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?	**Inadequate**
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 inspection took place on 12 February 2016 and was unannounced.

The service provides accommodation and care for up to nine people with the learning disabilities and autistic spectrum disorder. Some people also have a physical disability. The service also takes people for respite breaks.

There was a registered manager 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.

Staff had received training in administering medicines but medicines were not always well managed as poor stocktaking procedures made it difficult to be sure that people had received their medicines as prescribed.

Staff were trained in safeguarding people from abuse and systems were in place to protect people from abuse. There was a lack of clarity over some financial procedures which could have left people open to financial abuse.

Risks were assessed but action was not always taken to minimise these risks. Systems were not in place to ensure the safety of the service vehicles.

Staffing levels meant that people's needs were met, although some feedback indicated that sometimes people were not able to take part in certain activities due to staffing constraints.. Recruitment procedures were not always robust and references had not been sought for one person.

Training was provided for staff to help them carry out their roles but a structured induction was not in place. Staff were not well supported by the manager as regular supervision and appraisal were not in place.

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

People were supported with their eating and drinking needs and staff helped people to maintain good health by supporting them with their day to day physical and mental healthcare needs.

Staff were caring and treated people respectfully making sure their dignity was maintained. Staff were

positive about the relationships they had built with the people they were supporting and caring for.

People, and their relatives or legal representatives , were involved in planning and reviewing their care and were encouraged to provide feedback on the service. Care plans identified people's particular preferences and choices but plans and risk assessments had not always been appropriately reviewed. People were supported to play an active part in their local community and follow their own interests and hobbies.

Formal complaints were not logged but informal issues were dealt with appropriately and to people's satisfaction.

Staff were not always well supported by the management of the service. Staff were not clear about management roles and lines of accountability were not evident.

Quality assurance systems were in place and audits were carried out regularly to monitor the delivery of the service but these were not robust.

We identified several breaches of regulation during this inspection, and 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?

Inadequate

The service was not always safe.

Systems were in place and staff were trained in safeguarding people from abuse.

Risks were assessed but procedures were not in place to minimise all known risks.

There were enough staff to keep people safe but recruitment processes were not robust.

Although medicines were mostly managed safely, stock control procedures were not effective.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training to support them to carry out their roles but did not have a structured induction, supervision or appraisal.

People, or their relatives, consented to their care and treatment.

People were supported with their dietary and healthcare needs.

Is the service caring?

Good

The service was caring.

Staff were patient, compassionate and kind. Relationships between staff and the people they were supporting were good.

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

People were treated with respect and their dignity maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People, and their relatives, were involved in assessing and planning their care.

People's choices and preferences were recorded in their care plans but care plans and risk assessments were not always updated promptly.

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

Informal concerns were responded to appropriately and feedback was sought from relatives.

Is the service well-led?

Requires Improvement

The service was not well led.

Staff were not well supported or involved in developing the service.

There was confusion as to staff roles and responsibilities. .

Quality assurance systems were in place to monitor the delivery and safety of the service but they were not effective.

Futures Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 12 February 2016 and was unannounced.

The inspection team consisted of two inspectors.

Before we carried out our inspection we reviewed the information we held on the service. This included statutory notifications that had been sent to us in the last year. A notification is information about important events which the service is required to send us.

We observed care being provided to people who used the service, spoke with and received feedback from four relatives. We also spoke with three care staff, the manager who was in day to day charge of the service, the registered manager and two members of the local authority safeguarding and social work teams.

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

Inadequate

Is the service safe?

Our findings

Safe and effective systems were not in place to ensure transportation in use was effectively maintained in a timely manner. We had received information of concern about the minibus before our inspection. We looked at both of the vehicles which the staff used to take people out. One was a back-up vehicle owned by the provider and the other a minibus. We found that, although both had current insurance and MOT certificates in place, there was no effective system to ensure that the minibus was well maintained or that staff had the correct licences in place as these were not routinely checked. We had been told that the minibus had been operating with only one indicator working but were assured this was now fixed. We saw that vehicle check sheets were in place which staff were required to fill in to make sure the vehicle was safe before they took the it out. We found that these were very rarely filled out and those that we did see highlighted concerns with the safety straps for wheelchairs, interior lights and a broken door handle on a number of occasions and no action had been taken in response to this.

