Future Home Care Ltd

Future Home Care Southampton

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires improvement
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 17, 22 and 30 September 2015. The inspection was announced as the service provides domiciliary care and we wanted to ensure somebody was in the office we could talk with about the service.

We previously inspected this service on 06 September 2013 where no concerns were identified.

This was a planned inspection, although we had been made aware of some concerns through colleagues within the safeguarding team of Southampton City council.

Future Home Care Southampton provides ongoing support to 34 people who have a learning disability. This is through a domiciliary care service providing support workers to people living in a range of independent living services managed by the serevice. These are located

Summary of findings

within Southampton city and parts of Hampshire. There was a registered manager in place who oversaw all of these projects. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the time of our inspection all of the services provided in Southampton were due to be transferred to other providers to deliver support to people in their homes. As a large number of staff had left Future Home Care Southampton, people were not receiving their full package of support due to staff shortages. This had led to concerns being raised by commissioners and the involvement of the safeguarding team.

Some people were not receiving a safe service. Whilst staff were aware of how to identify and report abuse, staffing was inconsistent and management support was not always available. Staff had not received updates on safeguarding training.

Risks to people whilst receiving personal care had been assessed and were clear on steps required to reduce the effect of those risks. However, for a majority of people those risk assessments had not been reviewed and there were no records of amendments to those risks due to changes in the person's needs.

There were insufficient numbers of staff to meet people's needs. A large number of staff had left the service and people's hours of support were not always delivered according to those identified. The provider had not prepared a contingency plan to predict how to support people as a result of the large loss of members of staff.

People's medicines were not always managed safely. Established record keeping systems were in place and for most people these were accurate and up to date. One person's controlled drugs register had not been updated and administration of medicines had not been recorded appropriately.

Staff had not received regular supervisions and had not received any training since the beginning of 2015. New staff did receive an induction training programme and had received a number of basic training events that gave them some understanding of their role and how to support people.

Some people lacked the capacity to make all decisions or consent to their care. Best Interest decisions were made but not all of these were recorded. General mental capacity assessments had been undertaken but these did not relate to specific decisions staff were making on behalf of people.

People were supported to eat and drink enough although where some people had specific dietary needs associated with medical modes of receiving nutrition, not all staff were trained or skilled to support them. Specialist health care professionals were available to people but they did not always get medical attention when they required it.

Staff were caring towards people and where they had built good relationships with people they had developed good communication systems. Where staff had left the service, some people had lost valuable relationships with staff they trusted and who knew their needs. This meant that their views were not always known and they were not involved in the changes to the service. Staff respected people's dignity and privacy. People were comfortable with the staff who supported them.

People's care plans were personalised and there was information about each person's individual preferences, likes and dislikes in their care records. However care plans were not regularly reviewed and most were not up to date. People told us they did not understand why the service was changing and were unsure of when changes were going to happen and who would support them. The provider had tried to engage with them and had sought their opinion on the quality of the service but had not included them as much as they should have been in the specific changes at the time of our inspection.

For people who were going to continue to receive a service from Future Home Care Southampton there was an open, inclusive and empowering positive culture. For other people this had changed due to the difficulties experienced in maintaining their services during this transition period.

The service was not well led due to the priorities of trying to ensure a continued delivery of the service with a large number of staff vacancies. This had taken over a large

Summary of findings

proportion of management time and other areas of service delivery and continuity had been overlooked. This impacted on the quality of care delivered and affected the support people received.

During this inspection we found the service to be in breach of several of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. You can see what action we have told the provider to take at the back of the full version of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to 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.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

People were not always protected from avoidable harm and risks were assessed but not reviewed or updated. Staff knew how to identify and report abuse but had not received update training.

Medicines were not always managed appropriately and records were not completed as required.

There were insufficient numbers of staff available and where temporary staff were used this meant people received support from staff who did not fully understand their communication or their needs.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive the support or training to meet the needs of people they supported.

