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 Inspections: 09 December 2013
04 December 2013

Date of Publication: February 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✗ Action needed
Management of medicines	✗ Action needed
Staffing	✓ Met this standard
Notification of other incidents	✗ Action needed
Notifications – notice of absence	✗ Action needed

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

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

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 4 December 2013 and 9 December 2013, checked how people were cared for at each stage of their treatment and care and talked with people who use the service. We talked with carers and / or family members, talked with staff and reviewed information given to us by the provider.

What people told us and what we found

We found people who used the service were provided with personal care that met their needs. People told us they were happy with the care and support they received. Their comments included, "The carers are always there when I need them"; "They do everything I want, I've got nothing but praise for them all"; and, "They've helped me enormously. I don't know what I'd do without them".

Steps had been taken to identify and prevent abuse of people who used the service, but the process for reporting allegations of abuse was not fully robust.

People were supported in taking their prescribed medicines, but records did not always demonstrate that medicines had been given correctly.

Suitable arrangements had been made for managing the service and to make sure there were enough experienced staff to deliver people's care.

The provider had not notified the Commission of significant events, including the absence of the registered manager and an allegation of abuse.

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

What we have told the provider to do

We have asked the provider to send us a report by 25 January 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where we have identified a breach of a regulation during inspection which is more serious, we will make sure action is taken. We will report on this when it is complete.

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

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We reviewed the way that people's care was planned and delivered. The people we talked with said they were happy with the care they received, and spoke highly of their care workers. They told us they received the care they needed and said their workers were flexible in accommodating their needs. For instance one person said, "They took good care of me when I was poorly"; and a relative told us her mother had been given extra care when she came out of hospital. Other comments included, "All the carers are brilliant, they'll do anything for you"; "They give very good care to all of us", and, "The staff are lovely, they really do understand me and what I need".

We examined the care records of three people who used the service, each of whom was dependent on staff to meet their personal care needs. The records showed each person's needs had been thoroughly assessed when they started to receive services. This information was then used to develop personal support plans. These stated the desired outcomes for the person and described in detail the care and support they were to be given at each visit. The person's preferences and independent skills were specified. The number of workers needed to provide care safely, and any aids or equipment that were used, were clearly described. We saw care workers kept records of all visits they made and the care they delivered. These records matched with the care that was planned in people's support plans.

We saw risks were assessed and measures to manage or reduce risks to personal safety were documented. These included safety within the person's environment and during care delivery such as moving and handling, assisting with personal care, food preparation, and infection control.

The provider may find it useful to note we found people's care needs were not always kept under regular review. Where people's needs had changed, we saw this was responded to by updating support plans and providing additional care. A number of people received an increased level of care hours to those they were originally assessed as needing. However,

reassessments and reviews of care were not routinely carried out, or triggered by changes in people's needs.

For instance, we saw one person had required more extensive care when they returned home following a stay in hospital and respite care. Their personal support plan had been rewritten to reflect this, and they had been given care during the night for a period of time. The person now required two care workers to give their care and this was provided. However, no re-assessment or review of the person's care had been carried out. There was also no evidence of care reviews for the other people whose care we looked at. A locality manager told us it was usual practice to update assessments annually or when people's needs changed. They showed us that a full audit of care records was being conducted to bring all information up to date.

Safeguarding people who use services from abuse ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People who use the service were not fully protected from the risk of abuse because the provider had not always responded appropriately to any allegation of abuse.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Arrangements for protecting people who used the service from abuse were displayed in the entrance to the service. This included information telling people how to report any incidents of abuse.

Staff training records showed that all staff had been given training in recognising and reporting any issues of abuse. We were told training was being updated to reinforce the reporting process with staff. This meant the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

We had been informed by the local authority safeguarding team of a number of allegations of abuse relating to the service over recent months. A recent allegation concerned medication issues which the service had not reported to the safeguarding team, as it was obliged to do. An earlier allegation of abuse had been reported to the safeguarding team, but not notified to the Commission. This meant the provider had not responded appropriately to allegations of abuse.

