The Human Support Group Limited

# Human Support Group Limited - York

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

The inspection took place on 6 and 13 march 2018 and was announced. The provider was given notice because the service provides care at home and we wanted to make sure the manager and staff would be available to speak with us.

At the last inspection on 18 and 24 November 2016, we found the provider had not done all that was reasonably practical to assess, monitor and improve the quality and safety of the service provided. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17, Good Governance. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to meet the breach of regulation. At this inspection we checked and this action had been completed; the provider had achieved compliance with this regulation.

This service is a domiciliary care agency. It provides personal care to people living in their own homes in the community. It is registered to provide a service to people living with dementia, learning disabilities or autistic spectrum disorder, mental health and older people. The service also supports people who misuse drugs and alcohol, people with an eating disorder, people with a physical disability and people who may have sensory impairment.

Not everyone using Human Support Group Limited - York received a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

At the time of our inspection 75 people received a reablement service and 20 people received a domiciliary care service. Reablement is a short and intensive service, usually delivered in the home for up to six weeks. The purpose of reablement is to help people who have experienced deterioration in their health and/or have increased support needs to relearn the skills required to keep them safe and independent at home.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Quality assurance checks including audits provided oversight at provider level. People and their care workers were consulted and action plans formulated that aimed to improve the quality and delivery of the service.

Staff had access to a policy and procedure that provided with them guidance on working with people who might lack capacity under the Mental Capacity Act (MCA). Staff had completed training on the MCA and were able to discuss the importance of supporting people with their independence.

Care plans evidenced that individuals or their legal representative had been involved in their care planning. However, signed consent was not robustly recorded. Where a person was deemed to have lasting power of attorney to consent on the persons behalf checks had not been completed by the provider. Actions including checks were implemented during our inspection to improve this process.

Systems and processes were maintained to record, evaluate and action any outcomes where safeguarding concerns had been raised which helped to keep people safe from avoidable harm and abuse.

Associated risks for staff attending people's homes and for providing care and support to people were assessed and managed through individual risk assessments and support plans. These provided staff with information to help keep both people and themselves safe from avoidable harm with minimal restrictions in place.

The provider had systems and process in place to ensure sufficient skilled staff were appropriately recruited into the service to meet people's individual needs.

Procedures were in place to guide staff on the safe administration of medicines and staff had received medicines training. People confirmed, and the records we checked showed, that people had received their medicines as prescribed.

Staff had received support through a regular system of supervisions and observation. The process of appraisals had been improved and dates scheduled. Competency observations had also been completed to monitor staffs performance and ensure they were providing safe and effective care and support.

People had received an assessment of their need to ensure they were suitable for the service. Care plans were centred on the individual and reviewed monthly. Updates were added in 'real time' and staff confirmed that information was always up to date. We saw care plans included information regarding people's cultural and spiritual needs.

People were supported to maintain a healthy and balanced diet. We found that care plans contained details of people's preferences and any specific dietary needs they had, for example, whether they were diabetic or had any allergies.

The provider ensured they had close working relationships with other health professionals to maintain and promote people's health.

Staff had a good understanding of people's needs and were kind and caring. They understood the importance of respecting people's dignity and upholding their right to privacy.

There was information available on how to express concerns and complaints. People were encouraged to raise their concerns and these were responded to.

The provider worked effectively with external agencies and health and social care professionals to provide consistent care.

Everybody spoke positively about the way the service was managed. Staff understood their levels of responsibility and knew when to escalate any concerns.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

Systems and processes in place ensured people received their medicines as prescribed.

Safeguarding procedures and policies ensured people were protected from avoidable harm and abuse.

Assessed risks were well managed to help keep everybody safe.

### Is the service effective?

Good

The service was effective.

Staff were supported with training and supervision to ensure they had the appropriate skills and knowledge to carry out their role.

Guidance was available for staff to ensure they promoted people's independence and had knowledge of the Mental Capacity Act 2005.

People or their legal representatives were involved in their care and support and the provider was implementing actions to ensure consent was robustly recorded.

### Is the service caring?

Good

The service was caring.

Staff had access to appropriate information to be respectful of people's cultural and spiritual needs.

People's privacy and dignity was respected by staff who understood when to maintain confidentiality and when to share any concerns.

People told us they were treated with compassion, dignity and respect and that they were involved any decisions about their care and support.

## Is the service responsive?

Good

The service was responsive.

Care plans recorded information about people's individual care needs and preferences.

Records showed that people's support was regularly reviewed and any changes which were needed were put in place straight away.

There was a complaints procedure in place and people told us they knew who to speak with if they had a concern or complaint.

