UK Healthcare Group Limited

Forge House Services Limited

Inspection report

Forge House
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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
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.

People lived in a service impacted by the death of a long-standing member of the management team. People and staff were being supported with this.

Based on our review of the key questions safe, effective, caring, responsive and well led. The service was not able to demonstrate they were fully meeting the underpinning principles of Right support, right care, right culture.

Right Support:
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.
Where people lacked capacity to make decisions, the provider failed to put in place documents to support decision making. Not all restrictions were considered when looking at the least restrictive options for individual people. Some internal doors were kept locked to all people without considering how the risks for each individual person could be safely supported.

People did not have outcome focused support plans. People were not supported to agree plans with clear steps that would support them to develop skills and interests or support their sensory needs to enable people to cope with their environment.

People were not always enabled to access specialist health and social care support where appropriate. Staff did not always support people to lead decisions about their own health.

Risk management was poor. A lack of support plans and assessments in place meant people's needs were not identified, assessed or managed effectively. Staff were not provided with enough clear guidance to support people safely. A failure to monitor incidents meant there were missed opportunities to avoid and reduce reoccurrence.

Right Care:
Care was not always person-centred or designed to promote people's dignity, privacy and human rights.

People's care and support plans did not reflect people's individual needs and aspirations. People's strengths, levels of independence and quality of life was not always accounted for when planning and reviewing their care, and people were not involved in this process. People's care and support did not consistently focus on their quality of life or follow best practice.

People were not provided with opportunities to try new activities tailored to them that enhanced and enriched their lives. We observed people participated in group activities facilitated within the home rather than pursuing their own individual interests or seeking opportunities for volunteering or employment.

People were not always protected by a service that had safeguarding systems in place to report and respond to accidents and incidents. We found instances where safeguarding concerns had not been reported to CQC, or local safeguarding authorities. Leadership was not effective and did not identify that people were put at risk or subject to potential abuse.

There was a core team of staff who knew people's needs and were kind and caring.

Right Culture:
People did not lead inclusive and empowered lives because the ethos, values, attitudes and behaviours of the management and staff did not promote this. People were supported by staff who did not understand best practice in relation to the wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have. This meant people did not receive empowering care that was tailored to their needs.

There were indicators of a closed culture. There was a failure to identify and mitigate institutionalised practices and risks associated with closed cultures so that people received support based on transparency, respect and inclusivity. A number of restrictive practices were found, and the routines within the home were not always personalised to individual people. The service had not been supported by the provider to ensure they were aware of and implementing current best practice and guidelines.

Staff had not placed people's wishes, needs and rights at the heart of everything they did. There was a lack of information about preferences to support people with these. People were not always involved in planning their care. People were not leading inclusive and empowered lives.

The provider failed to ensure staff received appropriate training and support to understand people's individual needs and provide enabling support to people. The support people received was not in line with current best practice guidelines.

Risk assessments in place were not encouraging positive risk taking for people, were not evaluated and measured at regular intervals to assess their effectiveness.

The provider failed to develop effective governance and quality assurance system to assess the quality and safety of the support people received. There were a lack of audits and actions taken when things went wrong. Actions were not always documented, and it was unclear if actions were completed. This meant improvements were not always made to improve the care people received.

There were minimal internal quality assurance systems and processes to audit or review service

performance and the safety and quality of care. Where checks and audits were carried out, they had not always identified or prevented issues occurring or continuing at the service. Where issues had been identified, the registered manager and provider had not always ensured actions were taken to maintain, or improve the quality and safety of the support being delivered at 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 good (Published 19 May 2018).

Why we inspected
We carried out an unannounced targeted inspection of this service on 26 May 2022 where we identified some improvements could be made to person centred care and how people are supported to make choices. We discussed this with the registered manager who gave assurances they were committed to making improvements for people. We undertook this inspection to review improvements following this.

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 the service can respond to COVID-19 and other infection outbreaks effectively.

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 found evidence that the provider needs to make improvements. Breaches of legal requirements were found in relation to providing safe care to people, premises, recruitment, staff training, person centred care, safeguarding, consent to care, dignity and respect and good governance.

