Future Home Care Ltd

Future Home Care Limited Nottinghamshire

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an announced inspection of the service on 20, 27 and 29 March 2018 and 12 April 2018. This service provides care and support to people living in 20 'supported living' settings, known as 'projects' so that they can live as independently as possible. The projects referred to are people's homes. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

A registered manager was present during the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Future Home Care Limited Nottinghamshire currently supports 43 people, all of which received some element of support with their personal care. This is the service's second inspection under its current registration. During the service's previous inspection on 23 and 24 February 2017, we rated the service overall as 'Good'. During this inspection, we found some areas of concern and the overall rating has now changed to 'Requires Improvement'. The details of the reasons why are explained in the summary below and in the body of the main report.

The risks to people safety were not always appropriately assessed and acted on. Where people had identified risks to their health, assessments were not always in place to assist staff with reducing the risk to people's safety. Some people received continuous supervision as required however, others did not. There was an inconsistent approach to the writing and reviewing of people's support plans. Support plans were not always updated when people's needs changed and guidance was not always in place to enable staff to know how to respond to people's needs in the appropriate way.

Staff told us previously there had been a requirement for them to work longer shifts due to constraints on staff numbers; however, they also told us this had improved recently. Records showed that in one project some staff worked long continuous shifts, which could pose a risk to people's safety. Staff were recruited safely. Agency staff were used to covers shifts. Most agency staff had the required training for role although records showed one agency staff member did not.

People were protected against the risks of experiencing avoidable harm. Staff could identify the potential signs of abuse and knew who to report any concerns to. Staff had received sufficient training to reduce the

risk of the spread of infection. Assessments of the environment people lived in were carried out to ensure they were safe. Accidents and incidents were regularly reviewed, assessed and investigated by the registered manager.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible. Assessments of people's ability to make decisions had been carried out for some decisions where required but not all.

People's physical, mental health and social needs were assessed and provided in line with current legislation and best practice guidelines. However, further guidance would be beneficial for some health conditions such as epilepsy. People were supported by staff who had completed a detailed induction and training programme. However, the frequency of the supervisions for staff was inconsistent. Where people required support with their meals, this was provided and people told us staff prompted them to make healthy food choices. People had access to other health and social care agencies. Records showed processes were in place that enabled a smooth transition for people between different health services.

People felt staff were caring, treated them with respect and dignity and listened to what they had to say. Staff took the time to talk with people and showed a genuine interest in building positive relationships. Most staff communicated effectively with people with communication needs; however, other staff were less able to do so. Staff were knowledgeable about people's needs and people were involved with making decisions about their care. People's diverse needs and right to privacy were respected. People were encouraged to lead as independent a life as possible. People were provided with information about how they could access independent advocates. People's records were handled in line with the requirements of the Data Protection Act.

Some people had their goals and ambitions discussed with them and reviewed. Others did not. Some people led active lives, taking part in activities that were in line with the personal interests. Others did not. Staff told us the limited amount of staff that were able to drive sometimes placed restrictions on people able to do what they wanted, when they wanted. People's cultural needs had been discussed with them and people were able to practice their religion if they wished to. Although, we identified one example where a person had their visits to their local church reduced for reasons that were not suitable. People were supported to decorate their homes and personalise their bedrooms. Attempts had been made to ensure that information was accessible for all. People felt any complaints they raised were handled effectively.

The quality of the care provided in the 20 projects within this service was variable. Some projects were led by project managers who understood the requirements of their role and carried out their role effectively. Other projects were led by managers who struggled to carry out their role to the required standard. Management training workshops had been set up to address this and to instil a consistent approach from all project managers. The registered manager told us they felt able to oversee the 20 projects themselves and to address any issues through the analysis of monthly reports provided by each project manager. They felt supported by senior management and were confident that they could support the project managers to make the required improvements. People told us they were happy with the quality of the service they received. Some staff felt valued whilst others felt communication with the provider's officer based staff could be improved. Staff knew how to report poor practice.

This is the first time the service has been rated Requires Improvement. We identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The risks to people's safety were not always appropriately assessed and acted on. People's support records were not always reflective of people's current health needs and did not always provide staff with sufficient guidance to support them. Improvements were needed in the way people's 'as needed' medicines were managed. Some staff worked long hours and people did not always receive the continuous supervision they needed. Staff understood how to identify abuse and who to report it to. Accidents and incidents were investigated. Staff understood how to reduce the risk of the spread of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Additional information was needed to ensure people always received care in line with recognised professional guidelines. Staff were well trained; however they did not all receive regular supervision. The principles of the Mental Capacity Act 2005 were not always correctly applied. People were supported to make healthy food choices. Arrangements for a smooth transition to other health and social care agencies were in place.