A locality manager told us they had arranged to meet the safeguarding team to discuss and clarify current alerts. They were able to demonstrate that action had been taken to co-operate with the safeguarding team, and carry out investigations into the allegations. Measures had also been taken to prevent the re-occurrence of the issues identified and protect people from being harmed.

Management of medicines ✖ Action needed

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 fully protected against the risks associated with medicines because the provider had not made appropriate arrangements for the recording of medicines.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We reviewed the service's arrangements for supporting people to take their prescribed medicines. Where people required such support, we were told medicines were stored safely in a locked cupboard in their home. Medicines were provided, in the main, in blister packs for ease of administration.

We saw evidence that all care workers received medicines training, which was updated every two years. Locality managers told us this training was currently being given again to all staff and would include instruction on the newly-introduced medicines procedure. All staff were also in the process of having their competency to give medicines reassessed.

Care records showed that comprehensive assessments of risks associated with medicines were carried out. These covered all relevant areas including storage; the level of assistance required; whether the person co-operated with taking their medicines; and who took responsibility for ordering and collecting medicines. The support the person needed was then specified in their personal support plan. This meant care workers had access to information to guide them on individual's medicines routines.

We looked at a sample of the records workers completed when they administered medicines. These contained numerous gaps where workers had not signed to confirm they had given medicines. There were also some instances where recorded directions for applying creams and ointments were unclear. The records did not demonstrate that people received their medicines correctly at the prescribed times.

We were shown evidence that medicines audits were undertaken, but no audits had been carried out since July 2013. A senior worker told us an audit was in progress, and deficiencies were being followed up. The service was also starting to use weekly, rather than monthly, medicines administration records, and these records were being returned to the office each week for senior staff to check their accuracy.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

The service was provided by an on-site team of care workers who provided care and support to the tenants of the housing scheme across the 24 hour period. We talked with people who used the service, and with one person's relative. Most people told us there was enough staff and spoke highly of their care workers. Some people said workers were kept very busy and felt this was due to the number of tenants who now needed a greater degree of support.

We were informed that the registered manager was absent, and the service had been managed by locality managers and other managers within the organisation. At the time of our inspection, an experienced manager had just taken up post on an interim basis.

We were shown that the numbers of care workers on duty during the day had been increased, following a review of staffing and the level of care people required. Additional support was also being provided to senior care workers who were designated to lead shifts. Overall, we found there were appropriate staffing arrangements to meet the needs of the people who used the service.

Notification of other incidents ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The provider had not made suitable arrangements to notify the Care Quality Commission of an incident of alleged abuse.

This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

Prior to this inspection we were informed by the local safeguarding authority that the service had reported an allegation of abuse which had been subject to investigation since October 2013. The provider is required to notify the Commission of incidents, including any allegations of abuse, without delay. We found the provider had not notified us about this allegation. A notification was submitted retrospectively when this was brought to the attention of the provider.

Notifications – notice of absence ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The provider had not made suitable arrangements to notify the Care Quality Commission of the absence of the registered manager.

This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

Prior to this inspection we were informed by the local authority that the manager was absent from the service. The provider is required to notify the Commission if the registered manager is expected to be absent for 28 days or more; and of the arrangements to manage the service during the period of absence. We found the registered manager had been absent from the service since the beginning of October 2013 and the provider had not notified us about this absence. A notification was submitted retrospectively when this was brought to the attention of the provider.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Personal care	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: The provider had not made suitable arrangements to ensure people who use the service were safeguarded against the risk of abuse, in that they had not always responded appropriately to any allegation of abuse. Regulation 11(1)(b)
Regulated activity	Regulation
Personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: People using the service were not protected against the risks associated with the unsafe use and management of medicines in that there were not appropriate arrangements for the recording of medicines. Regulation 13

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

CQC should be informed when compliance actions are complete.

This section is primarily information for the provider

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

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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