The Human Support Group Limited

Human Support Group Limited - Gateshead, Angel Court

Inspection report

Angel Court
Waverley Road
Gateshead
NE9 7TG

Date of inspection visit:
03 April 2019
04 April 2019

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
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: Human Support Group – Angel Court provides care and support to people living in an 'extra care' setting, some of who may be living with a dementia. Angel Court contains 45 flats and has an onsite housing manager, communal dining areas, a shop, laundry, chiropodist and hair dressers. At the time of the inspection there were 28 people receiving support.

People's experience of using this service: During our inspection we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to the management of medicines, safeguarding people from abuse, person centred care and the effectiveness of governance arrangements. We also found a breach of the Care Quality Commission (Registration) Regulations 2009 as the service had not notified us of specific incidents. Details of action we have asked the provider to take can be found at the end of this report.

The provider and management team did not have sufficient oversight of the service. The quality assurance systems did not effectively monitor or identify problems relating to the safety and care provided to people.

People's medicines were not safely managed. Medicine administration records were not accurate and people were at risk of receiving the incorrect dosages of medicines. Care plans did not reflect the needs of the person and did not include all appropriate information to guide staff on how to provide support.

People did not have their needs assessed before the service provided support to them. People's needs were not reviewed regularly in line with best practice. Care plans did not reflect reviews or updates from other health care professionals which were detailed in people's daily notes.

There were policies and procedures in place to help keep people safe, but staff were not following these. Staff had received training in safeguarding. However, we found three instances were staff had identified a form of abuse but had not escalated this to the local safeguarding adults' team.

The service had not notified the Care Quality Commission (CQC) of 11 incidents which had been investigated by the local authority.

People gave positive feedback about the care provided by staff. Staff were respectful of people's privacy and

dignity. Staff worked with other health care professionals to provide support to people. People were encouraged to maintain social relationships.

Staff recruitment was safe. Staff had received training as part of their induction and this was reviewed regularly.

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

Rating at last inspection: This was the first inspection of the service since it was registered in November 2018.

Why we inspected: This inspection was carried out due to concerns we had received from partnership agencies and our own intelligence monitoring.

Follow up: We will continue to monitor the service through information we receive from the service, provider, the public and partnership agencies. As part of our process we will be requesting an action plan to be completed to address the issues identified and meeting with the provider to obtain assurances that they will meet the regulations. We will re-visit the service in line with our 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?

The service was not always safe.

Details are in our Safe findings below.

Requires Improvement

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

Human Support Group Limited - Gateshead, Angel Court

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by notifications of incidents received from the local safeguarding adults team and information shared with the CQC and other professionals.

However, the information shared with CQC about the incidents indicated potential concerns about the management of risk of unsafe medicines management and the support provided to people. This inspection examined those risks.

Inspection team: The inspection was carried out by three inspectors, an assistant inspector and an Expert by Experience who had experience in dementia care. 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: Human Support Group – Angel Court provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not

regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

The service did not have a manager registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The current manager had submitted their application to register with CQC.

Notice of inspection: The inspection was unannounced.

What we did: As this inspection was carried out due to our concerns about the service, the provider was not able to complete a Provider Information Return (PIR). A PIR is information we require providers to send us, as part of the inspection process, to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we held about the service such as when the provider told us about serious injuries or events.

We sought feedback from the local authority. We also contacted Healthwatch, who are the independent consumer champion for people who use health and social care services.

During and after the inspection we reviewed documentation provided by the service.

We spoke with nine people who used service, four relatives and eight members of staff including the manager and provider's nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed the care records for three people, medicine records for nine people and the recruitment records for three members of staff.

We looked at quality assurance audits carried out by the manager and the provider. We also looked at the staffing rotas, training records, meeting minutes, policies and procedures and information related to the governance of the service.

Requires Improvement

Our findings

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

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. Regulations were not all met.

