UK Healthcare Group Limited

Forge House Services Limited

Inspection report

Forge House
60 Higher Street
Cullompton
Devon
EX15 1AJ

Tel: 0188432818

Date of inspection visit:
15 December 2022

Date of publication:
24 January 2023

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service caring?	**Inspected but not rated**
Is the service responsive?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Forge House Services Limited is a residential care home. It is registered to provide personal care and accommodation to up to 11 people. The home specialises in the care of people who have a learning disability. At the time of our inspection there were nine people living at the home.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support:
People were supported to have maximum possible choice and control of their lives and staff sought to support them in the least restrictive way possible and in their best interests. Work was required to ensure ongoing improvement.

People were at reduced risk from harm. Risk management had improved. Further work was required to ensure improved practice was embedded and consistent.

People lived in a home where most environmental risks had been identified and were being addressed. Additional risks identified by inspectors were addressed following our visit.

Further work was required to ensure staff were provided with sufficient clear guidance to support people safely.

Incidents were reviewed with trends and learning identified to prevent from re-occurring. Incidents were being reported to other outside agencies.

People were protected from the risks associated with cross infection.

People were enabled to access specialist health and social care support where appropriate

Right Care:
Improvements had been made since the last inspection to ensure people received personalised care and support which was built around people's needs and preferences. Work was required to ensure ongoing improvement.

People's care and support plans had been reviewed and reflected people's individual needs. Work was

required to ensure care plans reflected peoples goals, aspirations and achievements.

People's needs and preferences to avoid social isolation were being met. Group activities within the home had reduced and individual activities within the community increased. Work was required to ensure ongoing improvement.

Right Culture:
Person centred care had improved. Further work was required to ensure improved practice was embedded and consistent.

Routines and practices within the home had changed. People had increased control over their lives because of the change of ethos, values, attitudes and behaviours of the management and staff.

People were now supported by staff to be involved in decisions about their care and support. Staff used individual communication methods to enable people to express themselves The provider had a system for seeking feedback about the quality of the service from people who used the service.

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 Inadequate (published November 2022)

Why we inspected
We undertook this targeted inspection to check whether the Warning Notice we previously served in relation to Regulations 9 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. The overall rating for the service has not changed following this targeted inspection and remains Inadequate.

We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Forge House 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 monitor the service and will take further action if needed.

We have identified a continued breach in relation to person centred care and risk management at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Is the service caring?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Is the service responsive?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Forge House Services Limited

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 Health and Social Care Act 2008.

This was a targeted inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 9 (Person centred care) and Regulation12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Forge House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Forge House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
Two Inspectors visited Forge House on 15 December 2022. We spoke with and communicated with six people who used the service. Some people we met were not able to verbally communicate with us. Their experiences were captured through observations, interactions they had with staff and their reactions.

We spoke with four members of staff including the registered manager and compliance manager.

We reviewed a range of records. This included five people's care records and a variety of records relating to the management of the service.

Following the inspection we asked the registered manager for further information related to the running of the service.

Inspected but not rated

Is the service safe?

Our findings

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

At our last inspection this key question was rated inadequate. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

At our last inspection the provider had failed to assess, monitor and manage risks to service users' health and safety and provide safe care and treatment. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Assessing risk, safety monitoring and management

- People's risks were not always mitigated. Care plans did not provide clear and accurate information to guide staff on how to support people's behavioural, physical or mental health needs. Behavioural support plans for two people who showed they were distressed or agitated had been completed and one person's physical intervention plan that guided staff to restrain this person if needed had been reviewed. These documents were not available to provide guidance to staff. The registered manager told us that this was due to them being sent to other professionals for review. The registered manager advised that they would make these documents available to staff immediately.
- Comprehensive risk assessments were not in place for all identified risks to people. A risk assessment for one person who was at risk of falls had been completed for this person using the stairs. However, this did not detail all actions staff needed to take when supporting them on the stairs. For example, where staff need to position themselves whilst supporting this person on the stairs.
- Environmental risks we identified at the last inspection had been addressed although further risks had not been identified by the provider. For example, the kitchen was now unlocked although the risk had not been assessed to ensure people's safety when staff were not present.
- We also highlighted other additional environmental risks during the inspection. These included a fire door being wedged open, and hot water in communal bathrooms and toilets being too hot. The manager told us these issues would be addressed.

The provider had failed to assess, monitor and manage risks to service users' health and safety and provide safe care and treatment. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Records of incidents and accidents were recorded and a system was now in place to review, investigate

and prevent them from re-occurring. This included looking for trends and identifying any learning to reduce the risk of an incident happening again. Incidents were now being reported to other outside agencies.
● Staff had received training in how to complete restraint safely.
● During the inspection we observed one person's choking risk assessment being followed. This was observed to not be followed at the last inspection.

At our last inspection the provider had failed to ensure infection control practices were safe. This formed part of a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement has been made at this inspection and the provider was no longer in breach of this part of regulation 12.