Consent to care was not always sought and Mental Capacity Act assessments were not specific to reflect those needs.

Some people received appropriate support to eat and drink enough. Other people who required support to receive nutrition medically were not always supported by staff who knew how to provide this treatment.

People were able to access health care professionals but some people were not supported to do this in a timely manner.

Is the service caring?

Requires improvement

The service was not always caring.

There were positive, caring relationships with people in some areas of the service. However, in other parts of the service staff were more task focused.

People relied on staff to help them to express their views and involve them in making decisions. When staff left the service, new staff were unable to respond to people and understand what they wanted to say.

Staff respected people's privacy and treated them with dignity and respect.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's care plans and records were personalised and contained personal information on their likes and dislikes. However, for many people these had not been reviewed or amended to meet their changing needs.

Summary of findings

The provider's system for gathering feedback on the quality of service it delivered had not occurred this year. People and staff felt they had not been involved in discussions about changes to the service.

Is the service well-led?

Inadequate 

The service was not well-led.

Due to staff changes in the service the positive culture of placing people at the centre of their care had not occurred. The provider did not have a contingency plan to staff the service as a result of staff leaving.

People and staff told us they did not have contact with managers regularly. Key management tasks were not completed as managers were covering hours.

The provider was not monitoring the quality of care regularly. Action plans to identify how to improve the service had not been checked.

Future Home Care Southampton

Detailed findings

Background to this inspection

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

This inspection took place on 17, 22 and 30 September 2015 and was unannounced.

The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. We left a message and confirmed by email that we would be visiting the office on 17 September 2015. Due to difficulties with the organisation's communication systems they did not receive these messages.

The inspection team consisted of an Inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was as a parent of a person with a learning disability.

Prior to this inspection we had received information of concern from the local authority safeguarding team regarding staffing levels and some individual safeguarding concerns about people who received a service from Future Home Care Southampton.

Before our inspection we reviewed previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The form was completed and returned to us within the requested timescale. We looked at this information provided, along with other information held about the service.

We visited five people in their own homes who received services from staff of Future Home Care Southampton and observed care given to them. We spoke with three of them and a further four people on the telephone. We were unable to speak with many of the people who used the service as they had limited verbal skills or were unable to speak with us on the telephone. We spoke with the registered manager, two project leaders and 13 members of staff. Two relatives of people who had used the service spoke with us. We also spoke with two health and social care professionals.

We looked at care plans and records of care for nine people who used the service. We looked at seven staff records of recruitment and support files. We looked at some policies and procedures used by the service, recruitment and training records, feedback received and complaints systems. We also looked at quality audit and monitoring records used by managers in the service.

Requires improvement

Is the service safe?

Our findings

We had been made aware of concerns around a shortage of staff, which had occurred following a recent exercise to re-tender for services by commissioners. The provider organisation had not submitted a tender and were in the process of transitioning all supported living services to other providers. This had impacted on staffing numbers as staff chose to leave in a number of services. The registered manager and remaining project managers were unable to find cover for all of the hours required by people's individual contracts of support. Bank and agency staff were employed but in some services this had not been adequate to cover all required hours. Commissioners and the local authority safeguarding team were monitoring this situation on a weekly basis.

We were told of an incident by two members of staff where one member of staff was on duty with three people for over 24 hours. The registered manager told us two staff had gone sick and they had to find staff. A project manager was sent to the site until both members of staff were replaced which took up to 4 hours to arrange.

At the time of our inspection the majority of hours had been covered for the next three days and they were working on filling gaps in shift patterns. We saw there were over 100 hours of support still to be covered over the following four days of our first date of inspection. Some members of staff told us they were regularly working over 60 hours a week as no one else was available. This meant some staff may have been physically tired and could potentially overlook some aspects of care. One member of staff said, "I am worried that where I have worked so many hours I might make a mistake with the medicines."