On 11 May 2015 a staff member had noted that 'most safety locks/ straps are broken' and 'passenger door broken – does not open! Not safe in fire'. Faulty straps were also noted on 16 May 2015 and again on 18 May 2015 along with interior lights being permanently on noting, 'they have been for months'. The same issues were again noted on 4 June 2015 and 14 June 2015. In between these times no defects had been noted which suggest that the checks may not always have been thorough, if they had taken place at all. The manager had not signed any of these forms and there was no record of when these issues had been rectified although we saw documentation from a recent service visit that confirmed that the vehicle was now safe and all straps and lift mechanisms were working correctly.

This was a breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 12 - (1) (2) (e).

We brought to the manager's attention the fact that a large bookcase in the entrance hall was not bolted to the wall and could pose a potential risk to people should it fall or be pulled over. Risks associated with day to day activities such as accessing the community, eating and drinking, relationships and using public transport had been assessed and actions put in place to reduce these risks were clearly identified. Specific risks associated with people's epilepsy had been assessed. We saw that one person had a sensor on their bed to alert staff that they might be experiencing an epileptic seizure as well as a safety mat on the floor to protect them if they fell from their bed during a seizure. Another person's risk of self-harm had been assessed and the plan contained clear information for staff about potential triggers for this behaviour and guidelines on how to manage it in order to keep the person safe.

Some risk assessments had not been reviewed appropriately. For example one person's moving and handling risk assessment had not been reviewed for more than seven months and did not contain specific information about the size of sling to use. We were particularly concerned about the risk assessments for people coming to the service for respite care. We saw that one person's medication risk assessment had not been reviewed since 22 August 2013 even though they had last attended the service in August 2015. We also found that their moving and handling assessment contained information about the use of a ceiling track

hoist which was no longer in use.

The provider still did not have a business continuity plan in place despite the matter being raised by CQC previously. Such a plan is designed to document how the service would continue to be delivered in the case of an emergency such as a fire or flood and to give staff clear and practical advice to follow. We had previously discussed this issue with the Nominated Individual at the service when the heating had broken down at their other service. They had assured us they would put one in place at both of their services. The provider had not taken reasonable steps to prevent avoidable to harm.

This was a further breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 12 - (1) (2) (a) (b).

Recruitment records showed that staff had followed an application process, been interviewed and had their suitability to work with this client group checked with the Disclosure and Barring Service before taking up their employment. We found that one person's references had not been thoroughly investigated and another's had not been received before they started to work at the service, and had still not been received at the time of our inspection. The manager told us that they had not got round to chasing the references up. The person had been in post for almost three months and although the manager told us that the staff member did not support people alone there was no risk assessment in place for this and this was not identified on the rota. Recruitment was not robust.

This was a breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 19 (1) (a).

One member of staff had been delegated to take overall responsibility for the management of medicines and we saw that staff had received training before they were able to administer medicines. Staff had their competency to administer medicines safely checked but this was not done regularly for all staff.

Each person had a medication profile which stated how they preferred to take their medicines and information about people's medicines was clear. Medicines, including controlled drugs, were stored correctly and creams and liquids were dated so that staff could ensure they were not used beyond their expiry date. Where people were prescribed medicines to be given as and when they needed them (PRN), such as for pain relief or epileptic seizure, we saw that there were clear guidelines for staff to follow and staff were aware of these. Medication administration records (MAR) charts were accurately completed after medicines had been given.

Although there were procedures in place to return medicines to the pharmacy we found that stocktaking was poor which meant that we could not be sure that everyone had received the correct amounts of their prescribed medicines. For example one person's relative brought tablets in for their relative and these were recorded as being received each time but there was no overall stock count which meant we could not be sure the person was having the correct amount of their medicines. We found that additional stocks of medicines were kept in another part of the service but stocktaking was not done in a comprehensive manner which included both stocks. We also found that tablet counts for two people's epilepsy medicines indicated that they may have received the incorrect amounts of medicine. A weekly audit of medicines was carried out but it had failed to identify the issues we found. We discussed out findings with the registered manager who agreed that medicines were not being accurately carried over from one cycle to the next and assured us they would immediately put a more effective stock control system in place.