## Is the service well-led?

Good

The service was well led.

The registered manager was aware of their responsibilities as part of their registration with the CQC.

Care workers understood their roles and responsibilities and when to escalate any concerns.

The service had oversight at provider level and quality assurance systems and processes were used to maintain standards and to demonstrate a commitment to continuous improvement.

# Human Support Group Limited - York

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 and 13 March 2018 and was announced. The provider was given notice because the service provides care at home and we wanted to make sure the manager and staff would be available to speak with us. The inspection was carried out by one adult social care inspector and two Experts by Experience (ExE) who had experience of care services for older people, younger disabled adults and people living with dementia. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to the CQC. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Record (PIR). This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make. We contacted the commissioners of the service to obtain their views about the care provided to people.

As part of this inspection we spoke with 13 people and four relatives over the telephone and four people in person. We spoke with the regional manager, the registered manager and six staff. We looked at the office care records for six people, including their medicines records and four care records in people's own homes. We looked at the recruitment records for six members of staff, training records and quality assurance systems.

Good

# Our findings

At the last inspection on 18 and 24 November 2016, we asked the provider to take action to make improvements to ensure care plans were reviewed, updated and included information for staff to follow to support people with their medicines. This action has been completed.

Systems and processes were in place to ensure people received their medicines as prescribed. Where assessments had confirmed people required assistance with their medicines, care plans included a detailed support plan and a domiciliary medication administration record which provided clear information for staff to follow. This included important contact information, and responsibilities for ordering, collecting and storing of medicines as well as details of the person's understanding and consent. People were encouraged with their independence and where this was appropriate; staff told us they only prompted them to take their medicines.

Staff had received training in medicines management and administration. Medication Administration Records (MARs) were completed by staff after they had observed the person had taken their medicines. MARs were returned to, and checked by, the office to ensure they were accurate. Where errors or omissions were noted, these were discussed with the relevant care worker and where appropriate further training and support was offered.

People told us the service and staff helped them to feel safe in their own homes. They said, "I am safe with the staff. I trust them and it feels like I have known them for years" and, "I am safe, the staff do make me feel comfortable." Staff had completed safeguarding training and were able to discuss types of abuse they would look out for. They were able to discuss the processes for reporting any concerns. One care worker told us, "If I had any doubts I would raise a concern with the office. We have a responsibility to keep people safe from harm."

The provider had a safeguarding policy in place and this was available for all staff to use as guidance. A safeguarding log recorded any concerns raised and included referrals to local authority safeguarding teams where this was necessary. The registered manager told us, "We copy head office into any safeguarding alerts; they have oversight and can ensure any trends are picked up and preventative actions implemented."

People had received assessments of their needs prior to commencing with the service. These included risk assessments to ensure care and support was provided safely without undue restrictions in place. A care worker told us, "Care plans include good information on the person's home environment so we can access

the property safely and with an awareness of any hazards. Any tasks we need to carry out with the person include assessments of associated risk with information to provide them [tasks] safely." Risk assessments were reviewed and kept up to date with any changes in people's needs. The registered manager told us how staff were able to instantly update the care coordinators in the office electronically on their mobile phones with any changes.

People received care and support from staff who had completed a robust recruitment process. The registered manager told us, "The recruitment process ensures only staff who are deemed suitable are employed. We complete a range of pre-employment checks that are controlled by head office. We cannot commence people on a rota without all the checks being satisfactorily completed." Staff records provided evidence of checks completed with previous employers; any gaps in employment history had been explored and recorded. Other checks were completed with the Disclosure and Barring Service (DBS). DBS checks are a way that a provider can make safer recruitment decisions and prevent unsuitable staff from working with vulnerable groups of people.

The provider tried where ever possible to ensure people were provided with a service from a regular group of staff. The registered manager said, "We recognise the importance of providing regular carers and consistent care. When people receive a short term six week reablement service we try and ensure regular staff attend; this isn't always possible to start with and is dependent on the type of care service provided." One person told us, "I have a few different staff attending but I am getting to know them all; they are all wonderful."

The provider had systems and processes in place to record and evaluate any accidents and incidents. Where these had occurred details of the event and those involved was recorded and thorough investigations had been completed. Outcomes were shared with head office who ensured any repeating incidents were identified with corrective actions implemented. An annual review of the systems and processes recorded, 'We monitor and record incidents continually, and annually review health and safety performance with an external, IOSHH qualified Health and Safety Consultant.' These checks helped to reduce the risk of further incidents and helped to keep everybody safe from avoidable harm.

