Hales Group Limited

Hales Group Limited - Huntingdon

Inspection report

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Ratings

Overall rating for this service	Good
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?	Requires improvement

Overall summary

Hales Group Limited – Huntingdon is registered to provide personal care to people who live in their own homes. The service's registered office is located in the town of Huntingdon. At the time of our inspection there were 50 people using the service.

This unannounced inspection took place on 29 December 2015.

The service did not have a registered manager in post. 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.

Summary of findings

Staff were recruited through a robust recruitment and induction process. This helped ensure that the quality and suitability of staff met legal requirements. People were supported with their needs and preferences by trained and experienced members of staff.

Staff were trained and had their competence to safely administer medicines safely regularly assessed. Safe medicines administration practices were adhered to. Staff had acquired the skills to be confident in identifying and reporting any harm should this ever occur.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The regional manager and staff were knowledgeable about the situations where an assessment of people's mental capacity could be required. No person using the service lacked the capacity to make informed decisions. The regional manager and staff were aware of the procedures to follow should a person need to be lawfully deprived of their liberty. Staff had an embedded understanding of the MCA.

Staff knew the people they cared for well, what their care needs were and how to respect their preferences. People's care was provided with dignity and compassion by staff who adhered to good standards of care. People were given the time they needed to make decisions about the aspects of their lives that were important to them.

People, their relatives and staff were involved in planning the provision of people's care. Advocacy arrangements were in place to support those people who required someone to speak up on their behalf. Regular reviews of people's care were completed to help ensure that people were provided with care and support based upon their latest information.

People were supported to access a range of health care professionals including community nurses and a GP. Staff responded promptly and action was taken for any identified change in people's health care needs.

People were supported to ensure they ate and drank sufficient quantities. People had the choice to eat their preferred choice of food and drink where they wanted to. Diets according to people's health needs were provided.

People were supported to raise concerns or suggestions in a way which respected their rights. Staff responded quickly to any changes to people's individual circumstances if the person was not happy. Information and guidance about how to raise compliments or concerns was made available to people and their relatives.

Audits and quality assurance procedures were in place. However, not all audits were effective. The provider had not always notified the CQC of events that they are required, by law, to do so.

Information from managers' forums was used to help ensure good practice was identified and shared with staff at the service. Support was provided to develop staff's skills and obtain additional care related qualifications.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 safe.

Systems were in place to help ensure that staff had the knowledge and skills to report and act on any concerns about people's safety if ever they had these.

A robust recruitment procedure and checks on staff's suitability helped the provider determine the suitability of the staff they employed. People's needs were met by suitably qualified and competent staff.

Measures were in place, including risk assessments, to help ensure that people's risk of harm was minimised or eliminated. Accidents and incidents were recorded and acted upon.

Good

Is the service effective?
The service was effective.

People were cared for by staff whose training and development prepared them well for their role. Management and care staff understood the requirements of the Mental Capacity Act 2005.

Care staff had the skills, experience and knowledge they needed to meet people's needs.

People were supported to access the most appropriate health care professional and staff recognised when people's health had changed.

Good

Is the service caring?
The service was caring.

People were cared for as individuals and staff respected people's preferences and choices including how these were to be met.

Staff put their care skills into practice by delivering dignified and compassionate care to the people they looked after.

Staff showed interest in people's wellbeing and involved people in making important decisions about their care.

Good

Is the service responsive?
The service was responsive.

People's relatives were involved in their family member's care in a way which responded to people's individually assessed needs.

People were supported to take part in hobbies and interests that were important to them.

Good

Summary of findings

A complaints procedure was in place and this was used to respond to people's concerns. People and their relatives knew who they could speak with if they ever had any concerns, suggestions or complaints.

Is the service well-led?

Requires improvement

The service was not always well-led.

The provider had not always notified us about events they are required, by law, to do so. This meant that the provider had not met their legal responsibilities.

The registered provider and management staff undertook regular checks on the quality of care and made appropriate changes where required.

Staff received the support they needed from management who promoted the development of staff skills.

Hales Group Limited - Huntingdon

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 29 December 2015 and was unannounced. The inspection was undertaken by two inspectors.

Before the inspection we looked at information that we held about the service. This included the number and type of notifications. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with 10 people and four relatives. We spoke with the service's regional manager, the branch manager, a care co-ordinator, field supervisor, senior carer and three care staff.

