

The Human Support Group Limited

Human Support Group Limited - Waterside Court

Inspection report

Waterside Court
1 Regent Wharf Place
Loughborough
LE11 5BP

Tel: 01509642597

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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?

Requires Improvement ●

Summary of findings

Overall summary

About the service

The service is a domiciliary care agency providing care and support to people living in an extra care housing complex. This consisted of 63 separate flats within the housing complex. 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 our inspection, 31 people were receiving personal care and support.

People's experience of using this service and what we found

People were not always safe because all risk was not identified or managed. Systems to protect people from abuse were not always effective because some concerns were not identified. Staff did not always have the time they required to spend with people so they could meet their needs and provide support in the way they preferred.

People and staff were not always supported because they did not always have confidence in the managers and found they were not accessible.

Systems in place to monitor the quality of the service were ineffective. They did not fully seek or listen to the views and feedback from people, relatives and staff.

Care and support did not always meet people's needs or was not delivered in the way people preferred.

Staff were mostly caring and treated people with kindness and respect. However, there were some instances when this was not the case and there was some tension between staff and people because there were differences in understanding and expectations around care and support arrangements.

People had their medicines managed in a safe way and were supported to take their prescribed medicines. Infection control policies and procedures were in place and staff had access to the protective equipment they required.

Staff received induction and ongoing training. The support and supervision staff received had recently been increased.

People had access to healthcare services and staff knew how to recognise when people's health was deteriorating.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

All care plans were being reviewed to make sure they met people's needs and preferences. Some people and staff did not feel confident making a complaint and did not always feel listened to. Action had been taken to address this concern. Rotas had been changed so that care team leaders were available every weekend and additional training was being provided to staff.

Rating at last inspection

This service was registered with us on 29 October 2018 and this is the first inspection.

Why we inspected

This was a planned inspection as per our inspection programme.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement

We have identified breaches in relation to assessing risk, safety monitoring and management and quality monitoring systems.

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 for 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?

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 always well-led.

Details are in our well-led findings below

Requires Improvement ●

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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 Care Act 2014.

Inspection team

The inspection was carried out by one inspector.

Service and service type

This service 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 bought or 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 but there was an acting manager who had submitted an application to become registered as the manager with the CQC.

Notice of inspection

We gave the service 48 hours' notice of the inspection. This was because it was a domiciliary care service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection

We reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection

We spoke with eleven people who used the service and five relatives about their experience of the care provided. We spoke with nine members of staff including senior managers, senior care workers and care workers.

Is the service safe?

Our findings

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

This was the first inspection for this newly registered service. This key question has been rated requires improvement. 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

- Not all risk was assessed or managed. One person had a history of falls but this was not identified as a risk and there was no care plan for this to instruct staff what to do in the event of a fall.
- Another person had a low body weight and had developed pressure sores. There was no risk assessment or care plan in place for this. This meant staff may not be taking the action required to reduce further risk.
- Fire risk assessments had not identified all fire risks. Staff were not familiar with the location of firefighting equipment such as fire extinguishers. When we did discover the location of fire extinguishers we found staff did not have access to them at night because they were in a locked office. While the provider was not responsible for the building and did not have landlord responsibilities, they must identify significant environmental risks including fire and refer concerns to the landlord.
- Staff had recently attended fire training with the housing provider. Staff were not clear about what they should do in the event of a fire and had not been shown any fire-fighting equipment. There was a difference in understanding among staff regarding evacuation procedures. Some staff told us there was a 'stay put policy' in the event of a fire and others said they would evacuate people closest to the fire to another location. People did not have individual evacuation plans and some people would not be able to mobilise without the use of equipment such as a hoist. It would be impossible to evacuate these people at night when there was only one night worker and there was no additional fire suppression equipment such as sprinklers for people who were at increased risk.
- Since our inspection, the provider had taken action to identify fire risks and had spoken with Leicestershire Fire Service and with the housing provider about fire risks and how these should be managed.
- Some staff told us they were concerned about staffing numbers at night because there was only one staff member and this was not sufficient to keep people safe.
- We were told about a situation when two people fell at the same time. This left the lone night worker attending to the first person while the second person was calling for assistance on the telephone. There was a risk to people should the lone night worker become unwell because there would be no other staff to assist them or to raise the alarm.