Is the service caring?

Good

The service was caring.

People felt staff were kind and caring, treated them with respect and dignity and listened to what they had to say. People and staff had built positive relationships. Staff understood people and ensured their diverse needs were respected. The majority of staff were able to communicate effectively with people. People were encouraged to lead as independent a life as possible. People were provided with information about how they could access independent advocates.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some people led active lives and took part in activities in line with their interests, for others the opportunity to do so was limited. People's cultural wishes were discussed with them and overall these were respected. People felt their complaints were acted on.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was an inconsistent approach to the management of each project. Some project managers carried out their roles effectively. Others needed more input from the registered manager. Workshops were in place to address performance and to raise standards. The registered manager felt supported by senior management and felt the quality assurance processes in place would help improve the service. People were happy with the quality of the service they received. Some staff felt communication with the office based staff could be improved.

Future Home Care Limited Nottinghamshire

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 20, 27 and 29 March 2018 and 12 April 2018 and was announced. We gave the service 3 working days' notice. We did this as we needed the provider to gain consent from people to allow us to visit them in their homes. Some of the people were unable to give their consent to a home visit from an inspector, which meant that we had to arrange for a 'best interests' decision to be made about this.

We visited people's homes on 20 and 27 March 2018 and 12 April 2018. People's homes were referred to as 'projects' by the provider. In total there were 20 projects and we visited 16 of them. We visited the provider's office on 29 March 2018 and 12 April 2018. At the provider's office we arranged to speak with the registered manager and office staff; and to review support records and policies and procedures. We also spoke with the area manager.

The inspection team consisted of three inspectors and two Experts by Experiences. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we received information of concern from Nottinghamshire County Council, which stated they had concerns with the way people were being supported at a number of projects within Nottinghamshire. We used this information to inform our inspection planning as well as other information we held about the service, which included notifications they had sent us. A notification is information about important events, which the provider is required to send us by law.

On this occasion, we had not asked the provider to send us a provider Information return (PIR). A PIR is a form that asks the provider to give some key information about the service. This includes what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt was relevant.

During the inspection we spoke with or observed 20 people who used the service. Some of these people were able to communicate verbally, others were not. We spoke with members of support staff and eight project managers. We also spoke with the registered manager and the area manager.

We looked at all or parts of the records relating to 16 people who used the service as well as staff recruitment records. We looked at other information related to the running of and the quality of the service. This included quality assurance audits, training information for support staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

After the inspection we asked the registered manager to provide us with a variety of documents including; staff training and supervision matrixes and company policies and procedures. These were all provided within the required timeframe.

Requires Improvement

Is the service safe?

Our findings

The risks to people's safety were not always appropriately assessed and acted on to reduce the risk of people coming to harm. For example, at one of the projects we visited one person had an assessment from a speech and language therapist (SALT) which stated they were at risk of choking, despite this there was no choking risk assessment in place. The guidance from the SALT had not been incorporated into the person's care plan. The member of staff we spoke with about this had an understanding of how to reduce the risk to this person however, the lack of risk assessment and information in the support plan placed the person at risk of harm.

At another of the projects we visited, records showed one person was unable to mobilise and was potentially at high risk of pressure ulcers, however no risk assessment in place. The person's support plan stated the person should be repositioned every one to two hours, but there were no records of any repositioning. This placed this person's health at risk.

We noted there was an inconsistent approach to the forming of these support plans and the planning of people's on going needs across the different projects for this service. In some projects we saw detailed plans designed to provide staff with the guidance needed to support people in the way they wanted and needed. However, we saw examples where people's needs were not fully reflected in the records used to care and support them. For example, for one person their support plan referred to constipation and a bowel monitoring chart was in place that showed significant periods between bowel movements. Records showed in one case this was for a period of five days. We noted the person was receiving medication for constipation but the support plan did not include details of what action staff should take if the person did not have a bowel movement for a number of days. The support plan also referenced a fluid chart being needed to record the person's fluid intake. We could not find evidence of this being used. This placed the person's health at risk.