Please see the action we have told the provider to take at the end of this report. 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 meet with the provider and request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the local authority and provider 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

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.

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
Two inspectors and an Expert by Experience carried out the inspection: 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
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 looked at all the information we had received about and from the home. 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.

During the inspection
Two Inspectors visited Forge House on 23 August 2022 and 8 September 2022. We spoke with and communicated with seven 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 14 members of staff including the registered manager and nominated individual.

We reviewed a range of records. This included six people's care records and a variety of records relating to the management of the service, including policies and procedures were reviewed.

An Expert by Experience spoke with seven relatives about their experience of the care provided.

We also sought feedback from professionals involved in the service.

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

Inadequate

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 we rated this key question good. At this inspection the rating has changed 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

- The provider did not have effective systems and processes in place to safeguard people from the risk of abuse.
- We were not assured that all incidents, which should be reviewed under safeguarding guidance, were being identified by the registered manager. This was because the system to review and monitor incidents was not effective.
- Safeguarding incidents were not always reported to the local authority. We saw records where a person had choked due to staff not following their choking risk assessment. Although this had been reported to the registered manager, and a review by a speech and language therapist requested, no further investigation had taken place to understand why the incident had happened. Another person had an unexplained bruise. This was reported as an incident but there was no investigation in to how it occurred, and it was not reported to the local safeguarding authority. Other incidents where people physically hurt others were also not reported. This lack of reporting, and investigation meant people were at risk of recurring harm.
- Some people in the home could harm themselves or others when they were distressed. Staff were not trained to use physical interventions, using the safest and least restrictive methods, as outlined in people's support plans. This meant the provider failed to ensure staff knew how to safely support people.
- Inconsistent support was being provided that was not in line with behaviour support plans. This included staff using restraint that was not in line with a person's physical intervention plan.
- In February 2022 an 'Incident Requiring Physical Intervention Reporting Form' had been completed. A person had been restrained and their physical intervention plan not followed. The manager's part of the form was not completed or signed, and there was no evidence the incident had been reviewed.
- Not all staff had been provided with safeguarding training, although staff spoken with understood their responsibility to report abuse and neglect and felt confident to do this.

The provider had failed to ensure systems were in place to ensure people were protected from abuse and neglect. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- After the inspection, we contacted the local authority and informed them about our concerns. A safeguarding investigation has been opened.
- Staff had policy guidance on safeguarding and whistleblowing. Staff told us they were aware of these policies. The safeguarding policy was viewed and had been reviewed by the registered manager in August 2022.
- Following the inspection, the registered manager confirmed that Prevention Management of Violence and

Aggression (PMVA) training has been booked for all staff to attend.
● Most relatives spoken with raised no concerns in relation to safety. Comments included, "They keep a good eye on [relative] and eye on [relative] in the night. No concerns about safety". One person spoken with told us they felt safe.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● 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. Two people who showed they were distressed or agitated did not have a behavioural support plan. This meant the provider failed to understand what the person's behaviour was communicating, or to provide clear guidance to staff.
● One person's physical intervention plan guided staff to restrain this person if needed. However, there was no clear guidance on how to restrain the person safely, which may have caused injury to the staff member or the person. Not all staff had received training in how to complete this restraint safely. This person was at risk of harm and unlawful restraint because some staff had not received the specialist training they required.
● Risk assessments were not in place for all identified risks to people. For example, a person's care plan detailed their physical disability could cause them to fall when they were walking. The registered manager told us there was no risk assessment in place regarding this person using the stairs, to establish how high the risk was for the person and what actions staff needed to take when supporting them.
● During the inspection risk assessments were not followed. For example, one person's choking risk assessment stated a staff member needed to be sat with the person during mealtimes encouraging the person to eat at a reasonable speed. During the inspection, it was observed that whilst this person was eating, the staff member was sat writing notes and not supporting the person. The registered manager was informed of this.
● Risks associated with fire and evacuation had not been properly assessed or mitigated. The exit doors to the back garden had no door handles on the outside. This meant staff could be unable to re-enter the property during an evacuation, should the doors close. One person's evacuation plan did not reflect their mobility needs on the stairs. This placed them at risk in the event of an emergency where evacuation was needed.
● Records of incidents and accidents were recorded, although the system to review and investigate safety incidents, and act to prevent them re-occurring was not effective. There had been a high number of incidents when people hurt themselves or others when they were distressed. Although the registered manager advised these incidents were reviewed, there was no recorded system in place to look for trends, identify any learning, and reduce the risk of an incident happening again. Incidents were also not always reported to other outside agencies, to help decide actions that could prevent these incidents happening in the future.
● When incidents had occurred, action was not always taken to reduce the risk. One person had a near miss choking on some food. The registered manager's part of the incident form was not completed or signed, and reviews of the persons care plan and risk assessment had not been completed.
● There was no lessons learnt process in place for incidents or accidents to be discussed with staff or discussions with staff about improving the support people received.