The failure to ensure people were supported by sufficient numbers of suitably qualified, skilled and experienced staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where risks were identified in people's care plans these were assessed. However, of the nine people's records we looked at, only two of these had been reviewed within the last year. This meant the other people's risk assessments were not current and any changes to risk factors had not been recorded in care plans. For example, one person had a risk assessment and care plan written by the epilepsy nurse but this was not updated to the person's care record for over a month. This resulted in the person being admitted to hospital for their epileptic seizures as staff did not have clear guidelines to follow on when to seek medical advice in connection to an increase in the person's seizures.

We observed medicine administration and records within two services we visited. In one service we saw a note within the staff conversation book regarding signing of the controlled drugs register. The controlled drugs register had not been signed when the medicine had been administered and the stock level had not been recorded. Whilst the medicine concerned was a topical patch application this was still a controlled drug and it needed to be administered according to legal guidelines. This was reported to the registered manager by the Inspector.

One person's care records did not contain a personal evacuation and escape plan in case of fire or other emergency situations occurring, that might lead to the person having to leave the building. This document should contain guidance on how to communicate this need to the person and the type of support they would require to do this. This person had limited verbal comprehension skills and was cared for in their bed due to their limited mobility and health concerns. This meant staff would need to know if they should move this person, or a risk assessment was in place which stated the person should remain in their room until fire brigade or help arrived. As this person was being supported by temporary and agency staff they would not know how to support this person in an emergency.

The failure to ensure people were protected from the risk of unsafe management of medicines and risks posed by the environment was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people said they felt safe whilst others shared their concerns about their safety were linked to the support they received from staff. One person said, "Staff know about safeguarding and I would have no problem going to them if I didn't feel safe." A member of staff told us, "I do worry that where we are using agency staff, people won't feel safe as they don't know them." A relative said, "I know my daughter is safe but it would be so much better when she has a stable staff team."

A member of staff told us, "I did some safeguarding training when I did my induction training a couple of months ago. If

Requires improvement

Is the service safe?

I saw something I would report this to the manager." One temporary agency staff told us, "I'm not sure who to report it to but I would report it to my agency manager." Other staff were aware of how to recognise abuse and knew how to report this. Although they said they were not too sure how quickly this would be picked up at the moment as they did not see project managers and the registered manager on a daily basis. They said they would notify the local authority or the CQC if they could not speak to a manager. Some staff told us they had not received update training since November 2013. Training records confirmed this. The provider's safeguarding policy stated all staff should be updated on safeguarding training every year. Guidance and reporting procedures were in line with the Southampton and Hampshire local authority policy.

The recruitment process showed the provider followed a robust process. All new staff completed an application form and attended an interview which identified their skills, experiences and knowledge. Appropriate checks were carried out which identified staff had disclosed their full employment history and any gaps in employment were checked up on. Satisfactory references were obtained and Disclosure and Barring Service (DBS) checks were completed. These checks were used to make sure that staff were suitable to work with people who need care and support.

When we visited one person in their home, we found an error in the medicine administration record (MAR) for one person. A medicine had not been signed as being administered the previous day, although other medicines given at the same time had been signed for. The senior care staff immediately reported this to their line manager and checked with the local GP the effect this may have if the person had not received this medicine. They then confirmed with the member of staff who had been on duty at the time, that the person had received this medicine. This was an appropriate response to the situation and ensured the person was safe.

Other records of medicine administration we looked at had been completed appropriately. Systems of ordering, storage and returning of unused medicines were appropriate in other areas of the service. Medicine checks were undertaken regularly by staff.

The registered manager monitored accidents and incidents to identify concerns and trends. For example an accident form we looked at identified that a person had fallen when a hand rail came off the wall. The person was not injured and their condition was monitored for 48 hours to check for bruises and swelling. A request was made to the provider's maintenance department and the handrail was repaired and replaced within 24 hours.

Inadequate

Is the service effective?