We found further examples at some projects we visited where the process for supporting people who may present behaviours that could challenge others were not fully effective. For example, at one project staff did not have clear information about how to safely support people whose behaviour may place them and others at risk. One person's behaviour support plan was very limited and did not contain clear information about how to reduce the likelihood of the person becoming upset and agitated nor did it detail what staff should do to ensure the safety of the person and others. In addition, there was no risk assessment in relation to this person's behaviour, which meant we were not assured appropriate measures were in place to reduce these risks.

These examples are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also noted examples where detailed risk assessments were in place and the risks to people's safety were managed effectively. For example, in one project we visited there was clear guidance for staff to support people with accessing the community, with agreed methods for supporting the person lead to an

unrestricted life. This included processes for keeping the person, the staff and people in the community safe. We also saw some good examples where staff safely supported people when they presented behaviours that may challenge. In one project we saw the triggers for the person's behaviour had been recorded and staff were clear how to support the person should they became upset. This helped to keep these people and those supporting them safe.

Assessments had also been carried out that ensured the environment people lived in was safe and did not pose a risk to their safety. We found the projects overall to be well maintained, decorated and had been adapted to support people living with a physical and/or learning disability. Processes were in place to support the safe evacuation of the premises in an emergency and regular servicing of gas installation and fire safety equipment took place.

When people required one to one staff support (also known as continuous supervision), many of the projects ensured that when people had specific hours assigned to them, sufficient staff were in place to keep them safe. We saw some good examples where staff used this time effectively to take part in activities that were important to the person, but also to enable staff to respond to people's changing wishes about what they wanted to do.

However, this was not consistently applied across all projects. For example, we noted in one project that two staff were present and they were supporting three people. Records showed two of the people should have been receiving one to one support. The third person's allocated one to one hours had finished earlier in the day. No other staff support was available. This meant that whilst two people received their one to one support, the other person had no staff available to them. The staff we spoke with told us they felt this person would not be able to support themselves alone and therefore the two staff available for that part of the day supported all three people. This meant while the provider was providing the commissioned hours, this needed to be reviewed with the local authority responsible for these people, to ensure there were sufficient hours to meet the needs of all the people supported.

We checked the staff rotas and found that on most days three members of staff were available when needed, but there was one period each day when only two members of staff were present. We raised this with the registered manager and the area manager. They told us they were currently in discussions about increasing this person's one to one hours, as they were not currently provided with sufficient funding to support this person once their daily one to one hours had finished. They recognised this affected the other two people living at this project. They told us they were due to meet with the Local Authority again soon and would notify us of the outcome of this meeting. At the time of writing this report, we have not yet received an update.

During the inspection we met some dedicated, hardworking staff who clearly had the best interests of the people they supported at heart. Many staff we spoke with told us they worked long shifts, through their own choice. They also told us that due to a high turnover of staff some had covered spare shifts to ensure people were safe. They told us this was due to a high turnover of staff. However, staff did also say this had improved and the requirement to work more shifts in some of the projects had reduced. We were concerned however, that some staff were working long hours whilst supporting people with complex and sometimes very challenging needs. For example, in one project we visited the person living there who needed two staff with them all day and then one staff at night. There were only four staff covering this rota, which meant some staff were doing consecutive day and night shifts of up to three days in a row with no gaps between shifts. This was not safe as it posed a risk of staff experiencing exhaustion and this increased the risk of error. In spite of this staff at this project told us they felt there were enough staff and said working multiple shifts in a row was their choice and benefitted the person, as they preferred consistency of staff.

People told us they felt safe and there were sufficient staff to support them. One person said, "Oh yes I do feel safe in here." Another person said, "Yeah, I'm safe here." They went on to say, "It's all alarmed up (their home), nobody can get in here." A third person said, "There are lots of staff here if I need them, but I don't always need them. I can do things for myself."

People were supported by staff who understood how to protect people from avoidable harm and to keep them safe. The risk of people experiencing avoidable harm or abuse was reduced because processes were in place to protect them. A safeguarding policy was in place. This policy was in place to ensure people were protected from abuse, neglect and harassment. Staff had received safeguarding adults training. They spoke knowledgeably about how they ensured people were protected. The project managers and the registered manager were able to explain how they ensured serious incidents were reported. This included reporting them to the local authority safeguarding team and the CQC.