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

● After the inspection, we contacted the local fire and rescue service and informed them about our concerns in relation to fire safety.
● Although a fire drill had not been completed, the provider did ensure that health and safety checks in the

home and fire safety had been reviewed. Maintenance records showed checks were completed by the in house maintenance person and external professionals.
● Comments from relatives included, "They help [relative] down the stairs, there were plans to put in a lift, [relative] has a new wheelchair, [relative] bedroom is on the first floor. Safety well looked after" and "He wanders around the home on his own, safe environment."

Staffing and recruitment
● People could not be confident that staff were safely recruited. Staff files did not give evidence that safe recruitment practices had been followed. Services are required to seek a full employment history, together with a satisfactory written explanation of any gaps in employment for staff. We looked at two staff files neither of which contained a full employment history including details of any gaps in employment.
● The provider did not have effective processes in place to ensure staff were assessed for their suitability to work with vulnerable adults. One staff file detailed that the staff member had previously been dismissed from their role within health and social care. No reference had been obtained from this employer and the registered manager was not aware of the reasons for this dismissal.

The provider had failed to ensure recruitment practices were safe. We found no evidence that people had been harmed however, this was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw there were enough staff to support people safely. Staff told us there were usually enough staff. However, last minute absence could impact staffing levels. We reviewed staff rotas and saw last minute absences were rare.
● Relatives told us there were enough staff to meet the needs of their relatives. Comments included, "There are usually quite a few staff" and "I visit every three months, always plenty of staff when I visit."

Preventing and controlling infection
● We were not assured that the provider's infection prevention and control policy was up to date. The infection control policy viewed contained no detail in relation to the current pandemic. A separate COVID-19 policy was viewed. This did not contain the most up to date government guidance.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the home. Some areas in the home were not clean, for example a step in the communal bathroom downstairs was covered in grime and the handrails next to the toilet were rusty and could not be cleaned effectively. This was pointed out to the registered manager on the first day of the inspection and was found to still be the same on the second day of the inspection. This presented an infection control risk.
● We were not assured that the provider was supporting people living at the service to minimise the spread of infection. The registered manager told us that an infection control audit had not been completed.
● During our inspection the local authority Environmental Health Officer (EHO) visited the home for an inspection. The registered manager shared the findings with us. This included areas for improvement around hygiene including handwashing, food storage and policies needing updating.
● Seven staff had not received infection control training to ensure the safety of people.
● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed. This was due to areas of the home not being clean.
● We were somewhat assured that the provider was preventing visitors from catching and spreading infections and responding effectively to risks and signs of infection. This was due to the provider's infection prevention and control policy not being up to date.

The provider had failed to ensure infection control practices were safe. We found no evidence that people

had been harmed however, this was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection, the management team were responsive and started to address the issues identified by the EHO.
● We were assured that the provider was using PPE effectively and safely.

