Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Housing 21 - Fountain Court

Armstrong Street, Bensham, Gateshead, NE8 4AF

Tel: 03701924665

Date of Inspection: 20 February 2014

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We inspected the following standards to check that action had been taken to meet them. This is what we found:

Safeguarding people who use services from abuse	✓ Met this standard
Management of medicines	✗ Enforcement action taken
Notification of other incidents	✓ Met this standard
Notifications – notice of absence	✓ Met this standard

Details about this location

Registered Provider	Housing 21
Registered Manager	Mrs. Tracey McCormick
Overview of the service	Housing 21 is registered to provide personal care for tenants at Fountain Court. The service is aimed primarily for older people.
Type of services	Domiciliary care service Extra Care housing services
Regulated activity	Personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Housing 21 - Fountain Court had taken action to meet the following essential standards:

- Safeguarding people who use services from abuse
- Management of medicines
- Notification of other incidents
- Notifications – notice of absence

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 20 February 2014 and talked with staff.

What people told us and what we found

We found that the provider was not protecting people who use the service from the risks of unsafe use and management of medicines.

The provider had improved processes to report safeguarding issues and notify the Commission of significant events at the service.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have taken enforcement action against Housing 21 - Fountain Court to protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

At our last inspection of 4 December 2013 we found that the provider had not always responded appropriately to allegations of abuse. We informed the provider they were not compliant with this essential standard and asked them to submit an action plan. This action plan was submitted and set out the actions which would be taken to achieve compliance. On this visit we reviewed the progress the provider had made with the actions.

We saw that all care workers had completed further training on safeguarding vulnerable adults, including how to report any allegations of abuse.

The care co-ordinator showed us that a central file was kept to co-ordinate information on safeguarding issues which had been reported to the relevant authorities.

Since our last inspection we had received information from the local authority safeguarding team. This information clarified the number of safeguarding alerts relating to the service and confirmed that remedial actions had been agreed with the provider's representative. The service had also notified us directly of safeguarding allegations and their action taken in response. This meant the provider was now responding appropriately to allegations of abuse.

Management of medicines ✖ Enforcement action taken

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider had not made appropriate arrangements for the safe administration and recording of medicines.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

At our last inspection of 4 December 2013 we found that people who used the service were not fully protected against the risks associated with medicines. This was because the provider had not made appropriate arrangements for the recording of medicines. We informed the provider they were not compliant with this essential standard and asked them to submit an action plan. This action plan was submitted and set out the actions which would be taken to achieve compliance. On this visit we reviewed the progress the provider had made with the actions.

Since our last inspection, we had received information from the local authority safeguarding team regarding several safeguarding alerts concerning issues with medicines at the service. We had also recently been notified by the service of two occasions when people had not been given their medicines.

We found that since our last inspection all care workers involved in handling medicines had been retrained and had their competency to give medicines reassessed.

We examined the current medicine administration records (MARs) for six people who used the service. We found recording deficiencies in five of the records.

We saw there were gaps to the MARs where administration of medicines had not been recorded. This meant we could not establish if people had received their medicines as prescribed.

We found that the MARs were not always accurately completed. Some directions for administering medicines were not clearly recorded and did not show the quantity of medicine to be given. There were times when no explanations were recorded for the reasons why medicines had not been given to people.

The MARs had instructions for staff to enter a code to confirm they had administered medicines, and other codes to be used to confirm the reasons why medicines were not administered. We saw that at times unrecognised codes had been recorded. There were also recording errors which showed staff had not followed the correct procedure of completing the MARs after they had given medicines, or after they had found any reason why medicines could not be given.

The MARs showed there were times when people did not receive their medicines because supplies had run out of stock. We also saw from staff records that there had been other times when care workers had missed giving people their medicines.

We concluded that the records did not provide evidence that medicines were safely administered, and, on several occasions, people had not received their medicines as prescribed to maintain their health and well-being.

We also found that the provider's action plan had not been fully implemented. In particular, weekly audits of MARs to identify any errors had not been carried out.

Notification of other incidents ✓ Met this standard

The service must tell us about important events that affect people's wellbeing, health and safety

Our judgement

The provider was meeting this standard.

The provider had made suitable arrangements for the notification of incidents to the Care Quality Commission.

Reasons for our judgement

At our last inspection of 4 December 2013 we found that the provider had not made suitable arrangements to notify the Commission of an incident of alleged abuse. We brought this to the attention of the provider and a notification was submitted retrospectively.

We wrote to the provider to request information to assist us in reaching a judgement about their compliance with this essential standard. The provider sent us the information we had requested. We reviewed this information, considered our response, and decided not to take any further action.

Notifications – notice of absence ✓ Met this standard

The service must tell us how they will manage the service safely when the person in charge is away

Our judgement

The provider was meeting this standard.

The provider had made suitable arrangements for the notification of absence to the Care Quality Commission.

Reasons for our judgement

At our last inspection of 4 December 2013 we found that the provider had not made suitable arrangements to notify the Commission of the absence of the registered manager. We brought this to the attention of the provider and a notification was submitted retrospectively.

We wrote to the provider to request information to assist us in reaching a judgement about their compliance with this essential standard. The provider sent us the information we had requested. We reviewed this information, considered our response, and decided not to take any further action.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 04 April 2014 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: The provider was not protecting people who used the service from the risks of unsafe use and management of medicines, by failing to make appropriate arrangements for the recording and safe administration of medicines.

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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