Fosse Healthcare Limited

Fosse Healthcare - Derby

Inspection report

Suites 1.1 & 1.2 Southgate Business Innovation Centre
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Date of inspection visit:
21 June 2021
22 June 2021
23 June 2021
24 June 2021
28 June 2021

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Fosse Healthcare - Derby is a domiciliary care service. It provides personal care support to people living in their own homes. Not everyone who used the service 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. At the time of the inspection, Fosse Healthcare – Derby was supporting 130 people with personal care.

People's experience of using this service and what we found
People were not kept safe from harm and potential abuse. This was because incidents were not responded to appropriately. People had complex health conditions, and care plans did not provide enough guidance to staff on how to support people. Staff reported that their knowledge and skills came from learning through work, rather than having high quality training and induction.

Medicines were not safely managed, which put people at risk of harm. We were informed that staff were not completing regular COVID-19 tests, one staff member was unaware that these tests were available. Not testing staff routinely put people at risk of COVID-19 transmission. Care visits were late or not completed, which meant people did not have their needs met as agreed.

The care provided did not meet current national standards. Staff supported people to eat, but did not always record the amount that people ate to ensure they were not at risk of malnutrition. External professional advice was not always sought and recorded to ensure that care was given effectively.

People were not supported to have maximum choice and control of their lives. Staff did not support them in the least restrictive way possible and in their best interests; and systems in the service did not support this practice.

People reported that staff were kind. However, the impact of late and missed calls did not create a caring ethos at the service. People felt that calls were often rushed. Professionals had reported that sometimes people did not receive thorough personal care. This poor quality personal care can be undignified.

People felt that complaints were not always responded to. Records showed that complaints were not always fully investigated to ensure improvements were made. At the time of the inspection no one was receiving end of life care. However, the poor practices we observed would mean that end of life care would not have been high quality.

The leadership at the service was not effective. Audits had not recognised that improvements were needed, and safeguarding allegations had not resulted in effective change. The service is expected to notify the Care Quality Commission of events that occur at the service, however we had not received these notifications as expected.

People were able to engage in social activities that were important to them. The service had alternative communication formats (like large written font), in case people needed this to understand information given to them.

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

Rating at last inspection:
The last rating for this service was Good (published 4 September 2018).

Why we inspected
The inspection was prompted due to concerns received. The local authority safeguarding team had informed us of allegations including neglect and poor quality care; including' medicines, diabetes, skin and catheter care. The provider is legally required to notify us of allegations of abuse, but we had not been made notified of these allegations by the registered persons. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needed to make improvements and that people were at risk. Please see the full report for details of our concerns. We forwarded our concerns to the provider and they sent us an action plan, describing how they intend to make the required improvements. We will assess the effectiveness of this action plan at our next inspection.

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 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were breaches of regulation 12 (safe care and treatment), regulation 13 (safeguarding from abuse and improper treatment) and regulation 17 (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 have received an action plan from the provider to understand what they will do to improve the standards of quality and safety. 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.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service.

This will usually lead to cancellation of their registration or to varying the conditions the 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
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. The service was not responsive.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

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
The inspection team consisted of four inspectors.

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 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. This was because the inspection was conducted during the COVID-19 pandemic and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

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 commissioning teams and the local safeguarding team.

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
On the first day of the inspection (21 June 2021) we attended the office. We reviewed a range of records. This included twelve people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. From 22 to 28 June, we were sent a variety of records electronically. These records were related to the management of the service, including policies and procedures. We considered safeguarding allegations made to the local authority.

We also made phone calls to gather feedback about the care provided. We spoke with eight people and two relatives about their experiences of using the service. We spoke with ten members of staff including the nominated individual and registered manager.

What we did after the inspection
After the inspection, we described our main concerns to the provider. They created an action plan to show what improvements they intend to make in the future.