The provider failed to ensure that care and treatment was always provided in a safe way. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staffing and recruitment

- Night staff were instructed to be available to respond to emergencies during the night and did not carry out commissioned calls. However, we were told that there were at least eight people who regularly called for

assistance during the night.

- A relative told us their relative had fallen on a few occasions and the night staff had stayed with them until the paramedic arrived but this had meant there were no staff available for other people.
- Some people had very high dependency needs. One person told us they had stomach cramps through the night because they needed to use the toilet but there was only one member of staff on duty and two were required to operate the hoist used to move them. Another person said they also could not use the toilet in the night and had to rely on incontinence products. They said, "It's a long night."
- People told us that at times the staff member allocated to do their care call was also carrying the telephone for responding for calls for assistance. This resulted in the staff member talking to other people during the care call while delivering care or support.
- A staff member also told us how frustrating this could be. They said, "We need extra staff, we are carrying the phone for wellbeing and if it keeps ringing, we have to answer it."
- Most people said staff arrived on time and stayed for the required amount of time for the care call. Some people said staff were late and did not inform them they were running late. Some people said staff often left the care call early.
- Some staff said they were 'rushed off their feet' especially when staff called in absent at the last minute as it was difficult to find replacement staff to cover the shift.
- Staff told us they had to rush to get people's meals ready and sometimes there was not enough food available. They didn't have enough time to do everything required to meet the person's needs. They said they did not leave the care call until everything was done but this often made them late for the next call. Some staff felt some people's needs were too high to be supported in this type of care service.
- The provider was aware of these concerns and were carrying out audits of night time calls and had asked the local authority to re assess people with high dependency needs to see if they required additional support. They told us they were seeking support from the housing provider to provide additional night time staff.
- Staff were recruited in a safe way. Checks were carried out to make sure as far as possible, that only staff with the right characteristics and skills were employed.

Systems and processes to safeguard people from the risk of abuse

- Some people did not always feel safe.
- Four people told us about incidents where staff members had been rough or rude. People told us they had reported this to staff but no action had been taken. This meant safeguarding systems and procedures were not working to keep people safe and were not encouraged or empowered to raise concerns.
- People and relatives said it was often difficult to find a manager to speak with especially at the weekend. Some people said they had raised concerns with staff but no action had been taken.
- Since our inspection the provider ensured that there were care team leaders on duty and available every weekend and took action to address the concerns raised by people about staff being rude or rough.
- Staff were able to describe the correct procedures to follow in the event of suspected abuse. They knew how to report and who to report to, including outside of the organisation to the local authority safeguarding team.
- We were given examples of when the provider had taken action to protect people from abuse and this had been effective.

Using medicines safely

- People told us staff assisted them to manage their medicines in a safe way (where this was required).
- Staff had received training about managing people's medicines and had their competency assessed.
- Care plans provided clear instructions to staff about the level of support people required and medicines required.

- Medicine administration records had recently been improved to make them clearer and easier to follow.
- Staff knew what to do in the event of a medicine error. They told us they would always seek medical advice.

Preventing and controlling infection

- Staff had received infection control training. They were aware of infection control policies and procedures and they knew how to minimise risk.
- Staff had access to protective equipment such as gloves and aprons.

Learning lessons when things go wrong

- The provider was working with the local authority to address shortfalls they identified and were taking action to prevent further incidents.

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.

This was the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- People said most of the staff were competent and knew how to meet their needs. However, some people said staff did not follow the care plan and were at times less attentive than they should be and did not always meet their needs.
- There was a learning and development manager employed. Staff received induction and ongoing training. We were told key staff had recently been trained to provide additional training to staff about moving and handling and medicine management.
- Staff received supervision and appraisal to discuss their training and development needs. We were told this was not fully up to date and additional supervisions and competency checks were taking place to bring these up to date.
- Staff told us about the training and support they received. There was a mixed response with some staff feeling unsupported by their managers.

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

- People had access to the healthcare services they required. Community nurses visited people to provide treatment and staff supported people to arrange doctors visits. However, staff had not sought further medical advice or taken enough action for two people who had increased nutritional needs and pressure sores.
- A relative told us staff were good at recognising changes to their relatives health and wellbeing and would communicate with them appropriately.
- Staff knew what to do when people required emergency healthcare support.

