Forest Homecare Limited

Forest Homecare Suffolk

Inspection report

Unit 22 South Suffolk Business Centre
Alexandra Road
Sudbury
Suffolk
CO10 2XH

Tel: 01787463222

Date of inspection visit:
14 March 2023
22 March 2023

Date of publication:
23 May 2023

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

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.

About the service
Forest Homecare Suffolk is a domiciliary care agency providing care to people in their own homes.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of the inspection there were 39 people receiving personal care and support from the service.

People's experience of using this service and what we found
The provider could not demonstrate how the service met the principles of right support, right care, right culture. This meant we could not be assured of the involvement of people who used the service in their care and support. Initially the provider told us they did not support any people who lacked capacity, had a learning disability or who were autistic. However, we identified that there were people being supported by the provider who had a learning disability.

Right Support
We found guidance within people's care plans for staff members to follow when supporting autistic people or people with a learning disability were not sufficient. Care plans and risk assessments did not provide staff with information on how to promote their independence.

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. Staff training in record keeping needed to be improved in relation of the use of the Mental Capacity Act 2005 (MCA).

The service did not plan for any staff travel time between care calls and care calls were frequently shortened to enable staff to be on time for the following person's care.

Right Care
People's care and support plans did not always reflect their range of needs or promote their wellbeing and independence. This meant they did not provide detail on the specific actions staff should take to ensure practices were least restrictive to the person and reflective of a person's best interests.

Right Culture
People were not empowered to influence the care and support they received.

The provider did not have adequate knowledge of the 'Right Support, Right Care, Right Culture' guidance. In addition, in July 2022 the Health and Care Act 2022 introduced a requirement that regulated service providers ensure their staff receive training on learning disability and autism which is appropriate to the person's role. The Oliver McGowan Mandatory Training on Learning Disability and Autism is the standardised training that was developed for this purpose and is the government's preferred and recommended training for health and social care staff to undertake. The provider had not heard about this training and staff working for Forest Homecare Suffolk had not undertaken it.

Quality and safety monitoring systems were not robust. There was a lack of governance processes and systems to help ensure the safe running of the service. This meant the provider could not be proactive in identifying issues and concerns in a timely way.

The provider was not able to demonstrate how they would meet the underpinning principles of Right Support, Right Care, Right Culture'. We signposted the provider to relevant information.

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 8 August 2019).

The overall rating for the service has changed from good to inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this report.

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

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We also received concerns in relation to the management of medicines and the leadership of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, staffing and governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Forest Homecare Suffolk

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.

Inspection team
This inspection was carried out by an inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

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

Notice of inspection
This inspection was unannounced.

Inspection activity started on 14 March 2023 and ended on 22 March 2023. We visited the location's office on 14 March 2023.

What we did before the inspection
We reviewed our systems and information we held about the service. We used the information the provider

sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We took this into account when we inspected the service and made judgements in this report.

During the inspection
We spoke with 8 people who used the service and 7 relatives about their experience of the care provided. We also had contact with 15 members of staff including care staff, office staff, review staff, the head of operations and the registered manager. We reviewed a range of records. This included 4 people's care plans and a variety of other records relating to the management of the service were also considered as part of the inspection.

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.

Assessing risk, safety monitoring and management

- Although people and relatives told us they felt safe with the care provided, we identified people were not always protected from potential harm. Risks to people's health and wellbeing were not always effectively identified, assessed, or mitigated.
- The provider had completed risk assessments as part of people's care and support. However, there were inconsistencies in the detail in risk assessments. For example, a risk assessment for one person, stated there was no issue with their skin integrity. This was despite them using three topical creams for their skin. The risk assessment and care plan therefore did not provide guidance to staff on how the risk was to be managed. This meant they were at risk of pressure ulcer and infection.
- For another person, there was no detail about how to manage the risk associated with their mental health or low mood. This placed them at risk of harm if staff did not have an appropriate plan of care to follow to meet the person's needs.
- The provider told us they would correct these inconsistencies. Whilst we did not identify that people had been harmed, these shortfalls put people at risk of harm.