Using medicines safely
● People were supported by staff who followed systems and processes to prescribe, administer, record and store medicines safely. Senior staff administered medicines who had received training to carry out the task. It was not clear their competency had been regularly monitored to ensure they maintained safe practice.
● We looked at a sample of medicines administration records and found they were signed when administered or refused. Staff kept a running total of medicines administered each day. This enabled the effectiveness of prescribed medicines to be monitored.
● There were suitable storage facilities for medicines. Medicines were stored safely and at the correct temperature.
● Medicines with additional controls due to their potential for misuse were stored in accordance with current regulations. We checked records against stock and found all but one was correct. We were assured these medicines had been returned to the pharmacist and some had been administered as prescribed. We discussed with the registered manager that they regularly audited medicines, but they had not identified that the register did not accurately reflect the secure medicines they had at the service.
● Some people were prescribed medicines on an 'as and when required' basis, for example for pain management. The service had protocols which provided staff with information about when these medicines should be given.

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.

Our last inspection of this service was a targeted inspection. We identified some improvements could be made within this key question, which we followed up at this inspection. Targeted inspections 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

At our last rated inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

- 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.
- People's care and support plans were not personalised, holistic, strengths-based and did not reflect their needs, preferences, aspirations and achievements. This was acknowledged by the registered manager during the inspection.
- People were not supported to identify what they wanted to achieve. There was no evidence of examples where people were supported to achieve goals, develop their knowledge and maintain and acquire new skills.
- At a targeted inspection on 26 May 2022 there was a three-week rolling menu, but people had not been involved in choosing meals or shopping. During this inspection a staff member was observed preparing the meal within the kitchen and brought this out to people on a trolley. Staff told us they were responsible to cook and provide meals for people, and that people are not involved in preparing and cooking their own meals and drinks. Staff told us that although people now have a choice of breakfast and supper the menu is devised by staff in line with individual's SALT (speech and language therapist safe swallow) assessment. The registered manager told us that menu choices are going to be put in place. At the time of the inspection this was still in the process of being changed. The registered manager told us that a chef is currently being employed who will complete the weekly menu with people.

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.

- The registered manager told us they planned to re-write all care plans within the next month.

● Despite our findings, most relatives spoken with were happy with the care their loved ones received. Comments included, "Fully satisfied, [relatives] the longest serving resident, settled quite well, [relatives] been there [number of years]. Feel it's [relatives] home, [relatives] very happy there", "I'm very happy with the care [relative] receives, been there [number of years]. Couldn't be in a better place" and "[relatives] happy, we're happy [relatives] happy, no reason to be concerned."
● People had individual food and drink sections within their care plans.
● One person told us the food was good, and that they choose to have a takeaway every Friday.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● There were no health action plans in place to identify and support people to work towards goals to be healthier or stay healthy.

The provider had failed to support people to understand their care and treatment choices and participate in decision making regarding this. 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.

● People were not always referred to health care professionals to support their wellbeing and manage risks. One person's records showed an increase in distress. The registered manager told us that no referral to health care professionals to review and identify any reasoning for this was made.

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

● The registered manager completed a weekly virtual 'ward round' with a nurse practitioner from the GP surgery. This meant people were receiving input with their physical health from a professional who knew them.
● Relatives told us people had access to their GP. Comments included, "they take [relative] to the doctors or hospital if [relative] gets trouble" and " They phoned me a few days ago to tell me [relative's] been to the doctor about [relative's] skin, they make sure [relative] sees the GP."

Staff support: induction, training, skills and experience
● The provider failed to ensure staff received training relevant to their roles. We reviewed the current staff training matrix. We found staff had not always undertaken the provider's mandatory or refresher training. At the time of the inspection some staff were working without the necessary training. This included eight staff members who had not received training on safeguarding vulnerable adults, 11 staff members who had not received training on moving and handling people, 10 staff members who had not received training on fire awareness and five staff members who had not received training on health and safety.
● Staff had not received the training they needed to support people effectively. People at the service lived with learning disability and autism. Not all staff had received learning disability and autism training. One person's behaviour support plan stated this person needed support with a sensory diet. Staff had also not received training in this, and some staff spoken with did not know what this was.
● Staff had not received training to understand the principles of Right Support, Right Care, Right Culture guidance. As a result, the staff team were not supporting people consistently and effectively to help people achieve positive outcomes, learn new skills and plan for the life they wanted to live.
● We found staff who delivered care did not have the understanding or knowledge of restrictive practices. We found restrictive practices were used by staff meaning people who had a learning disability did not have their human rights supported or respected. Issues identified during inspection demonstrated staff lacked