There were systems in place to reduce the risk of abuse and to ensure that staff had received training and

knew how to spot the signs of abuse and take appropriate action. Staff knew how to report safeguarding issues. Financial procedures and audit systems were in place where the service was responsible for people's money. On a daily basis these procedures were clear and we saw that staff kept an accurate account of people's monies. Some people's money was managed on their behalf by Essex Guardians at Essex County Council. We saw evidence of the registered manager working in partnership with Essex Guardians to ensure people's money was safeguarded.

There was, however, a lack of clarity with regard to how other people paid for the use and upkeep of shared vehicles and for activities. Some relatives expressed concerns about this to us. Some monies were paid as part of the core funding. Others were paid directly to the service out of people's benefits by their representatives but we were not able to see a clear rationale for how these amounts were decided or how they were accounted for. For example, one person paid a monthly contribution toward the use of the service vehicle but other arrangements such as how petrol costs were shared out when several people used the vehicle at the same time, were not made clear to relatives. Records were not kept as to which service users used the vehicle, and when, which meant we could not be assured that people were paying for a something and were always able to access it. We saw that the registered manager had already tried to address these concerns with individual relatives but the system remained confusing.

We saw that some service users had their own Motability vehicles but these were not present at the service. We were concerned that people were being deprived of an asset which was intended to improve the quality of their life and for which they were paying out of their benefits. We raised this concern with the manager.

We found that a minimum staffing level had been set by the service and overall rotas confirmed that staffing levels were provided in accordance with this. We saw that when an additional respite client came to the service the staffing was not automatically increased as this had already been factored into the staffing calculation. This was not widely understood by staff and relatives who were concerned about the impact of the addition of an extra person. We did note however that on the last occasion that this person had stayed at the service the staffing levels had actually been increased by one.

The service had a number of vacant posts and were covering these using additional hours for permanent staff and agency staff. Relatives gave a mixed picture about staffing levels with some feeling that staffing levels made it difficult for people to regularly attend activities and appointments. One relative was concerned that their relative had missed some hydrotherapy sessions as well as some health appointments. They told us, "[My relative] has missed a hospital appointment…. and has also missed dentist appointments". They felt that this was due to staffing concerns and not enough drivers to drive the service vehicle. Others relatives were more positive and we saw that people were recorded as taking part in a lot of activities outside of the service on a regular basis and as attending healthcare appointments appropriately. One relative commented on how staff had been able to support them when their relative had been taken into hospital and staff had driven them to the hospital and stayed there to provide support to them and their relative.

An on call system was in place for staff to seek guidance and advice out of office hours and was staffed by the registered manager and manager. Staff told us they were able to reach management if they needed to.

Requires Improvement

Is the service effective?

Our findings

The people who used the service appeared happy with the care and support they received and we observed good interactions between staff and the people who used the service. Although people were not always able to tell us about their experiences we observed staff supporting people in a skilled manner, offering choice and respecting people's preferences. One relative praised staff saying, "It's lovely here; I would recommend it to anyone. If you want someone they come and help. They don't just look after [my relative] they look after me as well".

We found that staff did not receive a structured induction when they started although the manager told us they had now developed one. We found that new staff did not meet regularly with the manager to assess their progress when they first started. We saw that one member of staff had started their employment at the service on 6 November 2015 and had not received a structured induction and there was no record of any probation meeting or supervision session since that time. Another staff member had started on 13 November 2015 and no record of an induction or any probation or supervision meetings.

The manager explained to us that when new staff began their employment they spent time shadowing more experienced staff for at least a week but this was not part of a structured plan. They also told us that staff began working through their Care Certificate workbooks but these were not available for us to see. There was no structured induction in place for agency staff but the manager told us that they were in the process of developing one and had asked the team leaders to do a pen profile for each person who used the service to rapidly introduce the support needs of people to agency staff.

The manager also confirmed that supervisions for all staff had been infrequent during 2015 and no staff had received any formal support since June 2015 and seven had no record of any supervision session during the whole of 2015. We noted that a new delegated system of supervision had been put in place for 2016 and six staff had received a supervision session during January and February. An annual appraisal system was not yet in place.

This was a breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation18 (2) (a).

