Fox Elms Care Limited

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Inspection report

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16 June 2022

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Ratings

Overall rating for this service	Requires Improvement

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

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
Fox Elms Care Ltd is a domiciliary care service providing personal care to those with a learning disability or complex needs in their own homes or a supported living setting.

People's experience of using this service and what we found
The service was partially able to demonstrate how they were meeting the underpinning principles of 'Right support, right care, right culture'.

Right Support
People had a choice about their living environment and were able to personalise their rooms. People could access specialist health and social care support in the community. The provider was working to improve and develop the relationships with healthcare professionals and the local authority.

Right Care
The service did not always ensure that risks faced by people in relation to medicines, epilepsy and infection control had been consistently identified, assessed and planned for. The provider was working to ensure the records relating to the management of people's care were up-to-date and reflective of their needs.

Right Culture
The provider had not had consistent oversight of the service since our last inspection. There had been a delay in implementing an effective quality assurance system which meant that records were inconsistent and the culture at the service was not always positive. Prior to our inspection a new senior management team had implemented a service improvement plan. They had made considerable progress, although more time was needed to fully implement and embed the necessary improvements.

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

Why we inspected
This inspection was prompted in part by the provider's notification to CQC of a significant event. The information shared with CQC about the incident indicated potential concerns about safe care and treatment. We also undertook this inspection to assess that the service is applying the principles of Right support right care right culture.

Enforcement and Recommendations
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 breach in relation to Regulation 17 (Good governance).

We have made a recommendation about the management of some medicines.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Fox Elms Care 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.

Inspection team
Two Inspectors, a member of the CQC medicines team 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
Fox Elms Care Limited provides personal care to people with a learning disability, mental health diagnosis or acquired brain injury living in their own homes or in supported living accommodation. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was due to be leaving the service and deregistering. The provider had identified a new manager who intended to register with the Care Quality Commission. The provider had scheduled for a handover period between the new and existing manager to ensure a handover of information was prioritised.

Notice of inspection
This inspection was announced. We gave the service 72 hours' notice of the inspection. This was to ensure that people and staff would be available during the inspection and to ensure people's relatives could agree to be contacted by the inspector by telephone as part of our inspection. Inspection activity started on 13 June 2022 and ended on 16 June 2022. We visited the location's office on 13 and 15 June 2022.

What we did before 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. We used the information the provider sent us in the provider information return (PIR) in July 2021. 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. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We communicated with seven people who used the service and 11 relatives about their experience of the care provided. People who used the service, who were unable to talk with us, used different ways of communicating including using Makaton, pictures, objects and their body language.

We spoke with 23 members of staff including care staff, Field Support Workers, Service Optimisation Managers, the deputy manager, Registered Manager and the Acting Operations Director.

We reviewed a range of records. This included four people's care records and a sample of medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at policies and procedures, training information and quality assurance records. We gathered feedback from nine professionals who regularly visit the service.

Requires Improvement

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risk assessments were in place for people depending on their support needs. However, risk assessments varied in detail from setting to setting, with some giving very detailed guidance about how to reduce risks, and others with less information and guidance. The provider told us they were working to ensure all documentation contained the necessary detail.
- Staff used recognised risk assessment tools to manage risk and ensure people's safety was consistent with national guidance and best practice. People with swallowing difficulties were offered food in accordance with the International Dysphagia Diet Standardisation Initiative (IDDSI) Framework. This framework provides a common terminology to describe food textures and drink thickness to improve the safety of people with swallowing difficulties. On inspection we saw food and drinks were being prepared safely, but no consideration had been given to the presentation of the food. The provider was now working to ensure blended food was more appetising.
- People who have a diagnosis of epilepsy did not always have clear guidelines and protocols for staff to follow to support them safely. We told management of our concerns in relation to two people, and they took immediate steps to ensure staff had the correct guidance in place.
- We saw examples of medicines care plans for people with specific conditions were detailed and up to date. However, we could not be assured that other medicines information in care records was always up to date or readily available when needed. This meant that staff may not know how to support people appropriately with their medicines.
- Where medicines were given covertly (disguised in food or drink), we could not be assured staff always sought appropriate advice. For example, for one person we could not see the record to support the decision to give medicine covertly. This meant that people's medicines may not always be given in a safe way as some food and drink may affect the medicine. The provider told us they always sought advice from relevant healthcare professionals when giving medicines covertly and would ensure the record was always available to demonstrate this.

We found no evidence that people had been harmed however, records relating to people's care were not always comprehensive and up-to-date. This placed people at risk of harm. This was a breach of regulation 17(2)(c) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Staffing and recruitment
● Recruitment and retention for staff had been difficult, and people had not always received correct staffing levels or expertise from staff who knew them well. The provider had identified this ahead of the inspection and now had measures in place to ensure sufficient staff were deployed to maintain people's safety and mitigate the risks associated with COVID-19 related staff pressures. A service optimisation manager told us, "We are now looking at implementing a system where we can streamline and match staff to people to prevent staff working with people who they are not trained or skilled to work with."
● Relatives told us they were concerned about the high turnover of staff and management at the service. One relative said, "[The Provider] is like a ship without a captain, as communication's non-existent…I just get to know staff, and they're gone." One person said, "Sometimes it can be difficult to remember names as we have lots of new staff."
● Staff were recruited safely. The provider undertook checks before new staff worked with people. These included obtaining references and undertaking Disclosure and Barring Service (DBS) checks. DBS provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely
● Medicines at one location were not stored securely. Actions were taken during the inspection to rectify this.