Robust recruitment procedures were in place that ensured the risk of people receiving care and support from unsuitable staff was reduced. People were invited to attend the interviews with the registered manager and/or project managers if they wished to. This ensured people could give their views on the staff who would be supporting them and the people they lived with. We reviewed staff files and records. Criminal record checks had been carried out and proof of identity and references had been requested before staff commenced working with people. We noted some agency staff were used when some shifts could not be completed by employed staff. Processes were in place to ensure they had received sufficient training before working with people. We did note that one agency worker did not appear to have completed the required training. The registered manager told us they would raise this with the agency they came from, as they had an agreement with them that all staff must have completed the required training before being sent to work for the service.

People told us they received their prescribed medicines when they needed them. Two people we spoke with told us they knew what their medicines were and why they needed to take them. They also confirmed that the staff administered them at the correct times every day.

We found people's medicines were managed safely and effectively in each of the projects we visited. We noted medicines were stored safely, people's medicine administration records (MAR) were in the majority of cases correctly completed and people's allergies and their preferred method for taking their medicines was recorded. Staff also had their competency to administer medicines assessed to ensure they continued to do so in line with current practice guidelines.

We did note there were a small number of examples where people's 'as needed' medicines did not always have the appropriate protocols in place to ensure they were always administered consistently. For example, one person who used the service was prescribed a medicine to be given 'as required' to help reduce their anxieties and consequent behaviour. Records did not always evidence that this medicine was given as a last resort and administration was inconsistent. We reviewed the person's medicines records which showed that this medicine was used interchangeably with an 'as required' pain killer in response to the person showing signs of agitation but no clear reasoning for this was recorded. Records did not evidence that all steps detailed in the person's support plan had been tried prior to the administration of medicine, nor did it evidence that the person's behaviour was placing them or others at significant risk to necessitate the administration of this type of medicine. We raised this with the registered manager who told us they and their project managers would review the processes for administration of these types of medicines to ensure they were being administered effectively and consistently.

Staff had completed infection control training and training to ensure food was prepared hygienically and

safely. Records showed a small number of these staff needed to take a refresher training course to ensure their knowledge met current best practice guidelines. People's homes were clean, tidy, and well maintained. This helped to reduce the risk of the spread of infection.

The project managers reported any accidents or incidents to the registered manager who carried out regular reviews to identify any themes or trends. This process enabled them to put preventative measures in place to reduce the risk of reoccurrence. Serious incidents were reported to the provider and where needed actions were put in place to address any immediate concerns for people's safety. Where amendments to staff practice were needed these were discussed during supervisions or team meetings.

Requires Improvement

Is the service effective?

Our findings

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.

There was an inconsistent approach of the application of the MCA across the projects within this service. In some of the projects we found the appropriate assessments and best interest decision documentation were in place that ensured people's rights were protected. This included decisions such as managing people's medicines and supporting them with their personal care. Best interest documentation was in place that recorded who had been involved with the decision. This ensured a wide range of views were heard before a final decision was made.

However, we also found some examples where the MCA had not been applied appropriately. One person had been assessed as being at risk with water, so at times their water supply was turned off. Whilst well intentioned, a mental capacity assessment had not been carried out which impacted on this person's rights. We also noted a mental capacity assessment had not been carried out to determine whether a person had capacity to decide to use bed rails. We raised these issues with the registered manager, who told us they, with their project managers would review the application of the MCA for all people to ensure all people's rights were protected.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. Applications had been made by the local authority 'deprivation of liberty in the community' (DOLIC) team to the court of protection, who make decisions on financial or welfare matters for people who can't make decisions at the time they need to be made. This includes appointing deputies to make ongoing decisions for people who lack mental capacity. It is the role of the DOLIC team to support services users and families with the Court of Protection process. This includes ensuring that people who lack the capacity to make their own decisions around their care and treatment are supported in such a way that is in accordance with the law, and are given every opportunity to be involved before a decision is made on their behalf. It also ensures that decisions made on their behalf must be in their best interest. Records showed that where these applications had been granted, staff supported people in line with their terms.