Staff had received training in health and safety and infection control awareness. Staff told us they had access to and used protective equipment, for example gloves and aprons to maintain hygiene and help prevent the spread of infections. One person said, "The staff never rush. They are careful to wash their hands and observe good hygiene practice by wearing protective gloves and aprons when they need to."

Good

# Our findings

People spoke positively about the level of service they received and confirmed staff had the right skills and knowledge to meet their individual needs. People told us, "Yes, the care workers do know what they are doing" and, "They ask my permission before they do anything; they are trained and skilled."

Staff received an induction to the service and were introduced to people as part of 'shadow shifts' completed with existing employees. This ensured staff were compatible with people's needs and enabled effective working relationships.

The provider supported staff to have the skills and knowledge to carry out their role. Staff completed a training programme that was mapped to the care certificate. The care certificate is a set of national standards that health and social care workers adhere to in their daily working life.

Ongoing training was provided and managed electronically. Records confirmed staff were up to date with their training or where refresher training was due this had been scheduled. A care worker said, "I can't fault the support we have with training and updating our knowledge. We can learn on the PC or sometimes we attend a classroom. For example, for moving and handling training when we complete practical simulated activities. I enjoy it all." Additional specialist training was available to ensure staff were able to meet people's needs in different situations. This included where people required full support to take their medicines, to support people living with dementia and to manage challenging behaviour.

Each year staff received two supervisions and two spot checks with an annual appraisal. A care worker told us, "There hasn't always been a robust process for our reviews but it has improved and more are now scheduled. They are a good opportunity to have a two way conversation about how we are doing in our role and any support we might need." Staff were invited to attend staff meetings where a generic agenda enabled staff to contribute to, and receive information about changes in the service, their role and any best practice. Where they were unable to attend, minutes were circulated electronically.

The reablement service was usually short term lasting up to six weeks and helped people to regain their independence for example, when leaving hospital after a fall or where a loved one had passed away. As part of this service people were offered an assessment by the provider's occupational therapist and an assessor with a company who supplied telecare equipment. With consent from the person this joint working approach enabled the assessors to identify useful technology for the person to live as safely and independently at home for as long as possible. Equipment available included a warden call service, falls,

door, and bed sensors, lifeline, medication dispensers, a checking service, and other aids and adaptations for the home. The manager said, "This provides people with additional security and safety and enables any incidents to be responded to immediately."

People were encouraged to participate in their care and support and their choices were recorded. People told us staff consulted with them during visits and when providing any care. One person confirmed this saying, "They [staff] do ask my consent whilst they are carrying out the tasks." People's capacity to make choices about their day to day care was considered in line with the Mental Capacity Act 2005 (MCA).

The 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 unable to make decisions about their care and support had been assessed in line with the MCA and records confirmed when decisions had been made in their best interests and by whom. However, consent to care and support was inconsistently signed and not always by the person or their legal representative. Where people's relatives had signed as having a Lasting Power of Attorney (LPOA), checks had not always been completed by the provider to ensure they had authorisation or the scope of the award. The registered manager was responsive to the concerns we raised and told us they had been told these checks had been completed by the local authority. During the inspection the provider implemented an action plan and used the Office of the Public Guardian Service to validate any LPOA they had on record. A new form was added to people's care plans to ensure consent was obtained at the initial time of assessment and audits implemented to improve the process.

People were supported to eat and drink according to their preferences, cultural needs and any dietary requirements. This information was recorded in people's care plans for staff to follow. We received positive feedback from the people we spoke with about this aspect of their care and support. People told us, "They [staff] help me with breakfast; my daughter does lunch and tea. I make drinks myself" and, "They make my breakfast and give me toast; this is what I like." A relative said, "Staff make meals for [person's name]. They enjoy the food and there is always a drink available." We observed staff offered people a drink when arriving to carry out a call and discussed what they would like to eat acknowledging and responding to their choice.

Care plans contained information about people's medical history and any significant health needs they had. Records provided guidance to staff about any support people required to meet their health needs, including support to take prescribed medicines. Alongside this, staff maintained records of any contact they had with healthcare professionals. These records evidenced regular contact with people's G.P's, occupational therapists and district nurses to ensure people's health needs could be met.

Good

# Our findings

People told us they were treated with compassion, dignity and respect and that they were involved in any decisions about their care and support. People assured us that staff cared about them, and helped them to remain living in their own homes.

Everybody spoke positively about the care and support they received. People told us, "They [staff] chat with me. They make me feel as if I have known them for years. They are always respectful; very pleasant indeed" and, "They [staff] are very caring and they speak to me which means a lot. They are always kind and compassionate to me." We observed one care worker discussing how a person had been that morning. The care worker got down to eye level and reassuringly held the persons hand offering emotional support and responding compassionately. This resulted in the person smiling and sitting up in their chair ready and discussing their lunch.