Our findings

People were not always supported by staff who had the necessary knowledge and skills to support them. One member of staff told us, "I haven't been on any training events this year and even if they found me some I don't think they'll be able to cover my time off work." Another member of staff said. "I have asked for an update on medication training as it was over two years ago I did this course." A third member of staff said. "Training was great when we were Future Home Care but since being taken over by Lifeways we have had no training."

Training records we viewed confirmed this. New staff received an induction and some basic training within this, however update and more in depth training was not being provided. Most staff told us they had not received any training in the Mental Capacity Act (MCA) or in Deprivation of Liberty Safeguards (DoLS). This was confirmed by the training records viewed. This meant staff would not understand if people did not have the capacity to make certain decisions. They would also be unsure of concerns about supporting people and restrictive practices which would be assessed under DoLS.

Most staff told us that support had not been good for them. Supervisions and appraisals were not happening regularly. One member of staff said, "I haven't got a line manager at the moment and haven't had supervision for months. I really need to know what I can do to support people better through the changes. Another member of staff said, I haven't had an appraisal which would help me to develop myself to support people better. Supervisions were not happening regularly and in some cases staff had not received a supervision session for over six months.

Where staff were not being supervised regularly information concerning people was not being passed on appropriately. Staff were not receiving feedback on their performance and told us they felt unsure about how they were working with people and how to get advice. An example of this was where a member of staff told us about something concerning a person they supported, they had passed on to their line manager. The line manager left and despite leaving messages the member of staff was unable to receive a solution from a project manager or the registered manager. They made a decision to discuss this with a person's GP and appropriate action was taken.

The failure to provide staff with appropriate support, training, professional development, supervision and appraisal was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people did not always receive the necessary support to maintain good health when they needed it. One person had an increase in epileptic seizures following a urinary tract infection. Whilst this was a known complication and was recorded in the person's care records there were no specific guidelines for staff on the need to seek medical intervention at the earliest opportunity.

We were made aware of a situation where one person was admitted to hospital following problems associated to their PEG feed. A district nurse had passed on verbal instructions to a member of staff concerning the change of the consistency of the feeds the person was receiving. This information was not recorded by either the district nurse or the member of staff. The person was ill during the night and aspirated their feed which required their admission to hospital.

The failure to assess and mitigate risks to the health and safety of people receiving care and treatment was a breach of Regulation 12 of the Health and Social care Act 2004 (Regulated Activities) Regulations 2014.

One person's care records contained details of the support they required around a known behaviour the person had. A risk assessment had been carried out in March 2015 of this, which identified signs when the person was becoming 'over elated' and methods the staff could use to assist the person to become calmer. One of the risks identified was when they were out in the community. Although the person was able to walk they required a wheelchair when they got tired. Guidelines stated that when the person became 'over-elated' their movements became upredictable and they could harm themselves or people near them. The guidelines told staff to place the person in the wheel chair and to place the lap belts of the wheelchair around the person's waist. Care records showed this had been suggested by the local health behaviour support team. There was no mental capacity act assessment concerning the person's capacity to consent to this procedure. A best interests meeting had not been held to confirm this was the

best practice to ensure the safety of this individual. This meant the person was at risk of being restrained against their will or in their best interest of safety and placed staff at risk who carried out this procedure.

People did not always give consent to care and treatment and decisions were not always made in the best interests of people. We saw that mental capacity assessments had been carried out but these were only for control of finances and administration of medicines. People's capacity to make decisions around their care and treatment had not been assessed. Whilst we saw in people's care plans decisions had been made in the person's best interest there were scant records of how decisions had been made. For example, one person who had no verbal communication and limited non-verbal skills did not have a mental capacity assessment in their care record on how they demonstrated their choices. Some staff knew how this person demonstrated their consent by their gestures but this information was not in their care plan. Where staff had not received MCA training this meant they were unaware of the need to record this.