Staff told us they felt they had the training they needed to carry out their roles and we saw that staff received a varied training programme which was designed to ensure they could meet the particular needs of the people who used the service. Specific training had been provided to ensure staff had the skills and knowledge to support people's needs relating to their epilepsy and nutrition. We saw that staff had been trained to administer buccal midazolam which is given to prevent recurrent epileptic seizures. Training had also been provided to support one person whose nutrition was supplied via percutaneous enteral gastronomy (PEG) straight into their stomach. This requires specialist skills and the training was refreshed annually. A relative of this person told us they were very pleased that this person had responded so well since this had been put in place and were very confident in the abilities of the staff to manage this successfully. We saw that the person had gained weight and was doing well.

We noted that people's consent was asked for before care and treatment was provided and the management and care staff demonstrated an awareness of the Mental Capacity Act (MCA) 2005. Staff had not been provided with any training related to MCA . We saw that people's capacity to make day to day decisions had been assessed. For example decisions regarding people's personal care and financial transactions had been assessed, and where people were not found to have the capacity to give informed consent we saw that appropriate people, such as their relatives or legal representatives, had been involved.

The registered manager was aware of the need to apply to the local authority in order to restrict someone's liberty for their own safety under the Deprivation of Liberty Safeguards (DoLS) and had made appropriate applications.

Staff had a good understanding of people's specific dietary requirements. Staff were able to explain to us how they help one person to maintain their weight by using full fat products and adding high calorie sauces. We saw this documented in their care plan and their food diary reflected this also. We found that food diaries were kept and recorded drinks people had received as well as exactly how much of each meal a person had eaten. People's weights were monitored and where any concerns were identified people were referred to appropriate healthcare professionals. Clear and effective procedures were in place to meet the needs of the person who received their nutrition via PEG.

Fridges were full of fresh foods and freezers were well stocked. Information about people's food choices and preferences was available in the kitchen alongside the weekly meal planner. Staff prepared meals for people and relatives told us that people were able to have an alternative if they did not want to eat what was being prepared.

People were supported with their healthcare needs and staff worked in partnership with other healthcare professionals such as specialist epilepsy nurses, psychiatrists and neurologists to meet people's need promptly. People were supported to attend healthcare appointments with opticians and dentists, although one relative raised concerns about some appointments being missed. One person had recently been diagnosed with a very rare genetic condition and we saw that the service was working in partnership with consultants to put a treatment programme in place.

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Good

Is the service caring?

Our findings

Relatives mostly told us they were very happy with the way staff provided care and support and we observed warm, kind and caring interactions between the staff and the people they were supporting and caring for. One relative said, "Staff here go above and beyond with people, they treat them like they are their own family".

We saw that people's wishes and preferences were documented in their care plans and respected. Important information about people's particular care preferences was known by staff. One relative told us that sometimes individual choices had to make way as there were not always enough staff and outings had to take place for several people at once for example. Although this certainly happened on occasion, most outings were planned and the service tried to take people's individual needs into account where they could.

Staff aimed to ensure that people were not in any distress. We saw that some people who used the service did not have good relationships with those they were sharing a house with. We noted that a risk assessment was in place for one person so that they were not in close proximity to another person on trips out. We were told by staff that these two people sit in different areas of the minibus to minimise the anxiety of one person. Although this was not an ideal solution it demonstrated that the service was taking a pragmatic approach.

We saw that people, or their relatives if appropriate, were involved in decisions about the service which would affect them. Meetings took place with relatives to give people a chance to put their views across and review people's care. One relative had asked for a separate meeting and this had been arranged.

Information was shared with people who used the service in a way they understood and which helped to increase their independence. We saw that objects of reference were used to help people communicate. These are objects which have a particular meaning for people and enable them to communicate more easily. Staff were patient and waited for responses when communicating with people without rushing them. Advocacy services were available for people should they be required although many relatives acted as advocates for people who used the service.

Staff practice promoted people's dignity and privacy and provided the support people needed whilst encouraging them to be as independent as possible. Staff were clear about people's rights.

Requires Improvement

Is the service responsive?

Our findings

Care plans documented people's choices and preferences and made clear what people's skills and abilities were as well as the things they needed help with. Information about people's particular health conditions was clearly documented and strategies were in place to ensure that these conditions were well managed in order that people had as full a life as possible.

