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

Dearman Road

Inspection report

1 Dearman Road
Sparkhill
Birmingham
West Midlands
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Dearman Road is a respite service offering accommodation and support for people with mental health support needs. Two people were supported at the time of the inspection.

People's experience of using this service:
Staff showed awareness of people's safety and risks, and demonstrated a caring approach. A person we spoke with told us they felt safe. They spoke positively about the service and the support of staff. People's privacy and independence was promoted. People were given choices and support to access further support from their mental health teams when needed. However, the provider's systems failed to ensure the quality and safety of the service with particular concerns as follows:

- People's risks had not been effectively assessed, including in relation to ligature risks at the premises. The provider's environmental risk assessments had not been completed robustly and action to improve the safety of the service had not been completed to the provider's own timescales.
- Health and safety checks were not completed robustly to ensure the safety of the service including in relation to fire safety.
- Incidents were not effectively investigated and used for learning to improve the safety of the service.
- Please see more in Detailed Findings below.

Rating at last inspection: Requires Improvement (November 2017)

Why we inspected: This was scheduled inspection based on the previous inspection rating.

Enforcement We identified two breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 around safe care and treatment and governance. We also identified a breach of the Care Quality Commission (Registration) Regulations 2009. Details of action we have taken can be found at the end of this report.

Follow up: During our inspection, we prompted the provider to address our safety concerns and to provide us with updates after the inspection. We shared our concerns with the local authority and commissioning team that arranges referrals to the service. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will

seek to take further action, for example cancel their registration, if we have not taken this enforcement action already.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or varying the terms of their registration within six months if they do not improve and similar action may have been taken already. This service will continue to be kept under review and, if needed, could be escalated to further urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Dearman Road

Detailed findings

Background to this inspection

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

Inspection team:
This inspection was carried out by one inspector and a specialist advisor with a specialism in mental health. A specialist advisor is a professional who assists us with current practice knowledge and expertise on inspection.

Service and service type:
Dearman Road is a registered care home without nursing. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

What we did:
Before the inspection, we reviewed information we had received about the service since the last inspection. This included any notifications we had received from the service and feedback we requested from external agencies including the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also took into account a serious incident which had occurred at another service registered with the provider.

Providers are required to send us key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We referred to this information to help plan our inspection.

During the inspection, we spoke with one person, three support workers, the registered manager and a new Service Manager. We also reviewed records related to two people's care and record related to medicines management, health and safety and quality assurance.

Some information we requested was not available to view during our inspection, including the training matrix, recruitment files and incident records. We were told these records were stored at the provider's head office. The provider sent these to us after our inspection.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Some regulations were not met.

Assessing risk, safety monitoring and management;
Learning lessons when things go wrong
The service supports people with mental health needs some of whom may be at increased risk following recent attempts of self-harm and/or suicide. Learning from a serious incident at another of the provider's registered locations, had not been embedded into practice at this service. The provider had not made timely or robust improvements to the safety of the service which put people at risk of harm:

- The provider had not taken planned action to their own timescales to remove and/or reduce ligature points they had identified at the service. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation.
- There were several other hazards including ligature points which the provider's checks had not picked up such as stair bannisters and light fittings, in the garden and home. The provider had not assessed or mitigated these risks to ensure the premises were safe. After our inspection, the provider confirmed they had carried out improvements to address this.
- Staff showed some awareness of people's safety in relation to the premises. A staff member had also proactively shared information with the staff group about ligature risks they had identified. There was no policy or written guidance available for staff to refer to however, to help ensure all staff were aware and vigilant on the premises.
- Although staff were mindful of people's safety, people's risk assessments did not accurately and sufficiently reflect all people's needs including access to ligature risks within the premises. The provider's planned improvements to how people's risk assessments were completed were not consistent or sustained. We prompted the provider to immediately reassess risks and we were informed this had been done shortly after our inspection. The provider had failed to demonstrate sufficient learning from a previous serious incident and to ensure the safety of the service at all times. The provider also failed to ensure learning was taken after the Commission and other external agencies brought health and safety concerns to their attention:
- At our last inspection in November 2017, we found the provider had not identified that their own weekly fire alarm checks had not been done for over six weeks. At our site visit to the service in September 2018, we found the provider had not identified malfunctioning smoke detectors and did not have systems in place to check smoke detectors.
- The provider had failed to improve their oversight of fire safety despite these concerns and to access current good practice guidelines in relation to this.
- At this inspection we found the provider's audits had not been developed to include checks of smoke detectors moving forward and to include checks of emergency lights. This disregarded current good practice and fire safety standards. We also found fire drills were not carried out at varying times to ensure all staff understood how to respond in the event of a fire. We requested that managers sourced current good practice guidelines to prevent oversights in future checks. We also shared our continued concerns with the