Staff had completed training in person centred care and in treating people equally whilst being respectful of any diverse needs. Staff confirmed the importance of treating people with respect and with maintaining their dignity. A care worker said, "When I provide any personal care, I always ensure that I have towels and everything I need to hand. I make sure the person understands what we are doing and encourage them to do as much for themselves as they can. I keep doors and curtains closed; no different to how I would want to be treated." One person confirmed this and told us, "They [staff] are very gentle and caring; they give me the utmost respect and dignity whenever they come. A relative said, "Care workers are wonderful, caring, kind and very, very respectful to [person's name]."

People's equality, diversity and human rights had been considered. People had been asked if they had any preferences for male or female care staff. Where they had identified a preference this was respected. A person confirmed, "I get both female and male care workers. I ask for female care workers for the shower as I do not feel comfortable with males. This is respected and they send only female's for the shower."

People's right to confidentiality was respected and information was kept confidential. Care records and staff files were stored securely, both in the office and electronically. Staff confirmed they maintained people's confidentiality and that they did not discuss information with anybody who did not need to know. Staff recognised people's right to privacy and to a family life.

The provider completed a shadowing checklist on staff that ensured they had a good understanding of providing people with person centred care, respecting beliefs, culture, values and preferences. Staff told us

they felt most care workers genuinely cared about the people they supported. They told us that they would raise any concerns with the office if they noticed or were made aware of any poor practice from other staff.

People we spoke with told us they were encouraged to do as much on their own as they were capable of doing. Care plans included an assessment of people's individual care and support requirements. A care worker told us, "Records clearly state the amount of support people require or if they are independent. I work in reablement which is all about encouraging people to regain their independence and to remain living in their own home." One person said, "I had lost my mobility after a fall. It knocked my confidence but [staff name] has been brilliant and I am slowly getting back on my feet with just the walking frame to support me."

Where people required additional advice and guidance to make day to day decisions the registered manager told us they would provide them with information to access local advocacy services.

Good

# Our findings

People confirmed they were involved with planning their care and support and that their views were recorded. One person told us, "I have been through the care plan with the office staff who attended with my social worker; they got me involved and listened to what I had to say." Another person said, "I have been through the care plan with the managers who took on board my needs. I haven't had any recent contact with them as there is no need to."

The provider ensured people received care and support that was responsive to their individual needs. We saw that care records for people included an initial assessment from the local authority and that this formed the basis of initial consultations with the individual by the provider. Support plans were then formulated which included details of everybody involved in the person's care.

Care plans included details about the individual, places they visited, hobbies and interests. Information was written in the person's voice which emphasised that the service was provided for the person and written in a way that they had agreed to. Examples included information to support the person in a way they had agreed to in a variety of situations. This included how to support the person in an emergency situation, with medication, maintaining their home environment, shopping, security, and with personal care.

Information was outcome focused with clear goals but did not include unnecessary restrictions. For example, one person received support with their meal time arrangements. Information recorded they were a diabetic and that they enjoyed chocolate, sweets and alcohol. The provider included guidance to reflect that this was the person's choice and that staff were required to monitor the person's diet and report any concerns to the office. A referral had been made to a dietician and the person received further support from a diabetic nurse. A care worker said, "We support people in a way that they agree to even if sometimes it may not appear to be the best approach; it's their choice."

People's records showed their care and support was regularly reviewed and any changes which were needed were put in place straight away. People we spoke with said they felt able to tell staff if anything needed changing or could be improved. Where people requested any changes, staff were able to send this information electronically to the office where it was reviewed and added on to the person's records. The registered manager said, "We respond to any emergencies without delay, other requests for changes are reviewed and updates are then added on to people's notes so all staff involved with a specific individual are kept up to date." Examples of this included changes to medication, daytime routines or referrals for further assessments to better support people with their individual needs.

People's diversity and human rights were highlighted in their care plans enabling staff to make the necessary adjustments to their care and support. The provider told us in the PIR, 'Specific work we have undertaken in the past 12 months to ensure the service meets the needs of people with protected characteristics.' We received examples of the provider working with and respecting people's religious and cultural beliefs. The provider ensured care and support was scheduled to fit in with daily routines and personal preferences. Where the provider supported individuals through transitioning/Transgender period pre-assessment, consultations ensured they were able to be respectful of preferences for any particular gender of care worker.