knowledge in regards of understanding risk management, behaviour management and communication leading to people being at risk.
● Not all staff had received training in how to remove themselves from a situation safely if they were at risk from a person's behaviour. One person's physical intervention plan stated for staff to restrain a person if needed. Not all staff had received training on how to hold a person safely. Not training staff on how to hold a person safely risks both staff, and the person sustaining an injury. We spoke to this person during the inspection, who could not recall being restrained, although records viewed during the inspection clearly detail an incident which resulted in restraint.
● Staff told us that they received induction training when they started working for the service. This included completing shadow shifts, being assigned a mentor, reading policies, paperwork and care plans, but did not include completing any formal training. The training matrix viewed showed that some staff, whose employment started within the last five months, had not completed any formal training in areas such as safeguarding, Mental Capacity Act and infection control.
● Not all staff had received competency checks to ensure the safety of people. This was confirmed by some staff spoken with.

The provider did not ensure that staff received effective and sufficient training to enable them to carry out their roles. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff had received regular supervision and staff told us that appraisals were booked in with the registered manager.
● Team meetings had restarted following a period of them not taking place.
● Staff were extremely knowledgeable about the people they supported. People freely and comfortably communicated with staff using their preferred method of communication. Interactions were seen that involved trust, and it was evident that meaningful relationships had been formed.

Adapting service, design, decoration to meet people's needs
● The house did not reflect a living environment that valued the people living within in it. The environment appeared neglected. The condition of the home meant the environment was hard to keep clean.
● We found parts of the home in need of redecoration to maintain people's safety and to meet people's needs. For example, the handrails in the downstairs bathroom were rusty.
● One relative told us, "I did query the house looked unkempt, it needed TLC, not obvious at the time they assured they are gradually making improvements. They had water through the ceiling, my son turned the bath on and it came through, took time to clear. Address issue to make home look more kempt."
● Consideration had not been made to people's individual needs. One person living at the service had a sight impairment. The lighting within the lounge was poor which didn't support this person's vision. This was pointed out to the provider during our inspection.

The provider did not ensure the premises was clean and suitable for the intended purpose. This is a breach of Regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's bedrooms were personalised and decorated in a colour and style of their choosing.
● The provider told us they had plans to commence a maintenance programme to ensure the environment was improved and met people's needs.
● Comments from relatives included, "[Relative's name] loves it, feels at home, knows way round as she is blind and staff. If she's happy, I'm happy."

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 MCA 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).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● People were subjected to restrictive practices that were not proportionate or appropriate. Most people were being supported with healthy eating. The decision making leading to this support was not recorded and had not been made in line with the MCA code of practice. Some people had no access to snacks and there were no condiments available to go with people's meals.
● One toilet within the home was locked and had signs on it saying, 'for staff use only'. The registered manager was unclear as to the reason for this. Making unrequired restrictions such as having a locked toilet in people's homes is contrary to the principles of the MCA. This practice also promoted a culture of inequality and did not value people or their home.
● People had some Mental Capacity Assessments and Best interest decisions in place, although not all restrictions had been identified during these assessments. The decisions made did not reflect the least restrictive principle of the MCA, this included bedrails for one person, a seat belt on one person's wheelchair which staff were only able to release due to the mechanism, and the kitchen which was locked to prevent people gaining access without staff. We found assessments had not taken place and there were no individual plans as to how to ensure the only restrictions in place were for the people who required them, and that those restrictions were the least restrictive methods.
● People's consent to care had not been sought appropriately. There was no record that anyone had been asked to consent to their care plan. One person had a physical intervention plan in place that included restraint. It was not clear who had been involved in agreeing this restraint. We were told the person had capacity and had consented to this themselves, although the space for the person's signature on the plan was not completed.
● Not all staff had completed Mental Capacity Act training and staff spoken with were not able to tell us how the MCA impacted their work.

The provider did not ensure that people's human rights were respected, and that appropriate mental capacity assessments and best interest decision making processes were in place. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were being deprived of their liberty without the legal authority. We found the Deprivation of Liberty referrals made did not detail all the restrictions that we found in place.