Inadequate

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People were not kept safe from abuse. This was because appropriate actions had not been taken when allegations were reported.
- Two people had made allegations that care staff had stolen from them. The registered manager had not made referrals to the police. This left people at ongoing risk of theft.
- One person had reported that staff did not attend the care visit as expected. An investigation found that this staff member had falsified the care records to suggest they were in the property. There had been no referral to the local authority safeguarding team to investigate this neglectful practice.
- A visiting professional had raised concerns that staff were moving someone unsafely. The service had sent messages to all staff reminding them of good practice. However, there had been no investigation into which staff member was observed caring for someone unsafely. This poor investigation would prevent this staff member being retrained and competency assessed.
- Multiple external professionals had raised concerns about unsafe care. However, action had not been taken to investigate these allegations and improve care. For example, the local nursing team alleged that a person had developed a serious pressure sore. No action had been taken to improve guidance for staff to ensure future care was safe. This puts the person at ongoing risk of skin damage.

Systems were not in place to ensure people were kept safe from abuse. This was a breach of regulation 13 (safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider created an action plan to make improvements, we will assess the impact of this at our next inspection.

Assessing risk, safety monitoring and management

- Care plans did not provide sufficient or accurate information on people's healthcare needs. Staff had poor quality guidance on how to support people's diabetes needs, skin integrity needs, choking risks and catheter care. This lack of staff guidance put people at high risk of harm from poor quality care.
- We had particular concerns about diabetes care at the service. Staff had poor quality diabetes guidance and training. We spoke to four staff about diabetes care, they all had limited knowledge and felt they lacked skills in this area. When we looked at daily records and gathered feedback we found staff did not respond to diabetic needs and ill health in an appropriate way. The nominated individual was informed of this high risk and advised they would review diabetes care at the service to ensure people were safe from harm.

Using medicines safely

- Medicines were not administered safely. This put people at risk of harm.
- Medicines were not given at the time prescribed. One person had paracetamol repeatedly given before the safe four-hour gap. This had already been recognised as a risk by the registered manager but not resolved

for the next month. One person required their medicine at a specific time for their health condition, however the time given was repeatedly varied. Another person required their medicine 30 minutes before food, however their medicine was repeatedly given with their food. Not following the prescribed time of administration can but put people at risk of ill health.

● There was no guidance in place for 'as needed' medicines. This meant staff would not have suitable information to decide when 'as needed' medicine needed to be given.

● Medicine errors had not been suitably investigated to prevent re-occurrence. There were repeated incidents of staff using medicines from different blister packs. This risks staff giving medicine that is no longer prescribed. Action had been taken to remove the multiple blister packs, but there was no evidence that the initial staff errors had been investigated to ensure errors did not re-occur.

● The service used an electronic system to record medicine administration. Sometimes staff also recorded the administration on paper records. One professional had made a safeguarding referral that the paper record was poorly written, they could not identify how much medicine a person had taken. Another professional had made a safeguarding referral that an inaccurate paper record resulted in the wrong medicine being given and causing a person's ill health. Despite these concerns being highlighted to the registered manager, there was no routine auditing of these paper records to ensure care was safe in future. This left people at risk of harm. The provider has advised that paper records will now be removed from the service to ensure that this risk is removed.

Preventing and controlling infection

● We were not assured that the provider was keeping people safe from COVID-19 transmission. This is because it is government guidance for staff was to take a COVID-19 test weekly. The service kept no record of which staff had taken tests and the registered manager believed this testing uptake was low. A staff member told us they were unaware that tests were available from the service. The failure to test staff as government guidance required, meant we could not be assured that people were safe from COVID-19 transmission. The nominated individual has advised that they will review why they were not recording COVID-19 testing and improve on the update of staff testing.

Staffing and recruitment

● We spoke to eight care staff and ten people/relatives. They all reported that calls were often late. One person said, "The staff are always late - there are no set times. It's not good. I never know when they are coming.". Staff reported that planned call times were not always in line with people's preferences.

● Records showed us, and people fed back that care staff sometimes didn't arrive as planned. This meant people went without support. One person said "Three occasions where they haven't arrived at lunch time. I called and they said they were running late – ten to fifteen minutes away. I waited and waited but no one came". These missed calls left people at risk of harm.

Staff did not have sufficient guidance on how to keep people safe, medicines were poorly managed, staff did not receive COVID-19 testing and there was poor timekeeping and missed care visits . These concerns were a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were safely recruited to ensure they were of good character. For example, gathering references from previous employers

Inadequate

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant 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

- National guidance requires care staff to keep a record of what care has been provided. We saw that daily notes kept by care staff were brief and did not include enough detail on what care was provided. The poor record keeping meant other staff and the management team would be unable to identify changes in person's needs and effectively support them.
- National guidance requires care visits to be a sufficient time to allow dignified and effective care to be provided. This guidance was not followed. People reported rushed calls that meant their needs were not met in a dignified way. One person's call had been routinely scheduled for 30minutes, despite needing their medicine 30minutes before food, and needing time to eat their meal with staff. By not arranging a long enough care visit, this risked the person not receiving care that met their needs effectively.

