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

College Road

Inspection report

155 College Road
Moseley
Birmingham
West Midlands
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Tel: 01217786020

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

People's experience of using this service:
People told us they felt safe and satisfied with the service, and they felt that staff were supportive. People's independence, choices and preferences were promoted. However, the provider had failed to ensure the quality and safety of the service with particular concerns as follows:
•□The provider failed to take prompt and sufficient remedial action following the death of a service user in May 2018.
•□Poor risk management in relation to people's known needs, lone-working arrangements and the premises. Medicines management processes remained unsafe and staff were not supported in their roles.
•□Please see more in Detailed Findings below.
Rating at last inspection: Good (January 2017)

Why we inspected: The inspection was prompted in part by information of concern shared with us by the coroner and notification of an incident involving the death of a person using the service. This incident may be subject to criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident, including from the coroner, indicated potential concerns about the management of risk in the service including ligature risks. This inspection examined those risks and found sufficient action had not been taken to keep people safe.

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.

Following the inspection we referred our concerns to the local authority responsible for safeguarding. In addition, we requested an action plan from the provider and evidence of improvements made in the service. We took urgent enforcement action due to our concerns about the safety of the service.

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.

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. We will have contact with the provider and registered manager following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

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 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

College Road

Detailed findings

Background to this inspection

The 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.

The inspection was prompted in part by information of concern shared with us by the coroner and notification of an incident involving the death of a person using the service. This incident may be subject to criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident, including from the coroner, indicated potential concerns about the management of risk in the service including ligature risks. This inspection examined those risks and found sufficient action had not been taken to keep people safe.

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:
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. The registered manager was not available during the inspection and had previously notified us of their absence.

What we did:
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.

This inspection included speaking with two people, a professional involved in people's support, two support workers, the service project lead (responsible for day-to-day management of the service), a deputy manager and the chair of the provider's organisation. 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 as we were told they were stored at the provider's head office. Although we asked for this information to be sent by 48 hours after our inspection, the provider failed to ensure this was done and some information we requested was not available to support our judgements.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. Although people told us that they felt safe and satisfied with the service, our inspection identified that people were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management;
Learning lessons when things go wrong
Before our inspection, we were informed of a person's death by suicide in May 2018. A Coroner's report raised concerns about the provider's risk management at the time of the person's death. Our inspection found the provider had failed to take timely and sufficient action to address those concerns which exposed people to ongoing risk of harm:

- There had been delays in seeking emergency support for the person in May 2018 partly because they were supported by a lone-worker. Our inspection found people were still supported by lone-workers. This posed risks to the safety of people and staff in the event of an emergency or incident.
- Although the registered manager had told us they had carried out health and safety checks of the service in May 2018 to remove and/or reduce ligature risks, there was no evidence either during or after the inspection that this work had been done. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation.
- During the inspection we saw several ligature risks throughout communal and private areas of the property, including in bathrooms, bedrooms and staircases. These ligature risks had not been assessed, removed or reduced where possible. A staff member told us that ligature points at the service were not included in health and safety checks.
- Staff had still not been given training and guidance on how to complete risk assessments, although this was an area of improvement identified by the person's death in May 2018. Our inspection found people's risk assessments were poorly completed, including for one person who had made a recent suicide attempt.
- Staff had received some training related to suicide prevention and the provider was organising further training in this area to help develop staff knowledge.
- The above concerns were brought to the attention of the provider and commissioners of the service for immediate action because people were being exposed to ongoing risk of harm.
- The above concerns demonstrated a failure to prevent avoidable harm or risk of harm which was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- People's personal circumstances, and most issues affecting people's health and wellbeing were known to staff. Staff showed some awareness of people's general safety at the service, for example reducing people's access to sharp items which could cause possible harm. A professional involved in people's care told us staff routinely escalated any concerns they identified in relation to people's health.
- We identified clutter and potential hazards in the garden area. The provider told us this would be addressed through improvement next year. We were told people did not routinely access the garden in cold weather and only did so to smoke.

•□Fire drills were regularly carried out at the service. We asked the provider to consider holding these at alternate times to ensure all staff regularly took part in drills and could confidently respond in the event of a fire.

Using medicines safely

•□Due to concerns we identified during inspections of the provider's other services, we met with the provider in April 2018 to reiterate their responsibilities around the safe management of medicines. This inspection identified the provider's continued failure to ensure people's medicines were managed safely.

•□People took 'as and when' (PRN) medicines, for example, to help people become calm. PRN medicines require protocols to outline the safe use of these medicines. Protocols we sampled were incomplete, and people's reasons for PRN use had not been recorded as required. There was also no evidence that people's increased PRN use had been reviewed or shared with their healthcare teams.