fire service.
•□The above concerns demonstrated a failure to prevent avoidable harm or risk of harm which amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
•□A person told us they felt safe at the service. People were involved in reviewing their risks and support needs with staff when they first joined the service. Staff were mindful of people's safety and known risks. Staff contacted people's healthcare teams if they had concerns about people's wellbeing.

Systems and processes to safeguard people from the risk of abuse
•□Systems were not always effective. Incidents were not proactively and sufficiently responded to, to promote people's safety.
•□An agency staff working at the service at the time of our inspection had not been informed of the provider's safeguarding processes. Regular staff told us they had received safeguarding training. They told us they would raise safeguarding concerns directly with managers or via the whistleblowing hotline.
•□A regular staff member had informed a manager of a police incident and potential safeguarding matter in mid-January 2019. The staff member had not received any feedback about this and had made their own safeguarding referral. The registered manager and Service Manager did not know about the incident. The incident had not been recorded or investigated through the provider's own processes. We prompted for this to be done.
•□A similar police incident had occurred in May 2018 whereby a person using the service was aggressive towards staff. There was no record of this or any other incidents on site to demonstrate how incidents had been learned from and shared with staff. The registered manager did not show awareness of this or other incidents that had occurred at the service.

Staffing and recruitment
•□Lone-working had been phased out, and staffing levels increased, a fortnight before our inspection. This helped staff monitor and ensure people's safety more effectively. Staff spoke positively about this change.
•□Safe recruitment checks were carried out to prevent the risk of people being supported by unsuitable staff. Records showed, and a staff member confirmed this included character references and checks through the Disclosure and Barring Service (DBS).

Using medicines safely
•□There was safe storage for people's medicines. One person told us they received safe support from staff with their medicines. The provider had introduced clearer medicines records to show how people were supported. Medicines audits were carried out.
•□The provider had not carried out assessments to ensure staff were competent and confident to support people safely with their medicines. We have previously informed the provider that these assessments are recommended in current good practice guidelines to ensure staff understand how to support people safely. The provider has not made this improvement to help ensure the safe management of medicines.

Preventing and controlling infection
•□The home was clean. A person told us, "The facilities are good, it's a nice home." Hand sanitiser and cleaning products were available.
•□People were encouraged to keep the home clean and tidy. A cleaner regularly visited and staff also helped with cleaning tasks. Staff had received training related to Infection Control and Health and Safety.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence. The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
Staff support: induction, training, skills and experience

- Staff training had included some relevant topics such as Mental Health Awareness, Mental Health, First Aid, Safeguarding and Health and Safety following their induction. Staff showed awareness and consideration of people's support needs, however they had not received training or guidance relevant to all people's support needs and known risks.
- We saw some generic guidance had been sourced and included in both people's care plans but this did not refer to people's known individual needs and diagnoses. This did not ensure people's identified needs would always be understood and met in line with current good practice. A staff member told us, "It would be helpful if [relevant] guidance was available... Most of the reading comes from [the healthcare team's] referral."
- Staff were receiving guidance about how to carry out risk assessments at the time of the inspection as part of the provider's ongoing improvements. This would help ensure records were accurately maintained and people's needs were effectively assessed.
- A person we met spoke positively about the service. They told us, "It's a really good place to be, it's nice, staff are really friendly and help you a lot." Staff told us they received regular supervision and spoke positively about their roles.
- Staff worked well together and used information available in people's support notes and provided by people's healthcare teams, to learn more about people's histories and risks. Handovers took place as planned and included regular checks of people's medicines and brief updates on how people were.