The failure to ensure current legislation and guidance on the use of consent was followed was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's meals were prepared for them by staff and some people received support from staff to prepare their own meals. Those people who could choose their own meals were able to do this with support from staff. Where people could not make choices, staff were aware of the kinds of foods people enjoyed and followed a weekly menu to ensure people received nutritious and balanced meals. One person said, "I like the food and staff help me to cook it." Another person said, "They (staff) know what I like to eat and help me to watch my weight." One person's care plan gave specific instructions on the person's diet which was mainly pureed. This information was contained in their 'hospital passport'. This is a document that a person could take with them to hospital and contained essential information about the person.

People were able to receive a wide range of health services. Whilst we were visiting a person another person in their home was receiving a massage from a qualified masseuse to encourage movement in their joints. This was recorded in their care plan and met a programme designed by a physiotherapist. People accessed their local GP and their care plan highlighted the support the person required to attend visits or if they needed home visits. We saw people who required support with eating were seen by a speech and language therapist and eating plans were in place. People were assisted by staff to access dentists, opticians and chiropodists or arranged for people to be visited in their homes by some health professionals.

Requires improvement

Is the service caring?

Our findings

People told us they liked the care they received from staff. One person said, "Staff are really good here, they help me with my independence." Another person said, "I really like my staff they understand me and care for me." A third person said his support workers were "polite and quite nice. I didn't choose them but they have been the same staff for some time now."

We saw staff had good relationships with people and had developed ways of communicating with people in a way they understood. In a Hampshire service, people were very relaxed with staff, enjoyed a joke with them and spoke about things they wished to do that evening. One person said, "I've known (member of staff) for some time now and am so glad they are still here. Although (a new member of staff) is really nice."

However, in the Southampton service we visited, staff were more task-focused with people. There was minimal conversation with people as staff provided care for them. Two of the staff had worked with the people for some time and were aware of communication difficulties with all three people. The other member of staff was an agency member of staff who had worked several shifts in the service. There had been a high turnover of staff in this service and other staff were not so familiar with the people who lived there. A project manager was meant to be based in the service but this position had been vacant since May. The registered manager visited the service to provide support and care on regular occasions.

People told us they did not always feel that staff listened to them. One person said, "We have had so many different staff working here that I don't know and when I have asked for things they tell me to wait until other staff are on duty." We were aware that one person had wanted to go out for the day but was unable to do this due to a lack of staff. Other people had cancelled a holiday as staff were not available to support them. This had an impact on the well-being of people.

Some people were able to access a wide range of activities within their home and in the community. We were told how staff were knowledgeable about people's history, their health and social needs. One person told us, "My staff are so helpful. They help me with my shopping and to keep my home clean." Another person told us that they worked in a canteen at a local supermarket and helped in a charity shop. They said, "Staff have helped me to become more independent and I have learnt a lot about how to look after myself. They told us they had booked to go to Scotland for their birthday and were going to see Dolly Parton in November.

We observed staff treating people with dignity and respect in their homes. They were referred to by their preferred names as identified in their care records. We noted one person's care records showed a different name to the one staff used. Their care records described this had been a name the person had been called when younger and they responded better to this than their birth name. Staff told us they showed respect to people by the way they asked them things and explained what they were doing with them. They said they helped people to maintain their privacy by reminding them to close their curtains and shutting their doors when they were in their rooms. One member of staff said, "If I have to go into (person's) room, I always knock and ask if it is alright for me to come in. I'd expect that myself."

Requires improvement

Is the service responsive?

Our findings

The care plans we looked at were personalised and individual to the person. We noticed the care plans held in the area office were consistent with the plans in the service. We found that most of these care plans had not been regularly reviewed and there were no amendments recorded where people's needs may have changed. However, in one service we found a care plan had been updated and changes made to it were hand written. This was not consistent with the one held in the main office. A care worker said, "I was reviewing the plan and had made changes but could not alter this on the computer."