•□One person's medicines records contained gaps and records did not always clearly show the medicines people took and why. This increased the risk of medicines errors.

•□The provider had introduced new medicines administration records (MAR charts) to safely monitor people's medicines use. However, staff had stopped using these records partway through people's medicines cycles. The service project lead told us this was because the new templates had run out. Reasonable and practicable action such as sourcing or photocopying more templates had not been considered and taken.

•□Medicines audits were not carried out, which meant the opportunity to identify and address the above issues was missed. This put people at risk of unsafe medicines support.

•□Staff had received refresher medicines training. The provider told us they had plans to follow training up with medicines competency assessments however this had been delayed. We have previously brought to the provider's attention that medicines competency assessments are recommended in current good practice guidelines to ensure staff continue to understand how to support people safely.

•□The above concerns demonstrated a failure to ensure the safe and proper management of medicines which was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□We saw people were supported to take their medicines with discretion by staff. Medicines were stored securely and checks were carried out to ensure storage remained at a suitable temperature. A professional involved in people's care told us, "With medicines, staff are always on top of it and prompting if [people's medicines] are running out."

Systems and processes to safeguard people from the risk of abuse

•□The two people we spoke with told us they felt safe at the service. They told us, "I feel safe in the house," and "I feel safe here".

•□Staff had received safeguarding training but did not show clear awareness of the types of abuse people could experience. One staff member knew how to make safeguarding referrals and other staff told us they would raise safeguarding concerns with management. Since our last inspection, managers had been informed how to make their own safeguarding referrals so concerns could be raised in a more timely way. Further improvements were required to ensure all staff understood their responsibilities in this area.

Staffing and recruitment

•□At the time of our inspection, people were still supported by lone workers and there was no evidence that this had been risk assessed against the current needs of people using the service.

•□Staff needed to carry out room checks to ensure people's safety, but did not all understand whether they could check people's rooms alone, or to wait until another member of staff came on shift. This had not been clarified. A staff member told us, "[We are told] we should never enter a service user's room on our own but

we have to do daily checks." Staff told us they had asked for guidance on this.

• Records showed, and a staff member confirmed, recruitment checks had been carried out before they started in their roles, which included character references and checks through the Disclosure and Barring Service (DBS). Recruitment checks were carried out safely to prevent the risk of people being supported by unsuitable staff.

Preventing and controlling infection

• The service was kept clean and tidy. Environmental health services had been sourced to remove pests identified in the garden area.

• People were encouraged to help maintain the cleanliness of the service.

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

- Although staff had a general awareness of people's circumstances and why they used this service, people's risk assessments did not accurately outline people's needs and guide staff on how to effectively support people to manage those needs. People's healthcare teams had provided information about people's risks, coping strategies and histories before people joined the service. However records did not show that this information was always used by the provider to assess people's needs and how these could be effectively met, either before or during people's stay at the service.
- Communication systems were not always effective to ensure staff always had the information and guidance they needed to support people effectively. Staff handovers were not documented which meant some information could get lost. One staff member told us, "Handover sessions are based on what's transpired on someone's shift and in the care notes supposed to read and sign them," however people's care notes were not signed to show they had been read.
- The service project lead told us one person had recently become distressed. They told us they had shared this update in a handover and so staff who had worked since this time should have been aware of it. However this communication was not documented, and nor had the person's support records been updated to reflect the person's needs. Updates were not clearly recorded to ensure all staff were made aware of changes to people's sense of wellbeing and any further support they may have needed.

Staff support: induction, training, skills and experience

- Staff had received training in some relevant areas such as Mental Health Awareness, Mental Health, First Aid, Safeguarding and Health and Safety following their induction. A staff member told us they had been supported to attain qualifications by the provider.
- Staff had received some suicide prevention training and the provider was sourcing further training as part of their ongoing improvements. This was in response to staff feedback to ensure training in this area met staff needs.
- Staff carried out risk assessments of people's mental health needs without training to do so. A staff member told us, "I taught myself how to do that," as had other staff, in relation to risk assessments and reviews of people's health and wellbeing.

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

- People had received recent contact and visits from their healthcare teams. The service project lead told us, "They speak to us and give us feedback, if everything's okay and any issues." However this feedback was not documented to ensure updates about people's progress and support needs could be shared with all staff supporting them.
- Staff told us, and professionals confirmed, that staff promptly contacted people's healthcare teams if they

had concerns about people's health and wellbeing. A professional involved in people's support told us, "It is standard for staff to call if they have concerns for example if someone needs to see a doctor. They bring to our attention people's drug and alcohol use." A staff member told us they helped people identify what had improved their wellbeing and shared this feedback with people's healthcare teams.