Staff support: induction, training, skills and experience

- Staff reported that their induction and training was basic and did not provide them with enough skills to safely undertake their role. Staff felt their current knowledge was from watching other care staff or getting advice from people they supported.
- People told us that staff would often ask them for advice instead of understanding what care was required. One person said "I would insist they train staff before they go to clients - some don't know what they are doing"
- We had particular concerns about the quality of diabetes training. This is because poor quality diabetes care was being provided. The provider advised they would take action to improve diabetes training immediately.
- Staff received spot checks and competency assessments. The registered manager advised that parts of the competency assessment asked staff if they know current guidance and recording their answer as 'yes' or 'no'. This process does not actively test staff understanding.

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

- People were supported by staff to eat and drink. Staff recorded when food and drinks were given but did not always record how much was consumed. When people are at risk of malnutrition or dehydration, a thorough record would allow staff to monitor how much they have consumed and reduce the risk of ill health.
- Care plans did not always provide enough guidance on people's dietary needs. For example, staff did not have guidance or training on suitable food types for people with diabetes diagnosis.

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

● External professionals were not always contacted to gather their advice on effective care. For example there was no evidence that professionals had been contacted for guidance on suitable diabetes care.

● Where professionals were contacted by the service; this communication with external professionals was not always recorded. This meant this professional guidance could not be effectively followed to ensure consistent care.

● Where professionals had raised concerns about care, this had not resulted in effective care being provided. For example, professionals had raised concerns about the use of paper medicine administration records. However, action had not been taken to review the effectiveness of paper administration medicine records.

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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). 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 and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● People's decision-making abilities were not clearly recorded in care plans. This meant staff did not have clear information on what decisions a person could make.

● Where people required support to make decisions, some records guided the next of kin to be consulted. The provider had not gathered evidence that these next of kin had the legal power to make decisions for the person (Power of Attorney). We found capacity assessments had not always been completed to assess if the person could make the decision themselves before informing staff to consult the person's next of kin.

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. At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People and staff reported that calls could be late, or carers could not arrive as planned. This could result in people feeling anxious. The impact of late and missed calls, impacts the caring nature of a service.
- Two people told us that when carers were late, their visits felt rushed. Otherwise people told us that staff were kind to them.
- People's life history and beliefs were recorded in their care plans. This meant staff had guidance on people's diverse lives.

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

- People told us that they had been involved in initial care plan creation. However, they did not feel well involved with care plan reviews.
- People advised that staff involved them with day to day decisions about their care routines. However, they felt that staff often asked how to provide care which should have been covered in their training.

Respecting and promoting people's privacy, dignity and independence

- We reviewed feedback received before the inspection. Three professionals reported that sometimes personal care tasks were not completed thoroughly, which left people unclean. Not providing high quality personal care tasks is undignified.
- Care plans provided staff with guidance on what people could do for themselves. This allowed staff to promote people's independence.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs. At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

●People reported that complaints and concerns were not always responded to. The service complaints policy stated that complaints would be responded to in writing within 28 days, there was no evidence that people's complaints had been responded to as the policy required.

● Where complaints had been received, ineffective action had been taken to improve care. For example, a professional had reported concerns that a person had pressure related skin damage, however the person's care plan had not been updated to guide staff on this person's need. This lack of guidance would prevent staff from being able to respond to the person's current condition or understand the skin risks for this person.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People's preferred call times were not always recorded. People felt that care calls were later than they preferred.

● Care plans included people's life history. However, care plans lacked detailed information about their physical, emotional and mental health needs. These details are needed so staff can provide personalised and responsive care to people.

End of life care and support

● At the time of the inspection, no one was receiving end of life support.