People and staff told us they had not been involved in discussions about the changes to the service. We were given an information sheet in an easy read format that explained Future Home Care were not going to support people in the future. It told them that they could remain in their home but with support from another agency. There was no mention of a timescale, who was going to be the new provider and if staff would be able to stay with them. In order to ensure peoples' concerns could be taken into account they had not been given sufficient information. The information they did receive was of such a complex nature that people may not have been able to understand what was happening. Some people had lost the way of getting their voice heard as new staff were unaware in some instances of people's ways of communicating their needs and understanding. Staff themselves were unsure of what was going to happen and told us they were not able to clarify things for people.

People's care records contained personalised care plans and information on their personal likes and dislikes. When people first received a service from Future Home Care Southampton an assessment was carried out using information from the person, their relatives, health and social care professionals and commissioners. This information identified a number of needs for people and care plans were written to provide support to meet these needs. Care plans contained sufficient information to deliver care and there were processes in place for staff to amend care plans where the person's needs changed.

The provider carried out an annual service user satisfaction survey. The registered manager shared with us the result of the 2014 survey. The 2015 survey was due to take place but had been put on hold while the transitions to people's packages of care took place. Looking at the summary of the report it stated that a lot of support was required from staff to aid people to answer questions and explain what they meant. It stated, "The input into the responses from some people is very limited but visual observation and use of sign, gesture and body language showed how happy they were with some areas of their life." They highlighted the importance to these people of staff teams that were consistent and able to understand their methods of communication. This important statement was unfortunately not happening at the time of our inspection to a number of people as those consistent staff teams had been broken up by the large number of staff who had left.

Some of the responses highlighted changes people wanted to their environment, such as; "Improvements to the garden to make it more accessible," and, "getting in and out of the bath". Plans had been put in place to make these changes and the person who wanted better access to their bath had an occupational therapy assessment to look at what kind of bath they could use. In order to assist people to choose paint colours for their rooms staff had prepared mood boards of paints and wallpapers so that people could state the colour they wanted and then choose from the boards the colour scheme they liked.

The provider had a comprehensive complaints policy with clear instructions and guidance on how people could make a complaint. There was an easy read version of this procedure on a notice board in one person's home we visited. One person told us, "If I wanted to make a complaint I would talk to the pproject manager, I'm sure they would sort it out." We looked at the last complaints the service had received. One was concerning communication with re;atives of a person who used the service. This had been managed within the time scales of the provider's policy for responses. This was resolved to the satisfaction of the relative who had made the complaint. The registered manager had arranged for training for staff on communicating with families.

Inadequate

Is the service well-led?

Our findings

We saw that services provided to people were supposed to be monitored by the provider on a monthly basis for the quality of the service delivered. Within the Southampton projects this was not occurring as most of the provider's and registered manager's time was spent in arranging cover and working with people due to the staffing difficulties. The newer Hampshire services had been audited when they first transferred to Future Home Care Southampton in April 2015. They had looked at the environment, care plans, risk assessments and health and safety concerns. A record of these visits was made and actions were agreed to improve the service where appropriate. The registered manager told us the provider audits for the service had not occurred since the transfer to Lifeways Community Care and a new audit system was due to have started in July 2015. These had not occurred due to the transition of people's supported living care packages to new providers. This meant the quality of the service had not been audited regularly and any actions or improvements to quality had not been identified or actioned in this period.

The failure to assess, monitor and improve the quality and safety of services was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Southampton safeguarding team members and commissioners carried out regular assessment visits to people in their homes to monitor the quality of the service they were receiving and how the staff support was being provided. During these visits some safeguarding incidents were identified by local authority staff. They reported these back to the registered manager and provider through safeguarding meetings that were occurring. Through this process we were aware of six individual safeguarding cases that the local authority were investigating. The registered manager and provider had not notified us about four of these safeguarding investigations. We received notifications for two of these. We requested the registered manager and provider to provide notifications for all incidents as identified within the regulations.