We looked at four people's care records and their daily care notes. We looked at staff meeting minutes. We looked at medicine administration records and records in relation to the management of the service such as checks regarding people's health and safety. We also looked at staff recruitment, training, supervision and appraisal processes as well as compliments, quality assurance, accident and incident and audit records.

Good

Is the service safe?

Our findings

People who used the service were supported to be as safe as practicable. One person said, "The reason I feel safe is that they [care staff] arrive on time. If they are going to be more than 10 minutes late the office generally let me know the reason for any delays." One care staff said, "I have the time to travel to people in my area." Staff were trained and were knowledgeable about what keeping people safe meant. Staff had a good understanding about how to respond and report any concerns they may have had. For example, to the provider's management staff and the local authority if this was required. This meant that concerns about people's safety would be recognised and acted upon swiftly.

The regional manager, office based senior staff and care staff confirmed that there were arrangements in place for staff absences. This was for situations such as leave as well as unplanned absences for sickness. This included the provision of shift rotas in advance and plans were in place if there were issues with traffic or weather. The care coordinator said, "Yes we do have occasions where office staff are required to help but if this is required then we all help. If we need staff in an emergency then we can borrow some from another of [name of provider's] locations."

Risk assessments were in place. This was to help ensure that people's safety was given due consideration. Subjects covered by risk assessment included people's moving and handling, travelling in the community as well as people who were at an increased of choking. Risk assessments were reviewed regularly for subjects including the safety of the place where people were cared for. This was to help ensure that people were cared for in a safe way. We saw that actions had been taken in response to issues relating to staff to prevent the potential for any recurrences. Measures were in place to manage risks such as two staff to support people and reminding people to use their walking aids. This included reminding staff to always inform the office if, for any reason, they were going to be late for, or had missed, a care visit.

During our inspection we found that people were supported with their needs by a sufficient number of staff. The regional manager told us that they were not taking on any more people's care until more staff had been recruited. Care staff told us that they had the time they needed to care for people however long this was. One member of care staff told us that they had had a recent emergency situation where they were not able to leave the person they were caring for. The office based staff arranged alternative care staff. Another member of staff said, "It helps having people I care for near to where I live especially if the weather is bad." The regional manager confirmed that they had recently reviewed where people and staff lived, especially as new people started to use the service. This was planned to help ensure that staff were available to arrive on time when rostered. Staff told us and records viewed confirmed that staff provided care at the allocated time and they stayed for the required period of time that had been allocated for people's care.

Robust recruitment processes and procedures were in place. This was to ensure that only those staff deemed suitable to work with people were offered employment. Checks completed before staff commenced their employment included recent photographic identity, evidence of previous employment history and enhanced checks for any acceptable criminal records. The regional manager told us that people's care, wellbeing and safety came first and foremost. They said, "We use our human resources department to ensure only the right candidates make it to interview." They added that it was then up to the branch manager to select the staff based upon their skills and performance at interview. One care staff said, "I not only had an interview I had to provide my driving licence, two references and history of employment as well as having a Disclosure and Barring Service check before I started work."

People were supported to take their medicines in a safe way. This included any person who required their medicines to be administered via an artificial feeding tube. This was for people who are not able to eat or drink orally. Staff confirmed that they had been trained in the safe administration of medicines. This included medicines that had to be administered under strict conditions such as before food. Staff's competency to do this safely was regularly assessed. However, we found in people's home we visited that staff had not always signed the medicines administration record (MAR). There were four occasions where staff had recorded the administration in people's daily notes. This meant that good medicines administration practice was not always being adhered to. One person said, "They [care staff] get my medicines out for me, make sure I take them with water and then they sign the [MAR] sheet." Another person told us that care staff

Good

Is the service safe?

watched them take their medicines. They said, “This is good because there are a lot of tablets at different times of the day.” Where people’s relatives administered their medicines the responsibilities for this were clearly identified and recorded. The regional manager explained that any updates were made known to the branch manager and that this was passed to staff either immediately or at a staff meeting.

Good

Is the service effective?

Our findings

Staff described accurately and in a detailed way how people's care and support was provided. Diets according to people's health needs were provided. One senior care staff described how people were supported with their eating and drinking through a an artificial feeding tube. They said, "When I train new staff I make sure they know exactly how much fluid the person can safely have." We saw that training for artificial feeding had been regularly completed by those staff who undertook this type of support.

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. We checked whether the service was working within the principles of the MCA. We saw that processes were in place, along with risk assessments, which showed how people could take risks and make unsafe decisions (within the MCA). At the time of our inspection all of the people who were using the service had the mental capacity to make informed decisions for themselves.