Using medicines safely.
● Medicines were not managed safely. People's care plans and records were inaccurate, up-to-date or reflective of best practice guidance
● Medicines administration records did not always accurately record all medicines prescribed or record the doses of medicines staff were administering. For example, one person was prescribed a liquid pain relief medicine, however, the dose recorded on the person's record was different to what was on the pharmacy label.
● Medicines with variable doses were not always accurately recorded and supporting information to guide staff was not available.
● We ensured the management team took immediate action to address our concerns.
● Risk assessments relating to chemicals, for example cleaning products, were not present

These findings were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

● Staff had received training around medicine administration and had their competencies checked.

Systems and processes to safeguard people from the risk of abuse.
● Staff had received training around safeguarding adults and there were policies and procedures in place at the service for staff to follow. We found staff were not always following this training and had not raised three concerns with the local safeguarding adults team.

These findings were a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.

● The management team investigated all safeguarding concerns passed to them by the local authority and provided reports to the local authority with the details from investigations.

Learning lessons when things go wrong.
● The management team told us they shared outcomes from investigations with people, staff and relatives. However, there were investigation reports present but these were not fully detailed, did not all include action taken, show who outcomes had been shared with or fully detail improvements made as part of lessons learned.

Assessing risk, safety monitoring and management.
● People had personalised risk assessments for staff to follow. For example, for choking and falls.
● Some risk assessments were not current and some were from a previous provider. We asked the management team to review everyone's risk assessments to make sure they were up-to-date.
● People felt safe with the support they were provided with. One person told us, "Oh, I feel very safe."

Staffing and recruitment.
● Staff recruitment was safe and all new staff had appropriate pre-employment checks in place to make sure they were suitable to deliver care.
● There was enough staff to provide support to people in line with their assessed needs. Feedback from staff and people was mixed about the amount of staff available to support people. One staff member told us, "Mornings are very busy, it's difficult to spend time with people due to the tasks we need to do."
● People commented that staff were busy but still took time to support them. One person said, "Of course I feel safe here; safe and comfortable. I wouldn't be here otherwise, would I? My wife feels safe too, although we could do with more staff."

Preventing and controlling infection.
● There was an infection control policy in place and staff had received training in this.
● Staff used gloves when supporting people. One staff member told us, "We have access to gloves, aprons and other PPE (personal protective equipment) if needed and are aware of infection control procedures."

Requires Improvement

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.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations were not fully met.

Ensuring consent to care and treatment in line with law and guidance; Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take 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 with appropriate legal authority. In community settings any restrictions placed on people need to be authorised by the Court of Protection.

We checked whether the service was working within the principles of the MCA whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- People receiving support from the service did not have their needs assessed and delivered in line with current national best practice standards and guidance, such as the National Institute for Clinical Excellence (NICE) guidance.
- We found not all people or their relatives had given consent to each aspect of their care.
- People did not have initial assessments or had their capacity to make decisions assessed before the service provided support to them. The management team were reviewing this and making sure all people's needs and capacity were fully assessed.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support.
- People had received visits from health care professionals. Information and updates were not updated in people's care plans to reflect the support or advice provided by other agencies, which meant staff could not follow accurate care plans for how to support people.

These findings were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Person-centred care.

● Staff supported people to access services, for example contacting their GP.
● People were reviewed by other agencies, for example the occupational therapist, and staff supported people with these reviews

Staff support: induction, training, skills and experience.
● Staff had received a full induction which included training appropriate to their roles. One staff member told us, "The induction was good."
● Training needs for staff were monitored by the manager and staff had their skills checked before delivering support to people. One person said, "They are very well trained. They bathe me without any hassle and use the hoist effortlessly."
● Staff had received scheduled supervisions.

Supporting people to eat and drink enough to maintain a balanced diet.
● Some people needed support with meals and they were encouraged to make choices about what to eat or drink.
● Staff supported people to access the communal restaurant or to eat in their own homes. One person said, "They make me tea and breakfast."

Requires Improvement

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations were not fully met.