The provider had failed to ensure systems were in place to ensure people were protected from abuse. This forms part of a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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

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

- People were not always supported to express their views and make choices. At a targeted inspection on 26 May 2022 it was not always clear how everyone was supported to make choices about their day to day lives. During this inspection there was still limited information available.
- At the targeted inspection we found people were not always involved in decisions which affected them. At the beginning of each shift the shift leader created a daily plan for care and activities. However, there was no evidence that people were involved in this plan, so it was based on the staff member's knowledge of the person. During this inspection the registered manager was asked how people were involved in the daily plan and choosing who supports them. We were told that staff initially choose for people. This meant people had to show they were unhappy with a choice rather than have an opportunity to develop positive choice making skills.
- People's support was not based around promoting independence. There was little opportunity for people to try new experiences or achieve steps to independence. Staff lacked guidance of how this could be achieved for people.
- There were no care plans or records of discussions with people about gaining more independence in any aspects of their life. This limited people's opportunities to progress to a more independent life in the future. For example, people had not been supported to consider if they wanted to develop the skills needed to look after their home or to make and maintain friendships.
- The provider had no effective system for seeking feedback about the quality of the service from people who used the service.

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

- At a targeted inspection on 26 May 2022 staff told us they had recently been trialling new activities at the home to see what people enjoyed doing. Although we were told that if people showed an interest then these activities would be individually tailored to them, during this inspection group activities within the home continued. On the first day of the inspection someone visited the home to provide a massage to all people. Staff were heard to ask this person "have you done everyone now".
- Some details recorded in care plans was not always respectful. For example, care plans state, 'I am

anxious and want attention all the time', 'I can present with aggressive and controlling behaviour' and 'I might not want to get out of bed and if I do get out to use commode I will shout and scream until you let me get back in'.

● Some language used by staff in records and in person was child-like and not always respectful or valued people as adults. For example, one care plan states, 'I like playing with my beads', 'I enjoy playing with blocks', 'Consistent boundaries for acceptable behaviour need to be applied' and 'I do not like being told no and I do not like being told not to do something that I want to do.' This demonstrated staff did not value people and view them as equals. The language used promoted a culture of viewing people as children or of the way they expressed themselves as negative.

The provider had failed to ensure people were always treated with dignity and respect. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On the first day of our inspection we found confidential personal information was not stored appropriately when not in use. This was addressed and on our second visit the information had been made secure.

● We observed staff interactions with people which were caring and showed people were treated with kindness and compassion. Staff knew people well and understood their likes, dislikes and preferences.

● Comments from relatives included, "Happy with care in general, like staff I talk to. Very caring I get impression", "I was there a week ago for tea, I observed how they behaved with other residents, they seem to be very professional and good about it all" and "I'm happy they do a difficult job and I'm happy, they do to the best of their ability. No lack of enthusiasm. Care and kindness to everyone. Very pleased with service."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.
Our last inspection of this service was a targeted inspection. We identified some improvements could be made within this key question, which we followed up at this inspection.

At our last rated inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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

- People were not receiving personalised care and support to meet their needs. Staff knew people well and they knew their likes and dislikes, however the support people received was not coordinated, consistent or planned. This meant that people could not achieve positive outcomes, and the routines and practices in the home were not always personalised to individual people.
- There was a care plan format in place. However, reviews of these had not been implemented effectively. People's care plans did not contain accurate information although they had recently been reviewed. For example, one person's care plan stated that their fluid intake should be reduced after 6pm, although the registered manager told us this was not correct.
- The registered manager told us that people were not involved in reviewing their plans together.
- At a targeted inspection on 26 May 2022 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. This meant that people did not always have opportunities to try new challenges or learn new skills. During this inspection care plans still focused on people's needs rather than their strengths and abilities.
- At the targeted inspection we found routines and practices in the home were not always personalised to individual people. For example, we saw that everyone used plastic mugs and bowls at lunch time due to the needs of one person. We discussed this with the registered manager who gave assurances that they were committed to making improvements for people. During this inspection plastic bowls were still used and mealtimes were structured by staff. We observed a person waiting for breakfast before the delegated time and being told it was not breakfast time yet, and a person asking for a cup of tea and was told they hadn't had mid-morning drinks yet.
- People's needs and preferences to avoid social isolation were not being met. When asked if their loved one was supported to spend time in their local community, comments from one relative included, "That never happens, he's taken out for a cup of tea or coffee. He doesn't mix, they take him out to the pub occasionally. He is not sociable. He used to go swimming and horse riding, hope it will start up again after pandemic."