Staff were aware of how they needed to support some people make certain decisions about their care. For example, by ensuring they obtained a valid consent and agreement from people before providing any care. This included supporting people to make informed choices about what they wanted to wear, the food they ate and the time they preferred their care. Staff had been trained in and they had an embedded understanding of the MCA. They knew what action to take if they suspected or found that a person's mental capacity had changed.

Staff told us about their induction and said that it enabled them to do their job effectively. Staff were introduced to people they were caring for. This was as part of their induction and shadowing so that new staff could get to know people as far as practicable, before they started to work on their own. One member of care staff said, "My induction was about one week in the classroom and then a period of time working with supervision and then I was on probation for six months. I had a meeting with my supervisor every month or so until I was confident to do things on my own."

The provider had a comprehensive and effective staff training programme in place. This included subjects such as: medicines administration, dementia care, safeguarding people from harm and moving and handling. Other more detailed training was also provided for subjects including Parkinson's disease, stroke awareness and catheter care. As well as formal training, staff were mentored and coached by more experienced staff in providing care based upon what worked well for each person. The training staff received helped enable them to do their job safely and effectively. One member of staff said, "The training is good. We have an in house trainer and they make sure we complete our training on time and keep this up-to-date." One person said, "They [care staff] know what they are doing and they know me as well as anyone can."

Staff described the support they had received from the management as "being there when required". One staff said, "I don't need to wait for a formal supervision I just go straight to the office." There is never an issue as they [management] listen to me." Staff confirmed their regular support and formal supervision was a two way conversation and an opportunity to discuss their plans for future training and any additional healthcare related qualifications. The regional manager told us and staff confirmed that opportunities were provided for staff to undertake the Care Certificate. This is a nationally recognised qualification for staff working in the care industry.

Records showed us that people generally had the same experienced staff and that changes were, in the majority of situations, made known to people or their family members in advance. The regional manager explained that over the Christmas period and whilst a new manager was being recruited that there may have been occasions where people did not receive their rotas in the post. They told us that this was being looked into and also improving the timeliness of staff rotas.

People were supported to eat and drink sufficient quantities. People were involved in decisions about what they wanted to eat. One relative told us, "They staff get

Good

Is the service effective?

three choices out for [family member]. My [family member can then chose what they want to eat." Another relative confirmed that staff always made sure that their family member was always left with a drink within their reach.

Staff informed people or their relatives if they identified a change in the person's health. One person said, "I am confident that if my health changed the staff would call my GP." A relative told us, "I am not always available to support my [family member] but the staff always let me know when the community nurse has been and if there has been any changes to medications." One member of staff told us that they had contacted the emergency services when they had found a person on the floor on their arrival to person's home. They said "I called 999 straight away." We found that staff's knowledge at identifying changes in people's health supported people to maintain their well-being.

Good

Is the service caring?

Our findings

People, relatives and staff we spoke with confirmed that people's care was provided with kindness and compassion. This was by staff who knew people and their needs well. Staff explained to us how they respected people's dignity by keeping people covered as much as possible with towels and clothing. This was whilst providing personal care such as when having a wash in bed. Other examples included reassuring people with conversation as well as having staff who shared common interests with the people they cared for. Staff also told us they gave people time to communicate their wishes as well as listening to what they had to say. One member of staff said, "I love my job and helping to make a difference to people's lives. Sometimes it is the little things such as making sure the person had a cup of tea in a tea cup."

Care plans detailed the way in which staff should announce their arrival at people's homes. Staff told us and we observed that when they arrived at people's homes they always announced themselves to the person or their relative. People had their personal care provided in the privacy of the room of their choice. Compliments from relatives included 'thank you's' for the way staff cared for people in their last few days as well as appreciation for the time staff spent with people in a meaningful way. For example, "Thank you for the care "Hales" has shown to [family member] and me." One person's friend described the care provided by the regular care staff as being "absolutely brilliant with [name of person]".

Staff were very knowledgeable about the aspects of people's lives that were important to people. They also respected people's right to a family life. We found that people were encouraged to maintain contact with their families as well as being supported to access the community wherever possible. The regional manager told us and staff confirmed that, as far as possible, staff were matched to the people they cared for. For example, if staff had a shared interest in a hobby such as reading, knitting or football. One person said, "All the girls [staff] are wonderful. I have no complaints about any of them. We saw in people's daily notes how staff recorded people's care with sensitivity and detail which showed how the care was provided in an individualised way. One care staff said, "The care plans contain the information I need to know, especially as I haven't worked for [name of provider] for that long." One relative said, "The interactions [from staff] are good and that the carers know about [family member] and what they like and prefer to do." They added, "Whenever [family member] needs anything extra doing, they [care staff] will help as much as they can, they don't forget little things like putting [family member's] coffee where she can reach it and checking she has everything before they go."

