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

Future Care & Support Service

Inspection report

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06 March 2019

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service: Future Care & Support Service is a domiciliary care agency that was providing personal care and support to two people living in their homes at the time of the inspection.

People's experience of using this service:
We were not able to speak with either people using this service however our findings suggested the quality and safety of the service remains inconsistent. A staff member told us they felt supported and showed care and concern for the person they supported. A healthcare professional spoke positively about the service and its benefits for a person. Another person continued to experience late calls and this issue had not been adequately addressed as found at our last inspection in June 2018. Records were not accurately maintained and staff had not received all training relevant to the support they provided.
The provider had gathered people's feedback on occasions and this was often positive. Improvements were still required to systems and processes to ensure people consistently received a good, safe and effective service.

More information is in the full report.

Rating at last inspection: Requires Improvement; June 2018.

Why we inspected: We inspected this service as this was scheduled based on the previous inspection rating.

Enforcement: This inspection identified a continued breach of the regulations around governance. We found the provider was also in breach of their conditions because they had failed to appropriate notify the Commission of a change to their registered location. Please see the end of the full report for action we have told provider to take.

Follow up: After our inspection we shared our findings with the local authority. We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our Safe findings below.

Requires Improvement

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not always well-led.

Details are in our Well-Led findings below.

Requires Improvement

Future Care & Support Service

Detailed findings

Background to this inspection

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

Inspection team:
This inspection was carried out by one inspector and an assistant inspector.

Service and service type: The service is a domiciliary care agency registered to provide personal care and support to people in their own homes.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We gave the service 48 hours' notice of the inspection visit because we needed to be sure the registered manager and staff would be available to meet with us.

Inspection site visit activity started on 05 March 2019 and ended on 06 March 2019. We visited the office location on 05 March 2019 to see the registered manager and to review care records and policies and procedures.

What we did:
Before the inspection, we reviewed information we had received about the service since the last inspection. This included any notifications we had received from the service and feedback we requested from external agencies including the local authority and Healthwatch. Healthwatch is an independent consumer

champion that gathers and represents the views of the public about health and social care services in England.

During the office visit, we spoke with the registered manager, the service manager and a member of staff. After our inspection we spoke with a healthcare professional involved in one person's care.

Some information we requested was not available to view during our inspection, including the training matrix and recruitment files. We received this information after our inspection.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm
Some aspects of the service were not always safe and there was limited assurance about safety.

Systems and processes to safeguard people from the risk of abuse
● A staff member was aware of the types of abuse people could experience and how to report this to help protect people. Staff had received safeguarding training.
● People generally managed their own finances. However where staff made occasional purchases on behalf of people using the service, this was not effectively monitored and reviewed to ensure people were always supported safely.
● At our last inspection, we found accidents and incidents were not analysed to identify any trends and ways to improve the service. At this inspection there was still no system in place to ensure this good practice to help protect people. We were told a system was being developed.
● Although the registered manager told us no safeguarding concerns or incidents had occurred since the last inspection, we were informed after our inspection that safeguarding concerns had recently been shared with the local authority and the provider about one person. These concerns had not been robustly risk assessed or documented to help promote the person's safety. The registered manager did not share this information with us or demonstrate they had considered doing so.

Assessing risk, safety monitoring and management;
Using medicines safely;
Learning lessons when things go wrong
Other concerns at our last inspection in June 2018 had not been adequately addressed:
● As at our last inspection in June 2018, people's risks assessments still did not contain enough information so staff would know how to support people safely, for example with people's mental health needs.
● One person had a healthcare condition but staff did not know how this presented or how to respond appropriately in the event of an emergency. This information was not available in the person's support records.
● There was still no robust system to ensure staff attended calls, and for the correct times and durations. One person still experienced recent late and missed calls although we had raised similar concerns with their provider at our last inspection.
● Neither person was supported to take their prescribed medicines. However, it is good practice to accurately record people's prescribed medicines, including the reasons for those prescriptions and any possible side effects to ensure people's support needs and possible risks were known to staff. ● A staff member showed awareness of fire safety and how to help to keep a person's home safe. Keypad codes were used so that people's homes could be accessed safely.

Staffing and recruitment
● Our sample of records found showed character references and checks through the Disclosure and Barring Service (DBS) had been done. A staff member told us these checks were carried out before staff started their

roles and repeat DBS checks completed. This helped reduce the risk of people being supported by unsuitable staff.

- People had been supported by familiar staff during their time with the service.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence
People often gave positive feedback about the service. However where people received support, systems did not ensure that the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
Supporting people to live healthier lives, access healthcare services and support

- People's support needs and preferences were known to the service but records did not always reflect the support that was required. A staff member showed general awareness of how to promote one person's safety and wellbeing.
- A healthcare professional confirmed a person had settled and benefitted from the support of the service.
- Both people were supported by one primary support worker each. One support worker had received the provider's mandatory training in areas such as Mental Health Awareness, Health and Safety and Equality and Diversity and told us they felt supported and had enough training for their roles.
- The second support worker had not completed the provider's mandatory training following their induction in July 2018. Various training was underway for this staff member.
- Staff had also not received training or guidance relevant to all people's needs to ensure they knew how to support people safely and effectively at all times. Staff were expected to contact healthcare services if one person became unwell due to their condition but there was no guidance about what symptoms to look out for.
- One person's blood sugar levels were occasionally monitored and recorded by staff, unknown to the service manager and registered manager. This support need was not identified in the person's care records and had not been reviewed. This did not ensure the person received appropriate support as needed.
- We asked the service to consider encouraging another person to visit the doctor as a staff member told us the person was often in pain. This had not been discussed with the person.