Supporting people to eat and drink enough to maintain a balanced diet

- People said staff did not have the skills required to cook even basic meals. One person had to rely on ready meals and told us they did not enjoy their meals.
- When people had been identified as at nutritional risk or having a poor appetite, there was no care plan for staff to follow. This meant there were missed opportunities for providing additional calories or meals and snacks the person preferred.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People had their needs assessed. However, these were not always reviewed when people's needs and choices changed. Some staff told us some people's needs had increased and could not be met by this type

of service. We were told the local authority were in the process of carrying out reviews for five people who had been identified as requiring increased support.

- Staff and managers kept up to date with best practice standards, guidance and the law through ongoing training and updates from professionals within the company and externally. The local authority improvement team were working with the provider to ensure best practice standards were being followed.

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 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 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.

Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, the DoLS cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty

- We checked whether the service was working within the principles of the MCA. Staff had received training and understood their responsibility to obtain consent before delivering care and support. We were told everybody using the service at the time of our inspection had the capacity to make decisions.

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.

This was the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People said there was a core group of staff who were very kind and caring. One person said, they always ask, "Is there anything else I can do? and on some occasions they go above and beyond." A relative said, "The staff are very friendly."
- However, people told us that some staff were difficult to engage with, could be rude and did not always provide the support they required with personal care or assisting with mobility.
- A relative told us, "Some staff are not as attentive as they should be."
- Some people told us staff were often in a rush and said they had to leave because they had another customer waiting.
- There was a difference in understanding amongst people, relatives and staff about the service provided. Part of the service was known as 'wellbeing.' People said they had been promised 24 hour staff support as well as commissioned calls should they require it. Some staff believed wellbeing was only available in an emergency but told us some people called for the wellbeing service for non-urgent tasks and assistance. A relative told us they had initially been told that 'wellbeing' could be used for requesting a drink, to check they are ok or in an emergency. However, many people who used the service and relatives, had a different understanding and believed a member of staff would attend to them if they were feeling unwell.
- People said they were told by staff if they called for the wellbeing service on more than two occasions they would be charged for a commissioned call. They told us some staff would do extra bits for them but were often worried they shouldn't be doing it. This made some people feel anxious.
- This difference in understanding resulted in people being unsure and unhappy about the service and created tension between some staff and people.
- One person told us that staff were often stressed or upset.
- Another person said, "85% of the staff are angels and will do anything for you."
- Records of the last staff meeting held in June 2019 informed staff they should leave care calls when the allocated time was finished, no matter what. There was no discussion about how staff should manage this to ensure people had their needs met and were comfortable.
- We saw staff and people interacting in a positive way and staff treating people with respect and kindness.
- One person told us how staff had supported them when they had been anxious about using mobility equipment. They told us staff had explained everything and this had reassured them.

Supporting people to express their views and be involved in making decisions about their care

- Most people we spoke with said they had not been asked for their feedback or views.

- A relative told us they had not been asked to be involved in any care review since they first began using the service. This was despite an increase in dependency and having fallen three times during the night.
- People had their care plans reviewed annually. We were told meetings were held with people so they could express their views and be involved in making decisions. However, there was no evidence that these meetings had been used to support people to make any changes they may require to their care and support other than changes made to call times.
- We were told a new system was being introduced to check on people's wellbeing and ask if there was anything else people required. The aim was to carry out these checks every three months, but this system had not yet been fully implemented at the time of our inspection.
- Some staff told us they did not always have the time they required to spend with people, so they could listen and involve them in making decisions. We were told care reviews were taking place because some people required more time and possibly additional calls to meet their needs.

Respecting and promoting people's privacy, dignity and independence

- People told us staff respected their privacy and dignity.
- People were able to be as independent as they could be.
- Staff had received training about privacy and dignity and gave us examples of how they made sure people had their privacy and dignity respected.
- Staff protected people's equality and diversity needs and knew about the equality act and applicable protected characteristics. People could express a preference of male or female staff and this was respected. There was a small and consistent group of staff that people knew. People were able to request not to receive care or support from particular staff members and this was respected.

Is the service responsive?