Management staff confirmed to us and we saw in people's care plans that a service user guide contained information about the advocacy arrangements that were available. This was through organisations such as Age UK as well as relatives or their representative. Advocacy is for people who can't always speak up for themselves and defends people's equal rights against discrimination.

Staff, relatives and the service's management staff confirmed that people were involved as much as possible in their care planning. One person told us, "I have [health impairment] and the staff really do know what I can and can't do. They never assume that I can or cannot do something. I can't fault them."

Good

Is the service responsive?

Our findings

Prior to people starting to use the service their care and support needs were assessed. This included the provider's assessment and the local authority single assessment process. The regional manager told us that the branch manager's role was to then check this assessment. They told us that this process helped ensure that people's needs and preferences were accurately determined. One person said, "They [senior staff] came to the house. They checked everything was working for my [family member] and that if there was anything that needed to be changed I just had to call them in the office."

Care plans contained relevant information and guidance for staff. Staff supported people to reduce the risk of social isolation and maintaining people's independence. For example, with information about the person's life history and what their favourite pastime was, such as going shopping, going into local towns as well as reading and watching TV. Staff confirmed that the care plans provided everything they needed to know about the person. Senior staff and managers had obtained important information regarding people's backgrounds and their assessed needs. This was from people or their family members. This was to help ensure that people's care was accurately determined. Staff said that this had really helped gain an in-depth and individual understanding of the aspects of people's lives that were important to them.

Senior care staff told us that as well as people's daily care records, regular telephone calls to monitor people's satisfaction were undertaken. Any changes to people's care were then implemented. For example, changes to the length of the care visit or changes to the persons' circumstances such as returning home from hospital. One person told us, "I recently had a [health condition] and I needed more care. My [family member] managed to contact the [branch] manager and make the changes smoothly without any problems." Staff also confirmed that any aspects of people's care that needed to be highlighted to the next member of staff visiting the person were clearly recorded. This information helped staff to respond to the person's needs based upon the most up-to-date information. Records we viewed confirmed that this was the case.

Complaints, complements and people's concerns were recorded by the provider, responded to and acted upon. The provider had processes in place to monitor the effectiveness of any actions taken. These included spot checks to help ensure that the required standards of care were adhered to such as staff's moving and handling. One person said, "I don't and never have had any cause or reason to complain." A relative told us, "We have had just about the same staff for years and I have never had to complain." One member of care staff said, "If ever anyone wanted to complain about something I would record this and report it to the office." People, relatives and family members had access to a service user guide. This included information about how to raise a concern or provide positive feedback. Information about other organisations people could escalate their concerns, should they ever have a need, included the Local Government Ombudsman for adult social care.

People were supported to make suggestions or raise concerns about their care. For example, recruiting more staff and responding more promptly to any concerns raised. We found and the regional manager confirmed that this was the case. Other actions taken included improvements to the staff interview process to ensure staff possessed the right skills. These actions were kept under constant review to help ensure they remained effective.

Requires improvement

Is the service well-led?

Our findings

The provider is required, by law, to notify the CQC of certain events such as those where neglect is suspected. Prior to our inspection we had received one notification about a missed call. However, at the inspection from records we looked at we found that between March and December 2015 there had been 10 recorded missed calls where people may have been neglected. On one occasion there had been three missed calls in one day where people had not had their care calls. Although the provider had been made aware of this after the event they had not always notified the CQC.

This was a breach of The Care Quality Commission (Registration) Regulations 2009 regulation 18.

The service did not have a registered manager in post. The regional manager told us that they had recruited someone into the position and they were going to apply to the Care Quality Commission (CQC) to become a registered manager.

The regional and branch manager told us how people and staff were actively involved in developing the service. This included an annual quality assurance questionnaire for people as well as a staff satisfaction survey. Other ways people were involved included regular monitoring of their satisfaction by telephone calls, home visits and contact with management and care staff. Views sought from people included comments and suggestions made during day to day care visits as well as the information from accidents and incidents. This was for those areas and subjects which worked well and where improvements were required. Key areas for improvement had been to recruit more staff and improve the monitoring of care call visits. We found that both these items were in progress. The regional manager told us that they were considering the implementation of a call monitoring system to ensure that people and staff were safe. This was by having an electronic notification when staff arrived and completed each care call visit.