Preventing and controlling infection
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the home. The areas in the home that were found to not be clean at the last inspection, and presented as an infection control risk, had been addressed.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection. Cleaning schedules were in place and an infection control audit had been completed.
● Following an Environmental Health Officer (EHO) visit, improvement around hygiene including handwashing, food storage and policies had been made.
● Staff had received infection control training to ensure the safety of people.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed. The areas in the home that were found to not be clean at the last inspection had been addressed.
● We were assured that the provider was preventing visitors from catching and spreading infections and responding effectively to risks and signs of infection.
● We were assured that the provider was using PPE effectively and safely.

Visiting in care homes
● The provider had visiting arrangements in place that aligned to government guidance.

Inspected but not rated

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 our last inspection this key question was rated inadequate. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

At our last inspection the provider had failed to ensure personalised assessments and care plans were in place, and that the service reflected people's preferences. This was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet

● At the last inspection we found people were not always supported with full assessments of their needs. Where people were regularly distressed and anxious, they did not always have behavioural support plans in place. Without behavioural care plans, staff did not always have guidance to follow to avoid people becoming distressed or to help them calm. At this inspection, although behavioural support plans for two people had been completed, and one person's physical intervention plan that guided staff to restrain this person if needed had been reviewed, these documents were not available to provide guidance to staff. The registered manager told us that this was due to them being sent to other professionals for review. The registered manager advised that they would make these documents available to staff immediately.

● Most care plans had been reviewed since the last inspection. The care plans viewed were personalised and reflected people's needs. Further work was needed to ensure they reflected people's goals, aspirations and achievements. Aims and achievements are now included within the monthly support plan review, although they are not detailed within the care plan.

The provider had failed to ensure personalised assessments and care plans were in place. This was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During this inspection, although further work was needed, we found improvements had been made to ensure the service reflected people's preference's. People were involved in their choices and decisions regarding their care, including shopping, choosing and preparing some of their meals.

At our last inspection the provider had failed to support people to understand their care and treatment choices and participate in decision making regarding this. This formed part of a breach of the requirements of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement has been made at this inspection and the provider was no longer in breach of this part of regulation 9.

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

- At the last inspection we found there were no health action plans in place to identify and support people to work towards goals to be healthier or stay healthy. The registered manager advised that health action plans were currently being undertaken with relevant health care professionals.
- At the last inspection the provider had failed to support people to understand their care and treatment choices and participate in decision making regarding this. A health care professional advised that best interest decisions have been made by the GP in respect of both cervical and breast cancer screening.

At our last inspection the provider had failed to manage risks to people's health and safety. This formed part of a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement has been made at this inspection and the provider was no longer in breach of this part of regulation 12.

- At the last inspection people were not always referred to health care professionals to support their wellbeing and manage risks. Improvements had been made and health care professionals were now involved.

Inspected but not rated

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 our last inspection this key question was rated inadequate. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

At our last inspection the provider had failed to support people to participate in decision making about their care and support. This forms part of a breach of the requirements of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement has been made at this inspection and the provider was no longer in breach of this part of regulation 9.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

- At our last inspection people were not always supported to express their views, make choices and were not always involved in decisions which affected them. During this inspection we found improvements had been made and people were being supported to make decisions about their care and support.
- The provider had a system for seeking feedback about the quality of the service from people who used the service.
- At the beginning of each shift a daily plan for care and activities was created by people using individual ways of communicating. For example, pictures, objects and symbols.
- At the last inspection, people's support was not based around promoting independence. During this inspection, although further work was needed, we found improvements had been made and people were now more involved in aspects of everyday living.

Inspected but not rated

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection this key question was rated inadequate. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

At our last inspection there was a lack of personalised support. This was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement has been made at this inspection and the provider was no longer in breach of this part of regulation 9.

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

- At the last inspection reviews of care plans had not been implemented effectively. During this inspection we found that most care plans had been reviewed, although one person's care plan that was yet to be reviewed still contained inaccurate information. For example, this care plan stated that their fluid intake should be reduced after 6pm, although the registered manager told us at the last inspection that this was not correct.
- At the last inspection people were not receiving personalised care and support to meet their needs and the routines and practices in the home were not always personalised to individual people. We saw that mealtimes were structured by staff and everyone used plastic bowls due to the needs of one person. During this inspection, although further work was needed, we found improvements had been made and the routines and practices within the home were individualised to people.
- At the last inspection we found care plans focussed on people's needs rather than their strengths and abilities. There was no information about people's goals or aspirations. The care plans viewed during this inspection were personalised and reflected people's needs. Further work was needed to ensure they reflected people's goals, aspirations and achievements.
- At the last inspection we found people's needs and preferences to avoid social isolation were not being met. During this inspection, although further work was needed, we found improvements had been made. Group activities within the home had reduced and individual activities within the community had increased.

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
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure personalised assessments and care plans were in place. This was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess, monitor and manage risks to service users' health and safety and provide safe care and treatment. This was a continued breach of regulation 12 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.