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

- People prepared their own meals and were assisted by staff when needed. The service project lead told us, "We always come and check on [people] and make sure they're okay." Staff were informed if people had any dietary requirements they may have needed help with.

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. We checked whether the service was working within the principles of the MCA.
- People using the service made their own decisions., and went out as and when they wished. People were supported to have choice and control of their lives.
- Staff had received training related to the Mental Capacity Act (2005) and told us that any concerns about people's capacity to make decisions, would be escalated to people's healthcare teams.

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. Systems did not always ensure people would always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well supported

- Although staff showed concern for people, reasonable and practicable steps had not been taken to ensure people's safety and welfare as far as possible, in relation to safely managing people's risks and ensuring the suitability of the environment. This had demonstrated failure to prevent avoidable harm or risk of harm which was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care

- Although advocacy information was on display at the service, this information had not been signposted to people and one person was not aware they could access this support. Our discussions with the service project lead and deputy manager found they did not recognise why people might benefit from impartial and independent support during their time using the service. People had not been supported to access such services as far as possible.
- People were shown a service user guide and asked to respect 'house rules' during their time at the service to promote everyone's safety. Copies of this information had not been proactively shared with people to ensure they had the information they needed. When we asked staff about this, we were told, "[Person] didn't ask for copies". People were not always given information they needed about the service.
- One person told us they did not have any concerns about the service. People were invited to monthly service user meetings. A staff member told us, "We talk to people and find out any issues," as well as confirming arrangements such as how to respond in the event of a fire. People were invited to reviews of their progress, wellbeing and recovery with staff.

Ensuring people are well treated and supported; equality and diversity

- People told us staff were respectful and supportive. One person told us they trusted the staff. Another person told us, "Staff are good people, always respectful." Our discussions with support workers showed they had a caring and considerate approach. Staff showed awareness of and respect for people's individual circumstances and preferences.
- A staff member told us, "I'm very proud of what I do. Sometimes it's being there [for people] and not speaking, but they know you're there, you can't push someone, you've got to gain trust." One person told us, "They will give me advice if I want it. I can speak in confidence."
- The service project lead told us, "We live like a home, make a cup of tea with [people], sit with them." The service had previously received thank you cards which made reference to the friendly approach of staff. One compliment stated, 'I always look forward to you coming on shift. I will miss our chats and your jokes.'

Respecting and promoting people's privacy, dignity and independence

- People's independence was promoted during their stay at the service. The service project lead told us,

"We prompt [people] to prepare meals and attend to personal hygiene because what we're here for is to promote independence."

- People were encouraged to go about their daily routines and to let staff know they were safe.
- The service was a mixed gender service and had adhere to requirements in relation to this so people had the privacy they needed.

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 not always met.

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

- Support planning processes were not robust. People's known needs and risks were not all considered and reviewed in care planning and documentation. For example, information shared with the service about one person's risks related to psychosis and suicidal ideation, and the person's known coping strategies, were not used and included in the person's risk assessments. The service project lead told us that information about the person's coping strategies had not been shared with the service, but our sample of records found it had. This meant information about the person to help promote their safety and recovery was not put to use.
- Processes were not always carried out as planned to review all people's support and ensure this met their needs. This meant opportunities were missed to check people's medicines, the date of their last clinical review and if they had been informed of upcoming service user meetings. One person's support needs had been reviewed with their input and had helped the person identify action points to continue to promote their health and following their time at the service.
- A staff member told us a person with epilepsy had previously joined the service although staff did not have the training or guidance to support this person safely. During our inspection, we saw evidence that the provider had since refused referrals to the service where they felt people's needs could not be safely met.
- People expressed satisfaction with the service. One person described the service as 'peaceful' and told us their symptoms had reduced: "They haven't gone but I can control them better. I am happy to be here."
- One person told us staff recommended activities to them they thought they might enjoy. A staff member told us, "We encourage people to go out, get out a bit more, to look at clubs around the area such as exercise classes." People, professionals and staff described how the service had supported one person with their living and financial arrangements which helped reassure the person.
- People's individual needs and preferences were recognised by staff, including around gender and religion. The service project lead told us they signposted people to community links including local religious places if people asked for this. One person confirmed they were asked for their preference of male or female support when they joined the service. A staff member told us, "Everyone has got different needs but everyone is the same, you treat them as people and respectfully, we're there to listen and reassure [people]."

Improving care quality in response to complaints or concerns

- People were given information about how to complain when they arrived at the service and some guidance was on display. One person told us they did not have any concerns about the service.
- The service project lead told us no complaints had been made.