Adapting service, design, decoration to meet people's needs

- The provider had not ensured people's individual needs were safely managed by the design of the premises. This was due to a number of ligature risks which had not been appropriately assessed and reduced as far as possible. The Service Manager told us improvements were underway to address this and to create a more homely and welcoming environment within communal and private areas of the service.
- Staff and the registered manager made use of a ground floor bedroom near to the office, where people considered at high risk, often when they first joined the service, could be monitored more closely by staff.

Supporting people to eat and drink enough to maintain a balanced diet

- People could access the kitchen to prepare meals as they wished and were supported by staff if needed. Both people using the service prepared their own meals. Staff remained mindful of any support people might need.

Staff working with other agencies to provide consistent, effective, timely care
Supporting people to live healthier lives, access healthcare services and support

•□People were regularly contacted and visited by their healthcare teams to help monitor people's health over their time at the service. Staff told us a healthcare team had been pleased with one person's progress over their time at the service.
•□Staff contacted people's healthcare teams with any concerns about people's health and wellbeing. People were signposted and supported to access other healthcare services if needed, for example to see a doctor if they were unwell.

Ensuring consent to care and treatment in line with law and guidance
•□The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. We checked whether the service was working within the principles of the MCA.
•□A condition of people's stay at the service was that people had capacity to take their own decisions. The registered manager told us if they had any concerns about people's capacity, they would raise this with people's healthcare teams for further consideration.
•□People using the service made their own choices and carried on their routines as they wished. People were supported to have choice and control of their lives.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. People were supported and treated with dignity and respect; and involved as partners in their care.

Supporting people to express their views and be involved in making decisions about their care
At our last inspection, reasonable and planned steps to involve people in service were not taken. For example, people were not invited to complete feedback surveys and monthly meetings were not held as planned. At this inspection we saw these improvements had not been addressed:

- There was no evidence of completed feedback surveys and meetings did not take place monthly as planned. These were missed opportunities to support people to express their views and be involved in making decisions about the service provided. This did not promote people's rights as far as possible in ensuring people were regularly reminded of the complaints process and how to access independent support such as advocacy services if they needed to.
- Before our inspection, the registered manager sent us key information about improvements they planned to make to the service, which helped us plan our inspection. The registered manager told us that they would ensure service user meetings were held and that people were more involved with the service they received. Another planned improvement was to arrange activities people could take part in at the service. These improvements had not been made to ensure people's involvement in the service as far as possible.
- There was evidence within people's care notes that they had been involved in decisions about their support, and informed of any updates for example when people's healthcare teams were due to visit. A staff member told us, "I sat down with [person] the day they came. We read through the risk assessment together, we signed and chatted it through." Healthcare professionals helped monitor people's views and experiences at the service.

Ensuring people are well treated and supported; equality and diversity;
Respecting and promoting people's privacy, dignity and independence

- We found the provider's poor risk management processes did not ensure people were well supported and that people's needs were understood and safely met at all times. The provider took action to address this after our inspection. Staff showed care and consideration for people's needs and personal histories. People were addressed by staff with respect and kindness; staff showed a friendly and positive approach and people responded well to this.
- One person told us, "I can approach all the staff and speak to them, they are good people in general."
- People's individual preferences and needs were considered as part of their support planning, for example accessing local religious services and maintaining social relationships. Assessments had considered, and staff had asked people about any religious needs they had.
- People's privacy was promoted by staff, for example people's support records were handled confidentially and we were asked to give one person privacy so they could take their medicines discreetly.
- People's independence was promoted as part of promoting their recovery and wellbeing during their time at the service.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs. People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- Although improvements were underway and staff showed awareness of people's needs, processes to assess, monitor and meet people's needs were not robust. People's known needs and risks were not all considered and reflected in support planning and documentation.
- Staff showed some consideration of people's values and beliefs and made use of information available to them from people's healthcare teams, but the provider had not ensured their own support planning systems were effective and promoted responsive support of a good quality.
- Processes were not always carried out as planned to review people's support and ensure this met their needs.
- A person spoke positively about the service and how this helped meet their needs. A staff member told us the person had started spending more time out of their room and had started a new role. Staff described improvements to people's wellbeing over their time at the service.