Our findings

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

This was the first inspection for this newly registered service. This key question has been rated 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

- People had care plans in place which instructed staff how to meet people's needs and preferences. Care plans did not fully reflect people's physical, mental, emotional and social needs,
- One person had been confined to their bed for many weeks because of their health condition. They had high dependency needs and relied on staff for support with most daily living activities and had a sensory impairment. We were told the person was confined to bed on instructions of the community nursing team and they were waiting for a more suitable chair.
- The person's care plan did not address the increased risks or social isolation experienced by this person. The care and support delivered was not person centred. We were told by the provider's head of compliance they had spoken with the community nursing team who said this person could now attend the coffee morning held in the communal area.
- Another person had experienced pain particularly when being assisted to move and transfer from bed to chair. There was no care plan in place for this and the person told us they had been in pain when being assisted by staff. There were no clear instructions to staff about how best to support this person or help them manage their pain when moving.
- We were told that all care plans were being reviewed and improvements were being made to make sure care plans were person centred and based on people's needs and preferences. We were shown examples of these and saw they were person centred. One person told us, "I have a new care plan in the office, I have been asked if I am happy with it."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Managers were aware of the accessible information standard.
- Staff knew how to communicate with people effectively.
- We were told written information could be provided in a variety of formats to meet people's needs. For example, documents were available in large print, braille, and could be translated into other languages.

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 lived in their own homes and there were no restrictions for people receiving their visitors. There were communal areas where people could spend time with their friends and family including other people

who used the service.

Improving care quality in response to complaints or concerns

- People and relatives told us they had difficulty finding senior staff to complain to particularly at weekends. They also said when they made a complaint no feedback was provided or action taken.
- A relative told us they had raised concerns with staff but there had not been any resolution or enough action taken. They said they had no confidence their concerns would be dealt with.
- Another relative told us they had raised concerns with various staff about the care and support provided. They were told on one occasion a manager would call them but they never did receive a call. They said they had no confidence anything would change.
- We were told action had been taken to address these concerns. Staffing rotas' had been changed to ensure care team leaders were always available including weekends.
- There was only one formal complaint recorded in the complaints log and this had been properly investigated and action had been taken.

End of life care and support

- Staff had received training about end of life care.
- At the time of our inspection people's preferences and choices for their end of life care and where they wish to die, including in relation to their protected equality characteristics, spiritual and cultural needs had not been explored or recorded.
- We were told many people did not want to discuss their end of life choices. There was nobody using the service in receipt of end of life care at the time of our inspection.

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.

This was the first inspection for this newly registered service. This key question has been rated requires improvement. 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

- There was a management structure at provider level. Senior managers held key roles such as head of compliance and head of practice. Senior management presence at the service had been increased since the local authority contract monitoring visit. However, systems for identifying, capturing and managing risks and issues were ineffective.
- Managers had not been aware of or kept under review, the day-to-day culture in the service. They had not identified many of the issues we identified at this inspection. including the attitudes and behaviour of some staff.
- Audits were being carried out to address risk and required improvements. This was being implemented and monitored by the provider's head of compliance at the time of our inspection.

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

- People and staff had not been routinely engaged or involved in developing the service. We were told this was being addressed through additional staff meetings and carrying out care plan reviews. The head of compliance had begun visiting people to ask for their views and feedback.

The provider failed to ensure they had effective systems in place to assess, monitor and mitigate risks relating to the health, safety and welfare of people. This was a breach of Regulation 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was not a registered manager in post and there had not been a consistent permanent manager for some time. At the time of our inspection the acting manager was on leave. They had applied to become registered as the manager with CQC.
- Some people said they had not yet met the new acting manager. However, they had only been in post for a few weeks.
- Most staff told us they had confidence in the new registered manager and said they had been supportive.
- Some staff said they did not have confidence in any of their managers, they felt they had raised issues, but no action was taken to make changes.

- Other staff said it was a pleasure to come to work but also said some staff were better than others and some staff did not give 100%.
- People and staff told us there was limited management cover especially at weekends. However, since our inspection the staff rota had been changed to ensure care team leaders were on duty every weekend.
- Staff meetings were being held monthly, but there had been a long period of time without any staff meetings. Meeting records showed there was limited opportunities for staff to give their feedback.

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 responsibilities to be open and honest when things went wrong. They sent us notifications about events that happened at the service as they were required to.

Continuous learning and improving care. Working in partnership with others

- There was an improvement and action plan to address shortfalls identified by the local authority at their last contact monitoring visit. This meant key staff including the chief operating officer were meeting regularly and carrying out audits to identify where improvements and further resources were required
- The local authority quality improvement team were working with staff to make improvements at the service.

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 Risk was not always assessed, identified or managed.
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess, monitor and mitigate risks relating to the health, safety and welfare of people were not always effective.