The lack of personalised support was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Relatives told us people were supported to keep in touch with their loved ones. Comments included, "I

don't go to the home he does visit me for two nights every six weeks" and "I ring (relative's name) on Sunday evenings, something for her to look forward to, she's by the phone at 6.30 on Sundays."
● All relatives spoken with fed back staff were responsive to their loved ones needs.
● Most relatives spoken with felt informed. Comments included, "Absolutely as much or as little as I choose", "I do keep in touch with them, they call me if problems, not often. I feel involved" and "Yes if anything with medication I ask if any changes, anything serious they'd be on the phone to me."

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● People had individual communication plans that detailed effective and preferred methods of communication, including the approach to use for different situations.
● Social stories were used to support the people living at the location to understand a unpredicted change in their support team.
● We observed how people communicated with staff and found that staff understood people.
● Comments from relatives, when asked if staff knew how to communicate with their relative in the way they understood included, "Very good all ones I know, especially if been there a long time", "They are very good, understand signs", and "Yes they do very good with [relative], what I've seen they communicate, and (relative's name) understands, they know what [relative] wants."

Improving care quality in response to complaints or concerns
● The service had no formal complaints recorded.
● Relatives we spoke with told us they had no reason to complain as they were happy with the service, although they were aware of how to raise concerns or complaints with the provider if needed.
● One staff member told us they were happy to raise concerns if needed, and one person told us they had no concerns with the service.

End of life care and support
● One person had an end of life plan in place. For others, no plan was in place with limited information recorded to ensure people had had an opportunity to express their wishes. The registered manager told us this would be addressed.
● Staff had not completed training in end of life care to enable them to be prepared to support people if they did need this support in the future.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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

- We found indicators of a closed culture within the service, due to a lack of registered manager and provider oversight. These indicators included lack of involvement from other professionals, lack of specific training, lack of reporting safeguarding incidents, restrictive practices used and poor application or understanding of the Mental Capacity Act (MCA) including not following the MCA and DoLS Codes of Practice.
- The lack of appropriate planning and risk assessing for people's support, the lack of training and mentoring for staff to understand current best practice when supporting people with a learning disability meant people lived restricted lives without opportunities to try new experiences or develop new skills.
- The provider and manager did not keep up to date with national policy to inform improvements to the service. Current best practice guidance was not being followed such as CQC's policy on Right support, right care, right culture.
- The systems in place did not ensure people were safeguarded against discrimination, harm and abuse. Records did not give a clear picture of incidents, triggers, or any analysis of learning to improve the service. Incidents were not reported externally in an open and honest manner when things went wrong.

The provider failed to ensure that systems and processes were operated effectively to ensure a positive culture. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager was eager to improve the service and was responsive to feedback during the inspection. The registered manager recognised that practice at the home needed to change.
- We escalated our inspection findings to the provider, and they responded openly and honestly with us. We were informed that a compliance review had been arranged for the week after the inspection.
- Most relatives told us they were kept informed. Comments included, "They are open and honest and keep people informed", "They phone me and let me know", "Manager's name brilliant manager kept in touch. I like Forge House, any problems they tell you and how they dealt which reassures you", and "they always call me if there are any problems". One relative told us, "They don't volunteer information and ring me, if I phone and ask they tell me things."