People's physical, mental health and social needs were in the majority of the projects assessed and provided in line with current legislation and best practice guidelines. People's health needs were met without discrimination and in line with the principles of the Equality Act. Recognised assessment tools were used in most cases to assess people's needs. These included falls and nutritional assessments. We did however note some additional guidance for specific health conditions would have been beneficial. For example, one person had epilepsy, there was no information about this in their support plan and the information in their health action plan was very limited. It did not detail what staff should do in the event of

the person having a seizure, at what point medicines should be administered or when to call emergency services. This could place the person's health at risk.

People were supported by staff that knew how to care for and support them. People told us they felt the staff knew them and supported them well. One person told us staff understood when they had started to feel angry and had worked with them to find a solution. They told us they were pleased with the support they received. They also said, "They know if I'm not happy and will try to make me happy." Staff spoken with had a good understanding of people's care needs and were able to demonstrate how they supported people in line with the requirements of their care records. When we asked staff about people's specific health and care needs they spoke knowledgably and confidently. This contributed to people feeling comfortable and confident with the staff who supported them.

Staff received an induction, on-going training and opportunities for professional development such as diplomas (previously known as NVQs) in adult social care. Training was completed in areas such as positive behavioural support, autism awareness and other learning disabilities. This was designed to equip the staff with the skills needed to support people effectively. All new staff, prior to working alone with people completed the Care Certificate induction programme. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers. The frequency of the continued assessment of staff performance varied in each project. Some projects had ensured staff had received at least one supervision and in some cases more, in the last four months. Others had not received any supervision. The registered manager told us staff should receive at least four supervisions a year, however this was not always achievable. The lack of regular supervision of staff performance could result in poor practice and lower quality of care and support for people. The registered manager told us they would remind their project managers of the requirement to ensure staff performance was monitored more regularly.

Where people required support with their meals and food preparation, they told us staff supported them in the way they wanted. One person told us they liked the food they cooked with staff. They also said, "Yes, they help you cook dinners." Another person said, "Yes it is nice food. I get to eat what I want," One person showed us two cook books that had been specifically designed for adults with a learning disability. These were used to prompt healthy eating choices. We observed fresh fruit was available for this person as an alternative to less healthy snacks. People told us they were able to plan their meals in advance and one person also said, "They (staff) encourage me with something different, they never force me to eat."

Care records contained guidance for staff on how to support people with making healthy food and drink choices. People's food likes and dislikes were also recorded. We were told by the project managers that we spoke with people did not currently have any cultural or religious needs that affected the types of food that people could eat, but, if they started supporting someone that did, then care records would be updated and staff informed.

People told us they were able to access their GP and other healthcare professionals when they needed them. We saw people had access to a wide range of health and social care services which staff supported people with attending. When people required a stay in hospital, a 'hospital traffic light' assessment was in place. This included information for professionals about each person that would aid the smooth transition between services. Information included people's ability to communicate, risks to their health such as allergies and their likes and dislikes. We saw examples where guidance and recommendations made by health care professionals involved with people's on-going care was then incorporated into their care records. This ensured people received the support they needed from a wide range of healthcare professionals, contributing to better health.

Good

Is the service caring?

Our findings

People told us they liked the staff who supported them. It was clear people and staff had formed positive relationships and they enjoyed each other's company. People commented positively about the staff. One person described the staff as "caring and nice". Another person said, "They're great to me!" In each of the projects we visited, we noted a calm and friendly atmosphere with staff and people joining in with jovial banter, discussions about the day's events and conversations about how people wanted to spend their day.

Staff spoke positively about the people they supported. In all of the projects we visited it was evident staff liked the people they supported and wanted to help people to better their lives. One staff member said, "I love it here, I love making [person] happy, seeing the smile on their face. I dance with them, play football and we go out every day." This view echoed the feedback we received from many of the staff across the provider's group of projects.

People had varying communication needs, some were able to communicate verbally and others needed the support of visual communication aids such as signs, symbols and pictures. We noted some staff were able to use these communication methods more effectively than others. For example, staff at one project we visited were not aware of some of the methods needed to communicate with one person. However, at other projects we also observed some good practice. We observed staff responded quickly to changes in the person's emotional wellbeing. Staff clearly understood the person's communication, they knew when the person needed space and provided this and they also recognised when the person wanted interaction and affection and they were available to provide this. This meant overall staff communicated effectively with people ensuring their views and choices were acknowledged and acted on.