Risk was not always assessed or managed to ensure support and care was delivered in a safe way. This put people at risk of harm. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Staffing and recruitment

- Of the people and relatives that we spoke with, half described inconsistencies in care, either receiving late care calls or calls from staff they were not familiar with. One person commented to us, "It's been a bit erratic over the last week. The timings are all over the place. They are usually late, it's happening a lot recently, I think they are short staffed." Another person said, "They are never punctual. Their timings are all over the place." A relative told us, "No they don't arrive punctually. They come when they have got time. It's dreadful. Sometimes they turn up at 10.15 for the breakfast call and then at 12 for lunch. It's just dreadful."
- Travel time was not routinely built into the care staff working hours. We viewed records of care calls for January and February 2023 and found that 78.1% of calls (5555 of care calls in total) had no travel time built in. In addition, many people and relatives told us that their care calls were often cut short. We found that 14% of people had less than half of the planned duration delivered. We also found that around 3000 care calls, during January and February 2023, had a significantly lower duration than planned.
- Systems in place, to monitor time keeping, ensure staff attended calls on time and stayed for the duration of the call, were not effective. One person said about the staff, "They do not stay for the full half hour. They are so busy and got to get to the next person." Another person's relative commented, "We think they only stay 10 minutes. They don't stay the full time. [Family member] may say they can leave, but I think they

should stop the full time."
● Many staff also told us that the lack of travel time between people's care calls placed them under pressure. One staff member said, "When they [provider] add calls on that are at the other end of town, or in another town it can get stressful trying to get there on time. If we hit traffic, we have a risk of running late, and then the [people] [are unhappy] at us for being late." Another member of staff told us, "I feel the notion of being paid for a [care] visit only, and not the travel time to get there, is not conducive to a fair working condition. With a finish time of one visit, and the start of the next visit at the same time, it is not 'manageable'. Some [people] live close to each other while others take over 15 minutes to get to. This accumulates during the day and results in hours working for nothing."
● Some staff told us they were often late arriving for people's calls. They said this was because rotas did not include adequate time for the distances they had to travel between visits.

There were not sufficient processes in place to ensure sufficient staff were available to meet people's assessed needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

● Records showed that relevant pre-employment checks, such as criminal record checks, references and proof of identity had been carried out. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. This ensured staff were suitable to provide safe care to people.

Using medicines safely
● Medicines were not managed safely. Good practice guidance was not followed, and effective systems were not in place to ensure medicines were given as prescribed and accurate records were made.
● We received feedback from people and their relatives that they were concerned about the safe management of medicines. One person's relative told us, "This is my biggest bugbear…There are always tablets remaining that [family member] hasn't had. I've found tablets on the floor. A whole packet of tablets as well."
● There were no recent management audits which would identify medicines errors and ensure people had received their medicines as prescribed. This posed a risk to people because the registered manager did not have the oversight needed to be able to pick up on potential medicines errors.
● People who required topical medicines did not consistently have a MARs or there was no information about where that topical preparation was to be used.
● When medicines were prescribed to be given "when required" or with a choice of dose there was limited or no information for staff to follow which meant they may not be given safely.

Medicines were not being managed safely to ensure people received their medicines in a safe way. This put people at the risk of harm. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Staff had received training on how to safeguard people from the risk of abuse.
● Staff understood their responsibilities in regard to reporting incidents however, not all staff were clear on their responsibilities to escalate any concerns to other external agencies for further investigation if needed.

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.

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

● Staff told us they were not supporting anyone who lacked the mental capacity to make their own decisions. At the time of the inspection there were no authorised court of protection orders in place.
● We were not made aware of any concerns during this inspection about people not having their consent to care sought.

Preventing and controlling infection
● Before our inspection we were made aware of a third-party concern about care staff use of personal protective equipment (PPE) The concern alleged staff were not following infection control best practice and wearing PPE. The provider told us that they had reviewed this concern and had re-visited infection control training with care staff to ensure they understood the expectations.
●The provider supplied staff with personal protective equipment (PPE), such as masks, gloves, and aprons so they could support people safely.
● People told us this equipment was used during their care. One person said, "They [care staff] all wear their PPE, and they change their gloves." Another person's relative told us, "They [care staff] always have a mask on, and gloves and an apron."