Supporting people to express their views and be involved in making decisions about their care.
- People were not fully consulted about their care as they did not receive a full assessment of their needs and records did not show that people had regular reviews of their care needs.
- People did not have fully documented care plans detailing their personal choices or that they had been involved in their care planning. The management team told us they would review everyone's care plans to make sure they were a current reflection on how the person would like to be supported.
- People were not provided with choices about the kind of support provided or had their initial needs assessed by the service. One person told us, "I recently had a meeting with them as I hadn't had a bath for 3 weeks, but that has been sorted now and I get one once a week."

Ensuring people are well treated and supported; respecting equality and diversity.
- People were positive about the support they received from staff. One person said, "They are kind and caring, they look after me."
- Equalities and diversity policies were in place and staff had received training around this.
- Staff knew people well, were positive about the outcomes for people since the service had taken over the care to people and we saw kind interactions between staff and people. One staff member told us, "We know people's personal preferences and people we care for seem a lot happier."

Respecting and promoting people's privacy, dignity and independence
- People were supported to remain as independent as possible and staff treated people with dignity and respected their privacy. One person commented, "They keep me independent by encouraging me to do what I can."
- Staff knocked on people's doors and asked permission before delivering care. One person told us, "They treat me with dignity, they make everything light and cheerful."

Requires Improvement

Our findings

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

People's needs were not always met. Regulations were not fully met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
● People's records did not contain initial assessments. People's choices were not clearly documented and incorporated into each care plan. Staff had not fully read care plans in place. One staff member said, "I don't always get time to fully read care plans, but I know they are there."
● People's records did not show that regular reviews had been completed in line with best practice.

End of life care and support.
● There was an end of life policy in place and staff had received training in delivering and supporting people with end of life care as part of their induction.
● One person was receiving end of life care in partnership with another external agency. We found there was no care plan present for this to detail the information provided by the community nursing team. Daily records showed the person had been reviewed by the community nurse but this information was not within the person's care plan for the changes to their support needs from staff.

Improving care quality in response to complaints or concerns.
● There was a complaints policy and process in place and this was included in people's service user guide.
● The manager investigated any concerns or complaints fully in line with the policy.
● People we spoke with knew how to raise a complaint.

Inadequate

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.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

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

- The provider had not ensured that the systems and processes in place were operated effectively by the staff to make sure people were kept safe.
- Records and audits relating to the quality and assurance of the service were incomplete or missing.
- Medicine audits had been completed but we found issues which had not been identified or addressed.
- The quality and assurance systems in place did not identify the issues we found during the inspection or reflect lessons learned from the provider's other services.
- The provider failed to have adequate oversight of the service.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility.

- The service had not submitted 11 statutory notifications to the CQC. Statutory notifications are information about incidents that affect the health, safety and welfare of the people who use the service. Providers are required to send us this information by law.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009: Notifications of other incidents.

- People were not fully involved in the planning of their care. Initial assessments or regular reviews of people's needs were not completed or present in people's files.
- When things did go wrong the manager addressed the concerns and provided apologies to people.

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

- Staff told us they were engaged and involved with the service. One staff member said, "The provider is very kind, they run incentives for staff which keeps us motivated."
- The management team planned to ask people and their relatives for feedback about the service.

Continuous learning and improving care.

- The service had an action plan in place to address areas where they needed to improve.
- Results from the quality and assurance audits, that were in place, were used as part of the action plan.
- Feedback from the planned survey was to be used as part of the learning for the service and to improve the support provided.

Working in partnership with others.

- The service worked in partnership with external agencies to deliver care to people.
- Involvement from other health care professionals was recorded in people's records.

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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 9 HSCA RA Regulations 2014 Person-centred care People did not have their needs assessed or reviewed. People's care plans did not fully reflect how people would like to be supported or included all relevant information. Regulation 9(1)(2)(3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not safely managed. Risks people and staff may face were not present or fully completed. Regulation 12(1)(2)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff did not identify potential safeguarding concerns or escalate these to the local safeguarding adults team.

	Regulation 13(1)(2)(3)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The quality and assurance systems in place were not effective. Records did were not accurately maintained. Regulation 17(1)(2)

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The service did not notify the Commission of incidents that affect the health, safety and welfare of people who used the service. Regulation 18(1)(2)

The enforcement action we took:

We have issued a fixed penalty notice to the provider.