Staff were respectful of people's opinions and choices. People told us they felt their views mattered. We noted people's support records contained a variety of methods used to gain their views. This included people signing their support plans to say they agreed or other methods used to record their views and choices. One service user was familiar with their support plan and told, us they were involved with developing this. People had regular meetings with key workers to discuss their support needs and project managers told us wherever able they ensured people had the staff they wanted to work with them. Information was also available for people about how they could access and receive support from an independent advocate to make decisions where needed. Advocates support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care. This ensured people's opinions and rights were respected and acted on.

People were treated with dignity and respect. People were supported with their personal care when they needed it. One person told us staff had "really helped me to look after myself more." Staff told us this person had previously had difficulties in ensuring they maintained a good level of personal hygiene, however this had now significantly improved. When we visited this person, they took pride in telling us they washed their own clothes and carried out domestic tasks independently of staff. We noted in people's support plans they were encouraged to do things for themselves. The level of support each person needed from staff had been recorded. This encouraged people to lead more independent lives.

People told us staff supported their right to privacy and left them alone when they wanted to be. One person told us that staff always knocked their bedroom door before entering which they found respectful. Our observations throughout this inspection supported this.

People's care records were treated respectfully within each project and within the provider's office ensuring people they were not left out for other people to see. This respected people's right to privacy as well confidentiality. The registered manager was aware of the requirements to manage people's records in accordance with the Data Protection Act.

Requires Improvement

Is the service responsive?

Our findings

Before people started to use the service an assessment was carried out to ensure people could receive the support they needed. Once it was agreed that people's needs could be met at the service, detailed support plans were then written to ensure staff had the guidance they needed to support people safely and to enable them to respond effectively to their health needs.

People were not always supported to achieve their goals and ambitions. In each person's support records we saw people had been asked what they wanted achieve and then there was a section for staff and the person themselves to record the progress made. Some of these documents had been completed and we saw progress had been recorded for some people. However, we noted in many of the projects we visited these documents were either sparsely completed or in some cases had not been completed at all. This meant staff had not always ensured people had been supported to achieve the things that were important to them.

People told us they felt able to take part in the activities that were important to them. One person told us staff were supporting them to source a variety of activities that matched their interests. These options included: hairdressing, pottery and drama. A second person told us they enjoyed bike riding and often went for rides supported by staff. Both of these people were also supported to go out at night and to attend a local disco with the support of staff. Other people gave us similar examples where they were able to do things that were important to them.

However, again this approach was not consistent across all projects. There were limited opportunities for meaningful activity and occupation in some projects. In one of the projects we visited we saw one member of staff was providing support to two people in their own home. Both of these people were fully reliant upon staff to provide opportunities for meaningful activity. We asked them what their plans were for the day and the member of staff told us, "we probably won't be doing much today, there is only me on and I don't drive." We reviewed their activity records and found little evidence that activities were based upon their interests. The majority of activities were based around going for a trip out in the car or doing the shopping. Records of activities in the home were also limited, for example an activity record stated, "watched staff cleaning the house." We also noted in another project that at certain times of the day a person was unable to go out because the staff member assigned to support them was also supporting another person. This limited their ability to do things that were important to them. The registered manager acknowledged that more needed to be done to ensure all people received the support they needed to follow their chosen hobbies or interests and this would be discussed with project managers to ensure this provided.

People's care records showed their religious and cultural needs had been discussed with them and support was in place from staff if they wished to incorporate these into their life. We noted some positive engagement with people able to attend to their chosen place of worship if they chose to. However, we did note that the support one person received was not responsive to their needs. Records showed the person had attended a local place of worship. However, the person tended to walk around during the ceremonies and consequently staff had stopped taking the person as regularly because they thought this meant they did

not want to go. Our observations of this person and their support records showed this was a known behaviour for this person and there was no indication this meant the person did not wish to attend. It appeared that an opportunity to enable the person to visit ordinary community places had been missed by staff.

People had been supported to personalise their own bedrooms and to decorate their home in the way they wanted. People took great pride in showing us around their homes. One person told us staff supported them to pick the furniture they wanted. They were also able to decorate their bedroom how they wanted to. This meant people's personal preferences had been respected.

Staff could explain how they ensured that people were not discriminated against as a result of their disabilities. The registered manager was aware of the Accessible Information Standard which ensures that provisions are made for people with a learning disability or sensory impairment to have access to the same information about their care as others, but in a way that they can understand. We saw some examples of easy read policies and procedures as well as the inclusion of pictures and other methods of visual communication within support plans. This enabled people to feel involved and included.