Before coming to live at the service each person had received an assessment of their needs and a care plan was developed to meet their needs. We found that care plans, although comprehensive, had not always been appropriately updated for people who used the service or for those who came occasionally to use the service for a respite stay. It was a particular concern that information for people on a respite stay was not current as staff, especially new and agency staff, would understandably not be as familiar with their needs.

We saw that staff supported people to play an active part in their community and to attend social functions and follow their own interests and hobbies. For example one person's activity record showed that in a 12 day period they had been out every day and activities included walking, lunch out, horse riding, dinner at a local pub, ice skating, a visit to relatives, a trip into town and a visit to the local park.

Staff told us that people who were wheelchair users did not have the same opportunities to go out to pursue leisure opportunities as others. This was felt to be because they required more assistance and staffing levels did not always ensure this could happen. Transport was also a consideration and it was thought that it would be beneficial for people who had their own Motability cars to keep them at the service. Staff also told us that there was not always enough stimulation and occupation for people within the service if they were unable to go out. There was no sensory room and little sensory equipment for people to benefit from and enjoy.

Surveys had been sent out to all relatives in December 2015 and January 2016 in order to ask for feedback about various aspects of the service. We saw that of the four replies, three were not positive and highlighted concerns with staffing, access to people's care plans and two issues which the manager had referred to the local authority safeguarding team for further investigation to ensure people were safe.

There was a complaints procedure in place although the people who used the service would need assistance to make any complaint. Relatives were informed about the complaints procedure and the issues raised informally in the annual surveys had begun to be addressed. One relative, who had never needed to make a formal complaint, told us, "If I have had a problem with anything…the problem has always been resolved". The registered manager met regularly with relatives who wanted to raise issues. A formal complaints log was not in place. A log would enable the manager to track complaints, identify trends and themes.

Requires Improvement

Is the service well-led?

Our findings

Following a very difficult period where some staff had left and others had been dismissed, the registered manager had begun to build the team and promote a positive and open culture. The registered manager divided his time between this service and one other but staff told us that he was always available to give advice and guidance should they need it. Staff also told us that they would feel able to contact the Nominated Individual for the service and the other director who both spend time regularly at the service and have management input. Another manager was in day to day charge and was intending to apply to be registered with the Care Quality Commission for this one location.

We found that formal support for staff through staff meetings was not in place. Staff meetings were not held regularly which meant that staff did not have an opportunity to receive feedback or to make their own contribution to the development of the service. We saw that night staff meetings had been held in December 2015. The staff team was divided into two teams and separate meetings were held but information was not shared effectively between teams and the manager did not have an overview of the issues raised. We saw that in 2015 one staff team had one meeting in January and we found an agenda but no minutes for a meeting in June. The other team had no records of any staff meetings. A full staff meeting had been held in January 2015 but only three people had attended. Given the lack of formal supervision for staff this meant that staff had limited opportunities to contribute to the development of the service and receive feedback from the management team.

The sharing of management responsibilities between the registered manager, the manager in day to day charge, and the directors, appeared to have contributed to some of the concerns we identified during our inspection. Staff were not clear about the management structure and could not confidently tell us about each person's role. Although both managers clearly had respect for each other, and communicated with the directors often, the management of the service was not entirely consistent and we, and some relatives, had concerns about the day to day leadership of the service.

There were systems in place to monitor the quality of the service but these were not always operated effectively. Audits failed to identify and resolve the issues we found. Weekly medication audits had not identified the issues related to stock control and there was no effective system to ensure that people travelling in the service vehicles were safe. The fact that some care plans and risk assessments had not been updated had not been identified and permanent and agency staff had not been supported effectively. An external audit had taken place in October 2015 and had identified some issues relating to recruitment but we were still able to identify some unresolved issues regarding one person's references.

The service had made a great many improvements to the environment since our last inspection and records had been reorganised. Whilst we could appreciate the amount of work that had been undertaken to make the improvements required at the last inspection we found that the service still needed to make some improvements and show strong leadership to bring these about.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that risks were assessed and all appropriate action taken to mitigate these risks. The provider also failed to ensure that equipment (a vehicle) was safe to use. Regulation 12 - (1) (2) (a), (b) and (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to operate an effective recruitment procedure which ensured that persons employed were of good character. Regulation 19 (1) (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that persons employed received appropriate support, supervision and appraisal. Regulation18 (2) (a).