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

● Governance processes were ineffective. A lack of oversight at the service and provider level meant the quality and safety of the service had declined. We found no effective monitoring in place, which had resulted in poor care. There was no effective system in place to monitor training, Mental Capacity assessments, Best Interest Decisions, Deprivation of Liberty Safeguards (DoLS) or restrictive practices, accidents and incidents were clearly documented by staff with no clear management oversight and the care plan review process was not effective.
● Although the registered manager told us during the inspection that they had identified areas which required improvement, they had not formed a plan or quality monitoring process to drive improvements.
● We reviewed audits completed by the registered manager and provider. These failed to identify the non-compliance with legal requirements found during the inspection and in some areas the audits were not accurate. For example, the registered managers audit completed in May 2022 stated there was an action plan in place to address areas of concern with the environment. The registered manager was asked for this action plan. They could not provide it and acknowledged there was not one.
● The providers audit completed in May 2022 stated staff are trained in restraint and breakaway, 'consent and MCA/ best interest decision paperwork and planning in evidence across all service users' and 'another good area for an enlightened balance between choice/ lifestyles and wellbeing is in Nutrition & Hydration where treats are not banned, but controlled in smaller quantities which if anything enhances enjoyment. This area of choice and restriction can be dangerous, but there is no evidence of reward/ punishment dynamic but rather an open, sensible balance of physical best outcomes with the reality of people being able to enjoy treats'. All these findings were found to be inaccurate.
● The provider failed to monitor the performance of the management and senior team at Forge House. This was evidenced by the failings we found at the inspection not having been identified prior to our visit. This failure of organisational oversight and governance created additional risks to the safety and effectiveness of service provision.
● After the inspection visits we asked the provider and registered manager for further information related to the running of the service. We did not get all of the information requested.

The provider failed to ensure that systems and processes were operated effectively to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● An unexpected change in the management team had an impact on the service. The whole team were supporting each other during a difficult time.
● The registered manager was eager to improve the service and was responsive to feedback during the inspection. The registered manager recognised that practice at the home needed to change.
● Relatives told us, "(manager's name) does a brilliant job and staff" and "Any suggestions I tell (manager's name) and he incorporates it if he can. Look after (relative's name)very well indeed."

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 had not always submitted notifications about incidents as they are required to do by law.

Failure to notify CQC about incidents as required was a breach of Regulation 18 (2) of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care
● At a targeted inspection on 26 May 2022 we found care plans focussed on people's needs rather than their

strengths and abilities, and it was not always clear how everyone was supported to make choices and be involved in decisions which affected them. During this inspection care plans still focused on people's needs rather than their strengths and abilities and people were still not involved in decisions that affected them.

- The provider completed Quality Assurance Questionnaires in April 2022 requesting feedback on the registered manager and new owners of Forge House from relatives and staff. A professionals quality assurance questionnaire was also completed.
- Staff told us they felt supported in their role.
- Staff told us they enjoyed working at the service. Comments included, "I enjoy helping people", "I am happy caring for people" and "It's a really rewarding job."

Working in partnership with others

- The provider needed to improve professional relationships with outside agencies to improve people's care. We did not find evidence that specialist input had been sought to ensure people received appropriate care and support.

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 18 Registration Regulations 2009 Notifications of other incidents Failure to notify CQC as required was a breach of Regulation 18 (2) of the Care Quality Commission (Registration) Regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure people were always treated with dignity and respect. This was a breach of Regulation 10 (Dignity and respect) 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 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure that people's human rights were respected, and that appropriate mental capacity assessments and best interest decision making processes were in place. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 13 HSCA RA Regulations 2014

personal care	Safeguarding service users from abuse and improper treatment The provider had failed to ensure systems were in place to ensure people were protected from abuse and neglect. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider did not ensure that the premises was clean and suitable for the intended purpose. This is a breach of Regulation 15 (Premises and Equipment) 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 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that systems and processes were operated effectively to ensure a positive culture that was open and honest. The provider failed to ensure that systems and processes were operated effectively to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good Governance) 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 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure recruitment practices were safe.

This was a breach of regulation 19 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 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that staff received effective and sufficient training to enable them to carry out their roles. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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
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, and that the service reflected people's preferences. The provider had failed to support people to understand their care and treatment choices and participate in decision making regarding this. The provider had failed to support people to participate in decision making about their care and support. This was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a warning notice. The provider must be compliant by 27 November 2022.

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. The provider had failed to ensure infection control practices were safe. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We served a warning notice. The provider must be compliant by 27 November 2022.