The regional manager told us and staff confirmed that they were provided with information which covered the principles and values of the service. This was during staff's induction as well as a newsletter, memo and staff meetings. These values included putting measures in place that reduced the risk of people being isolated such as the use of volunteer services and access to day centres. All staff confirmed that they worked well as a team and that supporting each other in the roles they were employed in. Other ways management staff kept themselves aware of the general day to day staff culture was by undertaking spot checks and also working shifts such as a double up call with care staff. This helped maintain the right standards of care as well as developing staff's skills. One person said, "I am totally satisfied with all my care. I can't fault any of the girls [care staff]."

We were told by staff and management that if poor standards of care were identified that these would be acted upon. Staff were also confident to report any poor standards of care if ever this was necessary by whistle blowing. One care staff said, "I would absolutely have no hesitation in reporting any staff that were not up to the mark." We found that the provider's disciplinary process was invoked should any staff be found to be not demonstrating the values of the provider in putting people first.

The provider had measures in place to review staffing based upon people's needs. This was by only taking on people's care once new staff had been recruited, inducted and trained to meet people's needs.

Staff told us and we found that links were maintained with the local community. This included supporting people to go out shopping, accessing a day centre or being visited by family members or friends. Staff confirmed that they assisted people to access the community and go where they preferred to. One person said, "I don't go out in the bad weather but I do get out and about when I can."

The regional manager explained to us that staff meetings were used as an opportunity to involve staff in making a difference to the quality of service they provided. Examples included where staff had been reminded to ensure they always notified the office if they were, for any reason, not able to make a care call. Staff were kept up-to-date with information from meetings by a newsletter, memo or e-mail. This helped ensure that staff were always aware of people's latest care details.

All staff told us that management support was available when they needed this. The provider had recently had cause to move out of their registered address. As part of their business continuity plan they had moved out to alternative accommodation for three months. During this period support to people and staff had not been affected.

Requires improvement

Is the service well-led?

This was confirmed to us by people and staff we spoke with. One care staff told us, "I have their [management] mobile number and can call them at any time. I rarely need to ask for any help but they are there for me if I did need them."

Staff were provided with opportunities to highlight what worked well and what support they needed. This included day to day support as well as formal supervisions, staff meetings and appraisals. Staff were also able to comment on any areas they felt would benefit people. One care staff told us that if a person's care arrangements and support needed changing then measures were put in place for this. For example, by ensuring, as far as practicable, that the same staff supported the same person. One relative told us, "They [care staff] have been coming to help us for a while and having the same familiar faces really helps my [family member]."

The provider subscribed to various organisations to help ensure that any changes to areas which affected or could affect people's care were implemented as soon as practicable. This included information regarding the administration, storage or disposal of people's medicines.

The regional manager visited the service on a weekly basis as well as supporting other registered managers at the provider's managers' forum. The branch manager and senior staff told us that the support arrangements worked well and that requests for additional support, such as whilst a permanent manager was being recruited, then this was provided.

Other support was available to the branch manager at managers' forums. This included sharing best practice with the provider's other registered managers. For example, where several staff had a lead role as skills champion for dignity in care. Staff told us and certificates we saw confirmed this was the case. Staff told us that this training had helped them gain further insight into what individualised dignified care looked like in practice. This was to help ensure that people were supported with their individualised care needs based upon best practice guidance.

Regular quality assurance monitoring was undertaken by management and senior care staff. This included an annual quality assurance satisfaction survey questionnaire. We saw that the 2015 survey had just been sent out and that the majority of responses to the 2014 survey were positive or very positive. This helped ensure that the expected standards of care were maintained and improved upon if required. This was for subjects including moving and handling, infection prevention and control and the accuracy of people's daily care records. One person told us, "They [managers] came round last week to check on my girls [care staff]. I never have a problem with the staff they are all amazing." One care staff said, "The first you know is when a car pulls up outside people's homes and the senior staff are there, unannounced." This helped ensure that the expected standards of care were maintained and improved upon if required. This was for subjects including moving and handling, infection prevention and control and the accuracy of people's daily care records. However, we found that these and other checks had not always identified when staff had not completed people's medicines administration on a MAR sheet.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents How the regulation was not being met: The registered persons had not always notified the Care Quality Commission about incidents they are required, by law, to do so. Regulation 18 (1) (2) (e).