The failure to notify CQC of incidents specified within regulations is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4)

People and staff told us about problems they had identified with management and leadership. One person said, "I don't like it when I have to have new support workers all the time. They don't know me." Another person said, "I wish the managers were open with us and tell us why staff have left." Staff told us they were not aware of changes within the provider organisation and thought the current situation was due to the take-over of Future Home Care Limited by another company. One member of staff said. "We've lost the project I work in from mid-October. Staff weren't told about these things. We had a right to know if we were moving to the new providers and who they were going to be."

The registered manager provided us with a briefing note which they gave to the project managers in June 2015. This was for them to update staff and people with so they could understand the situation fully. This did not give firm dates or details about what was going to happen to the services they supplied to people in their homes. It stated there were no plans for job losses or redundancies and explained how people could continue to receive support from Future Home Care if they were to go over to direct payments. This is a scheme where people could receive money directly from the local authority in order to purchase their own care. An easy read version of this was made available to people. Staff told us people were not able to understand this and relatives were confused about what this meant.

Staff we spoke with were not aware that the service they were working in would be moving to the new provider two weeks after the day we spoke with them. They were aware of who the new provider was going to be but had not spoken to them about their jobs. A project manager was not aware if they were going to be transferred over to the new provider when people changed to the new provider. The registered manager assured us they would be and this had been agreed between organisations. The provider had not prepared a contingency plan for this loss of staff and how they would manage to staff their committed hours.

Staff and project managers told us they had not received supervisions. Records confirmed this was the case in the Southampton services. This meant staff were unable to discuss care concerns with managers and obtain necessary feedback on their performance and discuss what was happening in the future. As staff were not receiving supervisions from managers working in the projects, they told us they felt they were unsupported. One member of

Inadequate

Is the service well-led?

staff said, “The service isn’t well-led. Management leave us to ourselves. If there’s a problem, there’s no one to talk to. Things like rotas and medical sheets were not being done.” They said, “We try not to let this impact on the people we support but they know things are not good at the moment as they do not go out so much and see a lot of new staff coming and going.”

Where care staff were receiving less support some direct care time was taken away from people as care staff were taking on aspects of the project manager’s role. For example a person required extra staff to attend a medical appointment but this was not identified by staff and a request for extra support was not made. This meant the person missed the appointment. They had to wait another week to attend the appointment.

Due to this lack of local management a situation occurred where a person was unable to use their mobility vehicle as tax had not been applied for it. This meant the person was unable to attend appointments and go out as identified in their care plan. A project manager told us, “Where a lot of project managers have left this has left us short of management cover. It has been hard to prioritise which service needs our support the most. We are just unable to give staff and people the support they need at the moment.”

Future Home Care Southampton had been recognised by Southampton city council for being a person-centred and empowering service before the loss of the care packages. The services provided to people outside of Southampton continued to provide this type of service. People told us they were involved in the care plans and had been able to identify positive changes. One person told us the service was much better now since they moved to receiving a service from Future Home Care. They had been involved in selecting a member of staff and were happy with the choice they made. Staff were receiving supervisions, although the frequency had been affected as Hampshire project managers were spending time supporting the Southampton services.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People's care and treatment was not always appropriate and failed to meet their needs. Regulation 9 (1) (a) (b) (3) (b) (c) (i)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People were at risk of receiving care without their consent or in their best interest. Regulation 11 (1) (3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were at risk of receiving care and treatment that was not safe, risks were not mitigated and management of medicines was unsafe. Regulation 12 (1)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services and others were not protected against the risks associated with assessing, monitoring and improving the quality of services, assess and mitigate risks, maintain records in respect of service users and act on feedback from relevant persons. Regulation 17 (1) (2) (a) (b) (c) (e).

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who use services and others were not protected against the risks associated with insufficient staffing and support from suitably qualified, experienced and knowledgeable staff. Regulation 18 (1) (2) (a)
Personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered manager did not notify the commission of incidents as required. Regulation 18 (1) (2) (a) (e) (g) (i)