We recommend storage of medicines is now reviewed across all locations to ensure it is compliant with good practice guidance

● Staff provided people with information about their medicines in a way they could understand. However, we could not be assured staff always assessed people to determine the level of support required to take their medicines safely in accordance with the medicines policy. This included when assessing the risks associated with people administering their own medicines.
● People were supported by trained staff who followed systems and processes to administer and record medicines.
● The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both).
● People could take their medicines in private when appropriate and safe.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were somewhat assured that the provider was using PPE effectively and safely. Staff did not

consistently wear PPE in line with the guidance and providers policy. The provider was aware of this and evidenced they were working with staff to improve awareness and compliance.
● We were somewhat assured that the provider was accessing testing for people using the service and staff. The routine testing scheme for staff had been recorded inconsistently. The provider was aware of this and was working to ensure consistent recording of routine testing for staff. We spoke to staff who confirmed they were testing but had not reliably been recording this information. The provider was working to improve the recording of routine LFD tests for all staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
We have also signposted the provider to resources to develop their approach.

Systems and processes to safeguard people from the risk of abuse
● Staff understood their responsibility in keeping people safe from the risk of abuse. They were able to describe the different types of abuse, signs to alert them to concerns and the reporting procedures to follow. One staff member told us, "Staff are competent and know safeguarding procedures and how to whistleblow."
● Staff had received training on safeguarding vulnerable adults and there were safeguarding adults' policies and procedures in place.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Prior to our inspection the provider had identified concerns in relation to the governance and monitoring of the service. However, because audits had not taken place routinely, concerns relating to staffing and inconsistent care records had not been identified in a timely manner and there had been a delay in making the necessary improvements.
- Despite the delay in auditing, the provider had identified the shortfalls we found at inspection. They had implemented a service improvement plan and were working towards the identified improvements. However, whilst making the improvements they had not given enough consideration to the interim safety measures to ensure the identified shortfalls would not impact on people. For example, although the provider knew people's epilepsy care plans and medicine care plans were not always up to date, interim measures had not been put in place and risks related to people's health conditions had not always been clearly documented. In the absence of clear guidance staff were unable to tell us how they would manage people's health conditions consistently.
- We saw evidence that encouraged reflective practice following medicines incidents however, we did not see evidence to prevent future occurrences.
- Processes for recording and reviewing information in care records did not reflect the medicine and covert administration policy, which meant people may not always get the best outcome from their medicines.
- Staff did not consistently know and understand the provider's vision and values and how to apply them in their work. One staff member said, ''I don't know what [the Provider] wants and I don't know what they stand for."
- Staff told us they did not always feel respected, supported and valued and some staff spoke negatively about the leadership. Comments included, "There is no clear direction from management." and, "I feel that management do very little to improve the service."

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate the service was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider told us they now had a clear vision for the direction of the service which demonstrated

ambition and a desire for people to achieve the best outcomes possible.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Relatives and professionals told us that communication could be improved. One relative said, "I haven't seen the care plan and there's quite a few times that the phone hasn't worked for weeks and weeks." One professional said, "The communication was driven by our team as opposed to [the staff] being engaged with our service."

● The provider recognised communication as an area of development and had actively sought feedback from staff, people, relatives and professionals. They were collating the feedback to identify and support service improvement. One professional said, "Communication from Fox Elms could be improved but we believe the service recognises this, they have recently sought feedback from partners and professionals."

Working in partnership with others

● The service worked in partnership with people, their relatives and health and social care professionals. We received mixed feedback about the effectiveness of this process. Some professionals told us they found it difficult to make decision about best care and treatment as they were not always clear they had up-to-date and accurate information from staff. One professional said, "We were concerned about the way the care plans/paperwork were stored as it seemed that information was very difficult to find."

● A new senior management team was put in place in May 2022 and was working with healthcare professionals and the local authority to develop close links and good working relationships. The provider required time to embed the new practices and make the improvements they had identified.

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 understood their legal responsibilities to report to the CQC.

● The provider was aware of their responsibilities under the duty of candour, to be open and honest about any accident or incident that had caused or placed a person at risk of harm.

● The service apologised to people, and those important to them, when things went wrong

● Staff gave honest information and suitable support, and applied duty of candour where appropriate.

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 17 HSCA RA Regulations 2014 Good governance Regulation 17 (2)(a)(b)(c) HSCA RA Regulations 2014 Good Governance We found no evidence that people had been harmed however, records relating to people's care were not always comprehensive and up-to-date, and systems were either not in place or robust enough to demonstrate the service was effectively managed.