility, rights and individuality, at the heart of the service. The philosophy of care also referred to adopting the five key principles of Valuing People published in 2016, of valuing people, integrity, respect and honesty and taking quality to its highest level. Although, the philosophy of care was on display in the entrance hall to the service; none of the staff spoken with were aware of this and were unable to tell us what the vision and values of the service were.

Annual Questionnaires dated 2017 had been sent to and completed by relatives. These reflected relatives were fairly satisfied with the care their loved ones received. Two out of the three responses seen reflected

they had seen an improvement in the service; however, one person felt there had been a decline. One person had commented, "I feel we go round and round in circles with Futures, it gets a bad CQC report, it appears to put measures in place to improve and then gets complacent at senior management level and slips back again into decline."

The previous inspection identified auditing and quality monitoring systems were not sufficiently robust to capture the extent of the failings in the service. Whilst some progress had been made, we identified that further work was needed to develop proper systems to assess, monitor and identify where improvements are needed to improve the safety and quality of the service. Whilst we saw evidence that some audits had been completed these were not being monitored to ensure action was being taken to make improvements where issues had been identified. For example, a senior member of staff was completing medication audits weekly, and had recorded where minor errors had occurred, however, there was no oversight by the service manager to reflect what action had been taken to address the issues identified and prevent similar incidents happening again.

The registered manager provided a copy of their most recent Monthly Quality Monitoring visit dated 06 June 2017. These visits were carried out on behalf of the registered provider at both of Futures services in Brightlingsea and Halstead. Information in the report was minimal, with yes or no answers to a range of questions, including but not limited to staffing, policy and procedure, finance and person centred care. The report contained little detail on the quality and safety of the service provided and demonstrated the registered manager's limited understanding of reviewing, analysing and understanding the significance of information. This was evidenced by their lack of follow up with breaches since last inspection, such as staffing levels and application of DoLS.

This demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People who use the service were being deprived of their liberty without lawful authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who use services and others were not protected against the risks to their health, safety and welfare because the registered provider continued not to have proper processes and systems in place to regularly assess, monitor and improve the safety and quality of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People who use services are not receiving the care they are funded for. The registered provider continues not to have sufficient numbers of staff available at all times in order to meet peoples assessed needs and keep them safe.