Learning lessons when things go wrong
● The provider had a system in place for recording and responding to incidents and accidents and there were none recorded since our last inspection.
● The provider was not able to demonstrate how they monitored or managed missed, late and shortened care calls. There was no system in place to enable this, or for any analysis to be undertaken to make improvements.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks, and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive, and empowering, which achieves good outcomes for people; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There was a lack of provider systems and processes for identifying, monitoring, and mitigating risk. The service was managed locally up until October 2022 but when this person left, a replacement manager had not been introduced. Instead, the service was being overseen by a 'head of operations'. The majority of feedback we received was that this was not an effective management arrangement.
- The registered manager did not have enough oversight of the service. They did not maintain a presence at the service or undertake any management audits. Many people who used the service and their relatives and care staff told us they were not aware of who the registered manager was. One person told us, "I can contact the office easily and can talk to all the office staff. They are all nice. I'm not sure who the manager is, it might be [care co-ordinator]."
- Many staff also told us they had either met the registered manager very infrequently or were unaware of who they were. A member of staff said, "I believe [name] in is the registered manager but I had to research that information. No, I have never seen them. At the Sudbury office, the office manager left at the end of last year and I have not seen the replacement, who I believe works at the [provider's] office. I have spoken to them on the phone once, but it was not a supportive call." Another member of staff commented, "The registered manager is [name] and nope I have never had the pleasure of meeting [registered manager] I have been with the company for [a number of] years."
- The provider's electronic call monitoring system (ECM) was not always used effectively because care calls were not planned safely and travel time between care calls was not included.
- The provider had failed to establish effective quality assurance and governance systems that identified areas of risk and improvement needed within the service.
- No specific management audits were completed. Instead, localised 'care audits' were completed by office-based review staff. These 'care audits' lacked detail and failed to identify the concerns found at this inspection.
- People's care records did not always include clear guidelines for staff in how to manage risks to their care.
- We raised with the provider that people's care records did not always contain respectful and dignified language and that their monitoring systems had failed to independently identify and addressed this.
- There was a call monitoring system which confirmed staff arrival and recorded when they left however, this was not used by the provider to enable effective monitoring to take place. We undertook call analysis and found that 28% of calls were short and staff delivered less than half the time planned.

● People were not safely supported with their medicines and were placed at risk of harm as a result.
● The provider had developed systems for people to give their feedback about the quality of the service. However, we received mixed comments about the service requesting feedback from them. One person told us, "They used to ask me about my care and any other queries, but it's not happened recently." Another person said, "I've not had any questionnaires or anything like that. I've not had a review, I've always had the same care package, but I would tell them if it needed changing." Another relative commented, "We've not had any surveys. They don't listen. Communication isn't as good as it should be." A third relative said, "We got a questionnaire after a year to ask if we are happy. I said not. I'm still not happy. So, it's pointless."
● The registered manager did not fully act on or understand their responsibility to show clear leadership of the service. The management systems did not provide an overall insight into the quality of care, service delivery. There was a failure to understand and implement the 'Right Support, Right Care, Right Culture' guidance.

Due to poor governance and oversight of the service people were placed at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite their views about being asked for feedback, half of the people and their relatives, that we spoke with, told us they were happy with the service they received and that they would recommend it. One person told us, "It's a top service, they are very nice."

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 management team demonstrated their understanding of duty of candour. They told us of actions that had been taken as a result of a recent concern raised by a third party.
● We were not assured, however, that the registered manager was fully aware of exactly what was considered a CQC notifiable incident or event.

Working in partnership with others
● The service worked in partnership with other agencies including health and social care professionals, however, some external stakeholders reported challenges obtaining information in a timely manner from the provider.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to effectively assess monitor and mitigate risks for people using the service.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person was not always effectively operating systems and processes to assess, monitor and improve the quality and safety of the services provided in carrying on the regulated activity.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Effective staffing systems were not in place to ensure people received safe, good quality care for the expected duration.