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. There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality 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;
How the provider understands and acts on duty of candour responsibility

- Despite assurances they gave to CQC and the Coroner, the provider and registered manager failed to ensure that prompt remedial action, and sufficient learning was taken, to improve the safety of the service following the death of a person using the service in May 2018 and to prevent future deaths.
- The provider had not completed planned improvements to policies and staff training within their own timescales. We also found planned action had not been carried out to ensure the safety of the premises and reduce and remove ligature risks wherever possible, eight months after a death at the service.
- Despite the nature of the person's death, it was of concern that the service project lead, responsible for the day-to-day running of the service failed to understand there were several ligature risks throughout the premises. These risks were not implemented into health and safety checks or discussed with staff.
- Although the registered manager told us checks had been carried out to improve the health and safety of the premises, as part of learning and improvements following the person's death in May 2018, there was no evidence to demonstrate they had been done.
- Before our inspection we were told room key checks had been introduced to ensure staff could always promptly enter people's rooms in the event of an emergency. Our inspection found these checks had not been carried out by staff as planned, and the provider's own checks had not identified and addressed this concern.
- Regular health and safety checks were carried out however records were not accurately maintained when fire alarm faults were identified. The provider had ordered new equipment but records of weekly checks over October 2017 until April 2018 failed to demonstrate that systems were regularly checked and were deemed safe in the interim. Monthly audits did not identify this.
- Records showed that external fire safety checks in May 2018 had found systems were unsatisfactory and indicated potentially dangerous conditions. We raised our concerns with the provider who submitted evidence after the inspection to demonstrate this had been an administrative error. This had not been picked up and addressed in the provider's audits in relation to the safety of the service.
- After our inspection we made an urgent referral to the fire service due to our concerns that people could be exposed to risk of harm in the event of a fire.
- 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.
- Concerns related to fire safety equipment were picked up in monthly audits, but not resolved until six months on. This was a notifiable incident that we have still not been notified of.
- Failure to notify the Commission of specific events and incidents is a breach of Regulation 18 of the

Health and Social Care 2008 (Registration) Regulations 2009. We are deciding our regulatory response to this breach and will issue a supplementary report once this decision is finalised.

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

- Despite our feedback through previous inspection activity, and our meeting with the provider in April 2018 to reiterate their responsibilities in relation to safe medicines management, this inspection found continued concerns in this area.
- During our inspection, we were told that a staff member had recently been suspended because they had made a medicines error. There was no rationale for the staff member's suspension or evidence that this incident had been analysed and shared with relevant partner agencies, eleven days after the error. The deputy manager told us, "The investigation, that's the one we will be starting tomorrow because of the holiday breaks." This response was of concern because there was no indication that leadership had acknowledged that their poor medicines management and record keeping increased the risk of medicines errors.
- The provider's own policies and processes were not always followed to ensure people's safety as far as possible. Our inspection found audits were not carried out as planned and failed to identify and address shortfalls in care planning, medicines management and the safety of the premises.
- 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 last CQC rating awarded was displayed as required to keep people informed of the last inspection findings.
- The provider demonstrated openness and honesty in their investigation into the death of a person using the service but had failed to complete improvement works in a timely way.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- A staff member told us they had been supported appropriately in terms of their own needs as an employee. Staff confirmed they had been offered counselling and support following the death of a service user in May 2018.
- Staff told us they enjoyed and valued their roles and the opportunity to support people, however they did not consistently feel supported.
- Regular meetings were held with people using the service and staff to gather views and feedback about their experiences and to share information.

Working in partnership with others

- A professional involved in people's support told us, "We have been getting very good support from the services."
- Management described improvements to partnership working with people's healthcare teams, as part of their planned improvements since the serious incident in May 2018. The chair told us they met with people's healthcare teams every week to discuss people's needs. The provider did not document these meetings to help demonstrate how this information sharing was used to assess, monitor and improve the quality and safety of the service.
- The provider was working with stakeholders to source mental health training for staff.

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 safe systems and to prevent avoidable harm or risk of harm. This included failure to ensure the safe and proper management of medicines.

The enforcement action we took:

We served a notice of decision under Section 31 of the Health and Social Care Act 2008 to impose the condition that the registered provider should not admit any service user until this condition is varied or removed from their registration. The term "admit" includes the re-admission of any service user.

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

The enforcement action we took:

We served a notice of decision under Section 31 of the Health and Social Care Act 2008 to impose the condition that the registered provider should not admit any service user until this condition is varied or removed from their registration. The term "admit" includes the re-admission of any service user.