People told us care staff never missed a call and stayed for the full duration of their visit. They confirmed their support needs were met. However, they recognised staff did not always turn up at the same time each day. We spoke with the registered manager about this. They told us, "Where people have a longer term package we can schedule dedicated staff to arrive at an agreed time appropriate to meet the person's needs. When we provide a short term reablement service, which can be up to six weeks, we provide people with a block time in which we will attend." They continued, "If the call is time specific for example, to provide support with people's medicines then we schedule this in and stick to it." One person told us, "The care staff always turn up during the times provided; they [staff] administer my medicines and they are on time for that." Another person said, "They [staff] are a great bunch, I don't always know when they are coming but they always turn up. Sometimes they aren't there to observe me taking my medicines; I am getting more independent with that which is what I want."

The provider had a complaints policy and procedure in place for people to follow if they were unhappy with the service they received and information was available in the service user guide. Everyone we spoke with told us they would feel comfortable to raise any concerns if they had any. The people we spoke with were happy with the service. They were also very confident that any concerns or complaints would be dealt with. Comments included, "I do not have any complaints at all but I do know how to complain; I have the number with me" and, "I do have the procedure but I have had no reason to use it."

One complaint had been recorded since our previous inspection; an investigation had been completed with appropriate actions implemented. The provider followed duty of candour and we saw a letter had been written to the interested party acknowledging receipt and providing an outcome.

The provider did not support people with end of life care. However, they told us they would work with other health professionals to support people to have a pain free death and to respect their wishes.

Good

# Our findings

At the last inspection on 18 and 24 November 2016, we found the provider had not done all that was reasonably practical to assess, monitor and improve the quality and safety of the service provided. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17, Good Governance. Following that inspection, we asked the provider to complete an action plan to show what they would do and by when to meet the breach of regulation. At this inspection we checked and this action has been completed, and the provider was no longer in breach of this regulation.

The provider carried out checks to maintain and assure the quality of the service provided. Monthly audits were completed of people's medication administration records, daily care records and accidents and incidents. Audits of people's care plans, complaints, medicines support, training and development and care staff supervision were carried out. Where any concerns were found as a result of the audits completed, actions were implemented to reduce further instances and to help drive improvements.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was aware of the requirement to notify CQC of important events affecting people using the service. Prior to the inspection we checked and found that we been notified of these events when they occurred.

There was overview and support for the registered manager at provider level. This meant the service was able to improve and share areas of best practice implemented at other locations owned by the provider. The registered manager kept up to date with best practice and changes in legislation through provider forums and a company portal giving access to relevant information from other similar locations. They told us they received updates from the CQC and the National Institute for Health and Care Excellence.

People told us they were happy with the service but we received some mixed feedback about the way the service was managed. Comments included, "Management have kept us in the loop, they have been really good and any little change they notify me. They ask my opinion and we can recommend this company" and, "I do not have much to do with the management. I have not received any questionnaires but my relative does keep in touch with them." Another person said, "Not that well led; a bit all over with the staff. I don't think they [staff] are well-managed and that's why." People's views were sought to make improvements to the service. They responded to surveys sent out in December 2017 and January 2018. Feedback was overall

positive but where areas for improvement had been identified the provider was implementing actions to address those concerns.

Staff told us the registered manager was approachable if they needed to speak with them but that the office staff were the first point of contact. One member of staff said, "The manager is approachable but they are quite busy so we need to schedule appointments if we need a chat; we can go into the office at any time and discuss any issues with the care co-ordinators."

There was a clear staff structure and staff told us they understood their roles and responsibilities and when to escalate any issues or concerns. The registered manager told us, "The office has an open door policy, carers regularly drop into the office for gloves/aprons, and have open discussions about service users within the office. Co-ordinators are first line managers and initial contact in feeding back any concerns/issues would be to a co-ordinator. Co-ordinators would only escalate up to me as registered manager if there was a major concern/safeguarding or something that they felt unable to deal with."

The provider had a reward system in place to encourage staff to send in detailed observations highlighting people's progress which in turn was used to evidence positive outcomes for people. The provider told us on the PIR, 'This has helped provide good quality observations from the staff and the worker has been rewarded in doing so.' Reablement statistics, which identified people regaining their independence or with reduced care, were recorded on a communication board in the main office. The board included information on any relevant training or information sessions that were being held within the office for the team. One care worker discussed with us the implementation of care forums where staff could attend a themed discussion. For example, dementia care, and afterwards have group discussions with their peers highlighting any best practice, concerns and having a general chat. The meetings were held without the registered manager present to encourage open dialogue.

The provider worked closely with the local authority including the quality assurance team. Documented visits with action plans were evidenced demonstrating how the provider was supported by the council to improve services and maintain best practice.