People told us they felt able to make a complaint and felt they would be acted on. One person gave us an example where they had asked for elements of their support to be changed as a result of them not being satisfied and this was dealt with immediately. They told us this made them feel listened to.

Records showed the registered manager was aware of their responsibilities to ensure that when a formal complaint was made, a response was sent to the complainant in good time, outlining what they had done to investigate the issue and where appropriate, what action they would be taking. Learning from complaints made, formed a regular part of senior management meetings. If required, discussions were held with staff to ensure they were aware of improvements that were needed.

Requires Improvement

Is the service well-led?

Our findings

We carried out this inspection as a result of information received by Nottinghamshire County Council (NCC) advising they had suspended this service. This meant that that NCC were not placing people there for the duration of the suspension. NCC told us they had concerns that people were not always receiving the care and support they needed.

Future Home Care Limited Nottinghamshire provides people with support with personal care in 20 separate 'projects' in Nottingham, Nottinghamshire, Derby and Derbyshire. Each project has a project manager who is responsible for managing their project(s) and reporting directly to the registered manager. The registered manager had ultimate responsibility for ensuring that each project manager was carrying out their role effectively. For some of these projects we saw this process worked well. Some project managers had a clear understanding of the requirements of their role and ensured the risks to people's safety were appropriately assessed and managed. However, it was clear that other project managers were not currently carrying out their role effectively and this had resulted in some of the concerns we have identified in this report. There were inconsistencies in the way in which people's care and support plans were assessed and monitored. The principles of the Mental Capacity Act 2005 were not always consistently adhered to. People did not always received person centred care and support. There were variations in the frequency of supervisions. This meant that across the provider's group of projects some people received high quality care and support whereas others on occasions did not.

We raised these issues with the registered manager and area manager. They told us they were aware that some project managers were more able than others in some areas and they had already put measures in place to address this. The area manager told us they had planned a series of management training workshops designed to improve the skills and expertise of all project managers, irrespective of their current ability. These workshops included, 'Disciplinary and grievance procedures' and 'Scenarios'. The latter giving project managers a variety of different scenarios they may come across in their roles and asking them how they would manage them. The area manager told us they felt these workshops along with a number of others, would help to improve standards but also to ensure a more consistent approach from all project managers. This, they assured us, would ensure all people would receive consistent high quality care and support.

There had been a recent turnover of staff in management positions and this had made some of the support staff and project managers concerned about how the service was being led. However, many of the staff we spoke with told us they felt things had improved recently and the registered manager offered them the support they needed to do their jobs. The registered manager had been registered with the CQC since March 2018 but had worked in the role for some months before this. They showed us the quality assurance processes that were now in place that were designed to help them to oversee the 20 separate projects and to help drive improvement where needed. Each project manager was expected to provide monthly updates which detailed staffing numbers, any changes to the risks to people's safety, accidents and incidents, staff training needs and many other areas. This then assisted the registered manager to identify which projects needed their attention and they could then offer support where needed.

We did raise concerns with the registered manager and the area manager and about the current structure of the service and whether the registered manager would be able to have sufficient oversight of all projects to ensure standards did not drop. They assured us that the quality assurance processes that were in place enabled the registered manager to identify these concerns quickly and to act on them. The area manager told us regular senior management meetings were held regularly and any increase in risk was discussed and addressed. The registered manager told us they had the support they needed from the senior management team, which they welcomed in order to help make the improvements required.

The people we spoke with told us overall they were happy with the quality of the service they received. No significant concerns were raised with us and people felt able to give their opinions and staff acted on them. Staff felt listened to by their project managers although many told us they did not see the registered manager often. Some staff felt communication with office staff could be better improved to make them feel more valued. Some staff felt their opinions were valued whereas other felt their views were not always listened to and respected. The registered manager and area manager told us they were trying to instil a new culture amongst the staff and this would take some staff some time to embed. However, they were confident that all staff would be able to adapt with the ultimate goal of improving the standard of care and support for all.

People were supported by staff who understood how to identify and act on poor practice. A whistleblowing policy was in place. Whistleblowers are employees, who become aware of inappropriate activities taking place in a business either through witnessing the behaviour or being told about it.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people and those seeking information about the service can be informed of our judgments. We noted the rating from the previous inspection was displayed at the provider's address.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe care and treatment 12.—(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks.