Fosse Healthcare Limited

Fosse Healthcare - Derby

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Fosse Healthcare - Derby is a domiciliary care service. It provides care for people living in their own houses and flats. People are supported in their own homes so that they can live as independently as possible. CQC regulates the personal care and support. Not everyone who used the service received personal care. There were 104 people using this service at the time of our inspection, 82 of those people received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
People were not fully protected from the risks of abuse as the provider had not always recognised when incidents should have been referred to the local authority safeguarding team for assessment. Improvements had been made to some aspects of medicines management however, some risks remained. Some people had experienced improvements to the timeliness of their care calls; other people still experienced variations.

The provider had made progress on the action plan they had put in place to address the issues identified at our last inspection. However, some issues remained, and governance arrangements were still not fully effective at identifying shortfalls.

The provider completed recruitment checks on potential staff members before they were employed so as to help reduce risks to people from staff who were not suitable for the job role. Staff had sufficient information and training for them to understand and meet people's care needs. The provider had taken action to protect people against the risk of infection. Staff had sufficient PPE and had been trained in what actions to take to reduce the risk of spreading infection.

Assessment processes were in place for people's care needs. Staff received training and checks on their competency and understanding to provide the care people required. People were offered choices and supported with their meals and drinks when this was part of their care. Other health and social care professionals were involved in people's care when needed, and records reflected their involvement.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The provider investigated and responded to concerns people raised and used these to help inform how to improve the service. People and their relatives were involved in reviewing their care and their views on the quality and safety of the service had been sought. The management team were viewed as approachable and supportive by care staff.

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

Rating at last inspection and update:
The last rating for this service was Inadequate (published 25 August 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, some but not enough improvements had been made and the provider was still in breach of regulations.

Special Measures:
This service has been in Special Measures since our last inspection which was published 25 August 2021. During this inspection the provider demonstrated that improvements have been made so that the service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We carried out an announced comprehensive inspection of this service on 21,22,23,24 and 28 June 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, safeguarding service users from abuse and improper treatment, good governance and Notification of other incidents.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions of Safe and Well-led which contain those requirements. In addition, it contains our findings in relation to the Key Question of Effective which was rated as inadequate.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion, were used in calculating the overall rating at this inspection. The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, effective and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Fosse Healthcare Derby on our website at www.cqc.org.uk

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, safeguarding people from abuse and good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.	**Good**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Fosse Healthcare - Derby

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
On day one the inspection team consisted of one inspector; on day two it consisted of one inspector and one medicines team inspector. Prior to the inspection, two experts by experience made telephone calls to people who used the service and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses, flats and specialist housing.

The service did not have a manager registered with the Care Quality Commission at the time of the inspection. Both registered managers 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 notice of the inspection. This was because the inspection was conducted during the COVID-19 pandemic and we needed to be sure that the provider would be in the office to support the inspection.

Inspection activity started on 11 October 2021 and ended on 3 November 2021. We visited the office location on 18 and 19 October 2021.

What we did before the inspection
We used information received about the service since the last inspection. We contacted local stakeholders

to gather feedback on the care provided. This included healthcare professionals and the local authority commissioning team. On the 11 October 2021 we made phone calls to 11 people who used the service and five people's relatives to gather feedback about the care provided.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We reviewed a range of records including the relevant sections of eight people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. We reviewed other records related to the management of the service, including the provider's action plan following the last inspection, policies and staff training records.

We spoke with seven members of staff including, the nominated individual, the Group Head of Quality, Safety and Compliance, the Area Manager, the Innovation Officer and three care staff.

What we did after the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our previous inspection, the provider had failed to operate effective systems to keep people safe from abuse, medicines were not safely managed, staff did not have access to sufficient information on people's care needs, the provider did not effectively monitor staff COVID-19 testing and people experienced missed and late calls. This was a breach of regulation 12 (safe care and treatment) and regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found some improvements had been made, however these were not sufficient to fully meet the regulations and the provider was still in breach of the above regulations.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
At our previous inspection, the provider had failed to operate effective systems to keep people safe from abuse. This was a breach of regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found some improvements had been made, however these were not sufficient to fully meet the regulations and the provider was still in breach of the above regulations.

- At our previous inspection, people were not always protected from the risk of abuse as appropriate actions had not always been taken when allegations were reported. At this inspection we found that the provider had made some safeguarding referrals. However, we found a safeguarding referral had not been made when a person had made an allegation of abuse. The provider told us they accepted a safeguarding referral should have been made at the time of this incident and they made a retrospective safeguarding referral shortly after our inspection.
- We found other incidents that had the potential to meet the local authority's safeguarding criteria. Whilst the provider told us they had taken action to reduce risks when there was the potential that adults at risk had been exposed to harm or placed at risk, they had not made safeguarding referrals at the time of these incidents. The provider did make safeguarding referrals for these incidents shortly after our inspection. Making safeguarding referrals where people are at risk of harm or placed at risk, offers the best possible opportunity for the local authority to ensure their safety. This is because local authorities have the lead role in coordinating safeguarding actions for adults at risk and can oversee and manage interventions to ensure people's safety.
- The provider's lack of timely safeguarding referrals for these incidents meant the local authority safeguarding team may not have been in receipt of all available information to help them assess how best to safeguard individual people.

This is a continuing breach of regulation 13 (safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems were not always operated effectively to ensure safeguarding referrals were made to ensure people's safety.

Using medicines safely
At our previous inspection, the provider had failed to operate effective systems to ensure medicines were safely managed, staff have access to sufficient information on people's care needs, the provider did not effectively monitor staff COVID-19 testing and people experienced missed and late calls. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At this inspection we found some improvements had been made, however these were not sufficient to fully meet the regulations and the provider was still in breach of the above regulations.

● At our previous inspection, medicines were not always administered safely or given at the time prescribed. Guidelines for 'as needed' medicines were not in place, medicines errors had not always been investigated and paper medicines administration records were not audited. At this inspection we found, some improvements had been made however, further improvements were still needed.
● The provider described a system for checking the medicines were correctly transcribed from the information supplied by the pharmacy or GP. However, we found only four out of the eight electronic medicine administration records (eMARs) seen had evidence this system had been carried out.
● The provider had a system in place to check whether medicines were being administered correctly, however the example we were shown had not been carried out in a timely manner. The audit took place on the 25 October 2021 looking at administration records that had been completed between the 1 and 7 of August 2021. Where errors were investigated this was not always done thoroughly. In an example we were shown, the provider did not speak with the care staff who could have made the error and the investigation did not conclude with any outcome. This put people at risk because systems to detect potential medicine errors were not robust enough.
● People had medication risk assessments which identified who was responsible for ordering and collecting/delivering the medicines and what level of support was required with administering the medicines. However, whilst supporting information such as the visit schedules described in detail the support people needed with their medicines, the medication risk assessments did not identify the risks around the administration of some medicines. For example, the need to apply a steroid cream sparingly or the safety requirement to ensure a minimum time gap between certain medicines.
● People who had been prescribed medicines on a 'when required' basis had written plans in place however, the information included was not sufficient to inform the staff of how and when to administer these medicines.
● We looked at the actions taken by the provider to ensure people did not have their medicines too close together. We found one person had had their medicines administered too close together on two separate occasions. Whilst the provider had identified these occasions and reminded staff to give medicines at the correct intervals, we found that staff attended this person's morning call later than scheduled. This meant the risks of staff administering medicines too close together or the person not being given their medicine as needed had not been reduced.

This was a continuing breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not all risks associated with medicines were reduced effectively.

● The eMARs were sufficiently detailed with information so staff could administer the medicines safely. The

eMARs were able to evidence that medicines were administered by their staff accurately and in accordance with the prescriber's instructions.
● Staff administering medicines had completed safe management of medicines training and staff were assessed for their competency to administer medicines safely.
● The medicines management policy reflected the current national guidance and best practice set out in the NICE guidance for managing medicines in the community.

Staffing and recruitment
● At our last inspection, people told us staff were often late and the care call times did not always meet their preferences and often varied in time. At this inspection, improvements had been made for some, but not all people. Where people required a 'time critical' care call due to health reasons, such as diabetes, the provider had taken action to ensure people received these calls on time.
●However, other people told us, and records showed they still experienced variations in the times of their care calls. One person told us, "Staff can come as early as they want to get me ready for bed, but it does vary; one care staff comes between 7.30 and 8pm. Other care staff come between 9 and 10.30pm and another staff member can come between 10.45 and 11pm, but it's not often that late. Once the night-time carer came before the teatime carer."
● The provider told us the care times that were originally commissioned were not always in line with people's preferences. They told us, and we saw, they were in the process of reviewing people's care times with them and trying to adjust these where possible so that people's preferences could be met.
● Recruitment processes were in place and followed by the provider. This included checks on the suitability of staff to work in care. This helped to inform the provider when they were making recruitment decisions.

Assessing risk, safety monitoring and management
● At our previous inspection, care plans did not provide sufficient or accurate information on people's healthcare needs. At this inspection we reviewed care plans and found they contained sufficient guidance for staff to follow and care plans had been updated when people's needs had changed. One care plan required further detail to help ensure staff provided consistent care and the provider told us they would update this.
● Staff we spoke with were knowledgeable on people's care plans and care needs.
● At our previous inspection, we had concerns about diabetes care. At this inspection people who received care to help them with their diabetes told us the service had improved. For example, one person told us, "Yes, I have diabetes which is why I needed my calls early and food before my medicines. Staff now manage my food being done on time so it's all good now." Staff we spoke with understood people's diabetes care plans. The provider had further developed diabetes training which staff had completed. The provider told us they had made sure people who needed care at a specific time because of a health need like diabetes received this.

Preventing and controlling infection
● At our previous inspection we were not assured that all staff were aware of the government recommendation to complete weekly COVID-19 testing and report this to the provider for monitoring and oversight. At this inspection staff were aware of the recommendation to test and the provider kept records of where staff had reported their test results. The provider had regularly communicated with staff to promote the uptake of COVID-19 testing to ensure risks to people from COVID-19 were reduced.
● The provider had taken measures to reduce the risk of infection to people. Staff had access to items of personal protective equipment (PPE) and had been trained in infection prevention and control measures. People we spoke with told us they felt all staff used PPE correctly. One person told us, "The carers wear masks and aprons and they wash their hands before they put gloves on. After they have helped me to have a

wash, they take their gloves off, wash their hands and put new ones on. They also wipe around with disinfectant." The provider was taking action to protect people from the risks of infection.

Good

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.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- At our last inspection people told us they felt their care calls were rushed. At this inspection people told us this had mostly improved; however, people told us they sometimes still experienced staff rushing. A relative told us, "My family member has a morning call of 45 minutes and three others of 30 minutes. Sometimes the morning call is rushed as the carers have a lot of people to go to and I am also not sure if they are short staffed. My family member has dementia, but they would tell me if they were bothered by the carers rushing." One person said, "The carers take their time, you get an odd one that rushes, but that is unusual."
- Other people told us they still experienced variations in the timings of their care calls, and this impacted on them. One person told us, "The lunchtime call is usually between 11 and 2.30pm and teatime is between 3 and 6.30pm. I am flexible though and just wait for them to come, someone always comes, you just have to wait your turn." Records we saw showed people experienced variations in the times staff attended to them.
- The provider had completed assessments on people's care needs and preferences. The provider gave examples of where they had reviewed people's calls and sought to change these where needed to give staff more time. The provider was continuing to review people's preferences and choices and how they could improve people's care call timings to meet these.
- At our last inspection we found records of care provided to people were not detailed enough. The daily care records we reviewed at this inspection were sufficiently detailed to effectively show any changes in their health and well-being. In addition, staff were prompted to check and report on any concerns with medicines, skin integrity or other relevant health and care concerns.

Staff support: induction, training, skills and experience

- At our last inspection we identified improvements were required to staff training. At this inspection we found the provider had renewed the training materials for diabetes care and skin integrity risks, and that these areas were now comprehensively covered. People told us they felt staff were knowledgeable and skilled. One person told us, "All carers are good and well trained in my opinion." Another person said, "Carers are all trained ok. Even the brand new one the other day knew what they were doing."
- Staff told us they were happy with the training and support given to help them feel confident in their role. One new member of staff told us they had requested additional time to shadow more experienced staff in their induction period. They said this was arranged and helped them feel confident in their skills to care for people.
- Training records showed the provider monitored staff training and identified where staff were required to repeat training if there were some aspects of understanding they needed to improve. The provider had completed staff competency assessments. These involved a range of questions and this helped the provider

make their judgements as to staffs' competency in specific areas.

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

● Where staff provided care to help people with their meals people told us they did this well. One person said, "They always ask what they can do for me."

● Care plans reflected people's dietary needs. Where staff were required to stay with people while they ate, they made a record of what food and drink had been taken. Where staff were not required to stay with people over mealtimes, records would often just record the food left with the person. The provider told us they would review the records required for food and fluids.

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

● Care plans reflected where other professionals were involved in people's care. Staff we spoke with were aware of other health and social care professionals' roles and what involvement they had in helping to achieve good healthcare outcomes for people.

● People told us staff would identify any concerns in people's healthcare needs and involve other professionals as required. One relative told us, "They are very good and if they spot anything, they let me know. Recently they spotted something and got the District Nurse in to sort it out. They are very good."

● The provider told us and records showed, where they were working with a multi-disciplinary team approach to try and achieve positive outcomes for one person.

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 when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

● Care plans identified where people had capacity for decision making and where any relatives had the legal authority to also be involved in decision making processes.

● The provider was involved in working with other professionals to establish a person's mental capacity in relation to their care needs through the MCA and best interests process.

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.

At the last inspection this key question was rated as inadequate. At this inspection this key question has improved to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others
At our previous inspection the provider had failed to ensure assessment and monitoring of the service and actions to improve and reduce risks and checks on the quality and safety of services were operated effectively and would lead to good outcomes for people. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found some improvements had been made, however these were not sufficient to fully meet the regulation and the provider was still in breach of the above regulation.

At our previous inspection the provider had failed to notify the Care Quality Commission about specific incidents in a timely manner. At this inspection, we found further evidence that indicated the provider had failed to notify the CQC for notifiable incidents in a timely manner as required. This is subject to further investigation by CQC.

- At this inspection we found the provider had not always made timely safeguarding referrals for several incidents as reported in the safe section of this report. The principles of the provider's safeguarding adults' policy had not always been followed by the provider in their decision-making process. In addition, audit processes had failed to identify that potential safeguarding incidents had not been referred to the local authority.
- Audit processes had not been effective at identifying where statutory notifications had not been submitted to the Care Quality Commission as required.
- Since our last inspection, the provider had implemented an action plan and made improvements in some, but not all areas previously identified as requiring action. At this inspection we found continuing shortfalls as medicines had not always been managed safely, safeguarding incidents had not always been recognised and action taken, and notifications were not always submitted for notifiable events and incidents. The provider actions to improve had not always been fully effective.

This is a continuing breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems and processes to identify, monitor and reduce risks and

assess, monitor and improve safety were not always operated effectively.

● The provider had policies and procedures to help manage the quality and safety of the service. We found one policy required additional information as the provider's medicines policy did not contain sufficient guidance to ensure people received their medicines as required should the electronic system not be available.
● The previous registered manager had cancelled their registration with CQC in August 2021 and a new registered manager was not in post at the time of this inspection. The area manager told us they intended to apply to be the registered manager whilst the provider undertook further recruitment to the registered manager role.
● At our last inspection improvements were required to care records, at this inspection we found that these had improved. People's care plans and staff notes were detailed.
● At our last inspection, improvements were required to the timings of people's call times. At this inspection, some improvements had been made and other actions to further improve were still in progress. The provider showed us what further steps they were taking to try and improve care call timings for all people.
● The provider had engaged with other local health and social care professionals to try and achieve good outcomes for people's care. People and relatives told us they were involved in their care and had their views listened to by the provider. This helped to achieve good outcomes for people.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● People told us when they raised concerns and complaints, their issues were dealt with quickly and resolved. One person said, "I did have [an issue] at the start but phoned them and it got sorted out quickly and I've not had an issue since."
● Records showed the provider investigated complaints and issues that had been raised with them.
● The provider had a policy that covered what actions they would take to ensure the duty of candour would be met in instances of this nature.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider sought people's views by a written survey and in addition, by a telephone survey. People told us they had received a survey as well as a telephone call. Records showed us people's views had been recorded and were being used to inform how the service could further improve.
● People and relatives told us, and records confirmed they were involved in planning and reviewing their care. Assessment processes took account of people's diverse needs and considered their equality characteristics.
● Care staff told us they found the management staff and office staff supportive and approachable. We saw the steps the management team had taken to stay in touch with staff and communicate updates and guidance to them.

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 Risks associated with the use of medicines were not always effectively reduced. 12(g)