Staff support: induction, training, skills and experience;

- We were able to speak with one staff member who knew the person they supported well and cared for the person's interests.
- Unannounced spot checks were carried out by the registered manager for both staff members. This helped the registered manager oversee aspects of people's support. A staff member told us, "My manager checks on me, checks I'm [at person's home] speaks to the person client sometimes while I'm there."
- Staff received supervision however this had not helped an ongoing performance issue whereby one person did not always receive their calls as planned.

Supporting people to eat and drink enough to maintain a balanced diet;
Adapting service, design, decoration to meet people's needs

- People lived in their own homes. People were supported to shop with staff to buy their chosen food and household items.

● People were accompanied to healthcare appointments if needed. The registered manager told us, "If [person] has a medical appointment and wants a carer [to accompany them], they will arrange it but it is not often."

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. We checked whether the service was working within the principles of the MCA.

● Both people were able to make their own decisions about their care and support.
● A staff member showed consideration for the importance of promoting one person's choice and independence.
● Only one staff member had received training in this area. Another staff member's training was underway.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect
People were supported and treated with dignity and respect; and involved as partners in their care. However the provider failed to ensure people were well supported with timely calls as planned and that care documentation accurately reflected people's needs and preferences.

Ensuring people are well treated and supported; respecting equality and diversity
- Feedback the service had received indicated staff were caring and had good relationships with people using the service.
- The registered manager told us they had previously given one person practical support and advice which had helped relieve one person's worries. Staff had raised concerns about the person's wellbeing which had led to this support.
- One person had expressed preferences around how they wished to be addressed. This preference was not appropriately documented or explored further with the person as part of their care and support planning. Staff had not all received equality and diversity training to ensure people's diverse needs and wishes would be effectively understood and met at all times.

Supporting people to express their views and be involved in making decisions about their care
- People had been asked for their views about the service and often gave positive feedback. Where this had identified ongoing improvements were required to one person's support, this had not been adequately addressed.
- People had signed their records detailing how they wanted to be supported.

Respecting and promoting people's privacy, dignity and independence
- A staff member told us they encouraged a person to do all they were able to do to continue to promote the person's independence.
- The provider's processes required people's support plans and life goals to be reviewed on a monthly basis, but this was not done. However, a person's expressed individual needs and goals were known to staff.
- A person was signposted and supported if needed to do things they wanted to do.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs
People received support to help meet their individual needs but systems did not ensure this would be consistently achieved.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
● The provider did not ensure people's needs and preferences were consistently met.
● A staff member gave examples of how they had open and supportive discussions with one person using the service. The staff member showed understanding of the person's individual needs and preferences, although this was not always clearly documented and reviewed as part of the person's support planning.
● People were involved in developing their support plan but records viewed did not accurately reflect all people's support needs.
● One person's call times had been changed based on their preferences, however another person did not receive their calls at an agreed time. This did not demonstrate a service of good quality which was consistently centred around people's needs and preferences.
● People were supported by staff of their preferred gender to provide them with support with activities of daily living.

Improving care quality in response to complaints or concerns
● The registered manager told us there had been no complaints. A staff member told us, "[Person] will tell me if they are not happy."
● One person had previously given feedback that they did not know how to complain. There was no record to show this feedback had been acted on, and information about the complaints process shared with the person and others.

Requires Improvement

Is the service well-led?

Our findings

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

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility;
Continuous learning and improving care;
Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Systems were still not in place to ensure people would receive their calls, on time and as planned.
- Duty of Candour is a requirement under the regulations that registered persons act in an open and transparent way with people and when things may go wrong in relation to the care and treatment provided. The registered manager showed some awareness of their responsibilities in relation to the Duty of Candour however had not acted openly and appropriately to ongoing concerns that one person received late and missed calls. The provider had not adequately addressed this despite concerns identified at our last inspection, to promote the person's choices and to ensure the person was treated with fairness and respect.
- Systems were still not in place to ensure incidents and safeguarding matters would be appropriately responded to and learned from to improve the safety of the service.
- Since our last inspection, people were asked more often for their views on the service. People often gave positive feedback however the provider still could not demonstrate that positive and/or negative feedback was used to effectively assess, monitor and improve the service.
- The provider had failed to adequately improve risk assessments following our last inspection. Records did not accurately reflect people's support needs. A new service manager had completed audits confirming this ongoing concern.
- The provider had failed to maintain an accurate registration in relation to their current location address. This is in breach of the provider's conditions. We are deciding our regulatory response to this and will issue a supplementary report once this decision is finalised.

There was still a lack of systems and process in place to effectively assess, monitor and improve the quality and safety of the service. The lack of robust quality assurance meant people were still at risk of receiving poor quality and unsafe care and the provider's systems would not pick up and respond to issues effectively. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others;
Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People had taken part in support planning and reviews. A staff member felt they were also invited to engage with the service and commented: "They listen to ideas, [the registered manager] will look at my

ideas and say why she agrees or not."

● A healthcare professional spoke positively about one person's experience of the service and how this had helped promote the person's health and wellbeing.

● The provider had not fully explored equality characteristics within support planning and ensured staff had relevant training and guidance in this area.

● The registered manager told us they called people and visited people unannounced every couple of months to monitor staff attendance and people's satisfaction with their support. The registered manager had not documented this oversight and used this to effectively improve the service.

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 17 HSCA RA Regulations 2014 Good governance There was still a lack of systems and process in place to effectively assess, monitor and improve the quality and safety of the service. The lack of robust quality assurance meant people were still at risk of receiving poor quality and unsafe care and the provider's systems would not pick up and respond to issues effectively. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.