● Our inspection found multiple concerns with medicine management, care plan guidance and the timeliness of care calls. These concerns would need to be resolved, in order to provide high quality end of life care

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Staff were able to take people into the community to avoid social isolation

● People were able to choose what activities they engaged in, and which activities were relevant to them.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The registered manager told us that they had information in a variety of formats (For example larger size font). They advised that this was available to people using the service, however no-one currently required

information in alternative formats so we could not assess the effectiveness of this.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was insufficient care plan guidance for staff to follow. Care plan reviews had occurred but not recognised that improvements were needed. This put people at ongoing risk of poor-quality care.
- Records kept by staff showed that care was not always safe and effective. The governance system had not effectively reviewed these records to improve the quality of care.
- All people and staff we spoke to reported that care calls were often late and not scheduled at a person's preferred time. People's preferred call times were not always recorded in order to improve rota creation.

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

- The provider's complaints policy stated that all complaints should be responded to within 28 days in writing. People reported (and we saw no evidence) that their complaints were not responded to in writing as the policy required.
- Professionals had made safeguarding allegations about the poor-quality care provided at the service. However there had been ineffective action taken to ensure that care improved following these concerns being raised.
- The failure to respond to incidents effectively meant the duty of candour had not been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service had not met regulatory requirements. This is because national guidance had not been followed and there were breaches of regulation.
- The registered manager and provider are legally required to notify the Care Quality Commission about events that occur at the service. We identified 16 notifications had not been made by the registered manager. The provider advised they had recognised this and spoken to the registered manager about improvements that were needed. We identified that since this discussion, the registered manager had failed to notify the commission of an additional six incidents.

The failure to notify the Care Quality Commission about incidents that occur at the service is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Continuous learning and improving care; Working in partnership with others

● Before the inspection, there had been two safeguarding allegations about poor quality diabetes care. We found there was poor quality care plan guidance for staff to follow. There was also poor-quality diabetes training. Records and verbal feedback showed us that diabetes care was unsafe. There had been a failure to respond to these safeguarding allegations to review and improve the quality of diabetes care at the service
● Before the inspection, there had been two safeguarding allegations about poor quality skin care at the service, putting people at risk of skin breakdown. We identified that people's creams were not correctly recorded on medicine records and irregularly applied. We also found that care plans did not provide enough guidance to staff on people's skin related risks. There had been a failure to respond to these safeguarding allegations to improve the quality of skin integrity care at the service
● Before the inspection, we had received two professional concerns about the use of paper medicine records at the service, which has impacted people. The registered manager advised that these paper medicine records remained in use at the service and were not audited. This did not follow the service policy of using electronic records. There had been a failure to respond to these allegations and prevent future medicine related errors.
● Where people had complex needs like choking risks and diabetes, there was no evidence that professional advise had been accessed on how to care for these people safely. It is important to gather professional advice, so staff know how to care for these people safely.

The leadership did not ensure the service was ran to a good standard. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider created an action plan to make improvements, we will assess the impact of this at our next inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were asked to complete a survey into the quality of care provided. However, the uptake of this had been poor. The provider was exploring other ways to gather feedback on the care provided.
● People received routine reviews of their care and were able to make complaints. We found that the routine reviews and complaints did not result in effective action being taken to improve care.
● People's equality characteristics (like religion) were recorded in their care plans. There was access to accessible information so people could understand information presented to them.
● We were informed that since the COVID-19 pandemic, staff meetings had been stopped. Instead of meetings, national guidance was sent out via email. Instead of meetings, staff had access to one to one supervision meetings.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not kept safe from harm. This was due to; poor quality care plans, late and missed care calls, unsafe medicine management and a low uptake of staff COVID-19 testing. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider created an action plan to make improvements, we will assess the impact of this at our next inspection.

The enforcement action we took:

We have sent the provider a warning notice. We will review their compliance with this by completing another inspection.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not in place to ensure people were kept safe from abuse. This was a breach of regulation 13 (safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider created an action plan to make improvements, we will assess the impact of this at our next inspection.

The enforcement action we took:

We have sent the provider a warning notice. We will review their compliance with this by completing another inspection

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The leadership did not effectively oversee the running of the service. Incidents were not responded to, to ensure that care was safe. This

was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider created an action plan to make improvements, we will assess the impact of this at our next inspection.

The enforcement action we took:

We have sent the provider a warning notice. We will review their compliance with this by completing another inspection