Improving care quality in response to complaints or concerns

- Information about how to complain was on display. A person confirmed they would look at this information or speak to staff if they wanted to complain.
- The registered manager told us no complaints had been made at the service.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations were not met.

Systems and processes to assess, monitor and improve the quality and safety of the service;
Continuous learning and improving care;
Working in partnership with others
The provider's systems failed to ensure people's risks were safely managed, including to ensure the safety of the premises:

- The provider did not have robust systems to adequately assess and ensure the safety of the premises. Checks had not picked up all hazards and ligature risks at the service. The provider had also failed to act on the risks they had identified to their own timescales.
- The provider had not carried out other improvements as planned to their policies, staff training and risk assessments to improve the safety of the service. This showed poor recognition of, and learning from a serious incident at another service registered with the provider.
- For example, the provider told us they had made masterkeys to allow prompt access to people's rooms when needed for their safety. This had not been done. This was despite an incident a month before our inspection, where a person prevented staff access to their bedroom. Staff did not have a masterkey or other means to access people's rooms for example in the event of an emergency. We needed to prompt the provider to carry out their own plans to improve the safety of the service.
- Before our inspection, we raised concerns with the provider about the poor quality of risk assessments completed for people in their care. The provider later reviewed and improved a risk assessment for one person staying at Dearman Road. On inspection we found this learning was not applied across the service. Another person's risk assessment was completed to a similarly poor quality and contained limited information about their risks. This did not assure us that the provider would make proactive and sustained improvements to the safety of the service.
- Staff were starting to receive guidance about how to complete risk assessments appropriately and had not received training previously on how to do so. Staff made their own interpretations as to how this should be done and the quality of risk assessments varied.
- Incidents were not all known to managers and escalated appropriately. Records of incidents were not available on site which was a missed learning opportunity for staff. Managers told us this would be looked into.
- The provider had failed to learn from previous concerns brought to their attention by the Commission and other external agencies in relation to health and safety matters. This included concerns raised at another service registered with the provider in relation to ligature points, and continued concerns raised by the Commission in relation to fire safety systems. The provider had failed to introduce robust systems in these areas to ensure the safety of the premises at all times.
- The above concerns demonstrated a failure to effectively assess, monitor and improve the quality and safety of the service which was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.
•□The provider was working alongside service commissioners and with the new Service Manager at the time of our inspection, to improve how the provider's policies and processes were followed.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility;
Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
•□We are currently considering our regulatory response to the provider's breach of a condition of their registration, identified in September 2018. The provider had supported over the maximum number of service users. This demonstrated a failure to understand and adhere to their regulatory responsibilities.
•□The last CQC rating awarded was displayed at the service and on the provider's website as required to keep people informed of the last inspection findings.
•□The provider had made reference to CQC guidance and the fundamental standards of care.
•□A new Service Project Lead was due to be recruited. Staff told us they still received supervision, audits of the service and attended staff meetings which they found helpful.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•□People were shown care and respect by staff.
•□Before our inspection, the registered manager sent us key information about improvements they planned to make to the service. These improvements had not been fully carried out. For example, although some relevant training related to mental health had been provided since our last inspection, training related to Equality and Diversity had not been updated for all staff. Support planning processes did not ensure all people's individual needs were assessed and reviewed effectively.
•□The registered manager had not fully carried out their planned improvements to how people were involved in the service. One person told us they had not taken part in any service user meetings and we saw these were not held as often as planned in line with the provider's processes.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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 care and treatment was provided in a safe way for service users and to prevent avoidable harm or risk of harm.

The enforcement action we took:

We have issued a notice of proposal to vary the provider's registration to cancel the registration of this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to implement and operate systems to effectively assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

We have issued a notice of proposal to vary the provider's registration to cancel the registration of this location.