Hales Group Limited

Hales Group Limited - South Tyneside

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Hales Group Limited South Tyneside is a domiciliary care agency providing personal care to over 350 people at the time of the inspection.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People and relatives had significant concerns about the care Hales Group South Tyneside provided. People were not provided with information to let them know which carer was attending at what time. They told us they did not have consistent care workers, and care workers regularly arrived later or earlier than expected or did not stay for the full length of the call. People and relatives gave numerous examples of how this impacted on personal care and medicines, potentially placing people at risk of harm. Care rotas corroborated these experiences, including for time critical calls. There were also occasions where two carers were required to attend, but the second carer was significantly late.

Most people confirmed care staff were caring. However, the manner in which rotas were managed significantly impacted people's wellbeing and quality of life. Some people described how they did not feel their dignity and respect were a priority.

The provider described how they were working to improve the situation following challenges relating to the transfer of care from the previous provider and the COVID-19 pandemic.

Some safeguarding concerns had not been reported, or not reported in a timely way, to keep people safe. The provider had also delayed in making statutory notifications to the Commission about these incidents. Most staff had completed safeguarding training and knew how to raise concerns.

Management of rotas was identified as the root cause for most complaints and safeguarding referrals. However, the improvements the provider introduced to date had not yet delivered sustained improvements. Staff gave similar feedback about rotas being unmanageable, often planned late and constantly changing.

New staff were recruited safely. The provider was renewing Disclosure and Barring Service (DBS) checks for all staff who had transferred to the service.

Due to the number of early and late calls, people did not always receive their medicines when they needed them. Risk management plans for managing medicines safely and to mitigate other risks contained generic statements which were not specific to people's needs. The provider was reviewing care records for all people to ensure they were suitable to meet their needs.

Most people told us staff followed personal protective equipment (PPE) guidance. Staff gave positive feedback about the provision of PPE and said they had access to the supplies they needed.

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

Most staff told us they did not feel supported working for Hales Group Limited South Tyneside. The provider was making progress with plans for all staff to complete training, to update their knowledge across a range of care related topics. However, staff providing stoma care required more in-depth training and support. People were mostly supported with having food and drinks of their choice.

People and relatives described how they received poor responses following complaints and had raised the same issues repeatedly with no improvement.

Care records lacked personalisation and contained a high level of standard statements. Since recently taking over the service, the provider was making good progress with reviewing people's care plans. Although, staff had access to personalised information through an app on their mobile phone. The quality of recording in daily logs was inconsistent.

Staff gave mixed feedback about the culture of the organisation. Some staff did not feel able to approach management, felt their views were not always listened to and did not get feedback about their suggestions. Staff also described staff morale as very low.

People, relatives and staff all raised concerns about difficulties in getting through to the office and the attitude of office-based staff. They also had concerns about the lack of local out of hours arrangements. This was in part due to circumstances outside of the provider's control. The provider had acted to continually monitor and resolve this situation. This included providing additional phone lines and customer service training for office staff.

The provider's current systems of quality assurance had not been successful in improving the experiences of people using the service. The quality improvement plan had been updated following our visit to the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 25/09/2020 and this is the first inspection.

Why we inspected
The inspection was prompted due to concerns received about poor management of care calls which impacted on people's safety and wellbeing, poor communication and lack of response to concerns and a failure to resolve issues. A decision was made for us to inspect and examine those risks.

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

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

The provider has taken action to mitigate risks to people. However this has not been effective, and people

remain at risk of harm.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to safe care and treatment, safeguarding people, staffing and good governance.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will also meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Hales Group Limited - South Tyneside

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
One inspector and two Experts by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We gave a short period notice of the inspection because we needed to arrange telephone calls with people using the service and to contact staff prior to visiting the office.

Inspection activity started on 17 December 2020 and ended on 8 February 2021. We visited the office location on 8 February 2021.

What we did before inspection
We reviewed information we had received about the service since the last inspection and sought feedback

from the local authority. We used this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with 30 people who used the service and relatives about their experience of the care provided. We received feedback from 45 care workers by email. We also spoke with the Director of Operations and the registered manager. We reviewed a range of records. This included 10 people's care records and multiple medication records. We looked at seven staff files to check recruitment. We also looked at a variety of records relating to the management of the service, including policies and procedures.

After the inspection
The provider sent us additional information which we considered when making judgments.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- People did not receive the care they needed, when they needed it, impacting on their wellbeing and safety. Due to poor rota management, people did not always receive care from a reliable and consistent team. Over three months one person received care from 59 different carers, for another person the number was 42.
- 21 out of 30 people and relatives gave negative feedback about the care provided. They said they were not sent a rota, care workers changed regularly, were often early or later than expected and did not always stay for the full length of the call. They told us this negatively impacted on their care and wellbeing.
- People and relatives commented, "We had a letter at the start saying continuity was paramount, carers would continue. That is clearly not happening, four visits a day and four different carers. The majority [family member] had never met. [Family member] can get agitated, a carer [family member] doesn't know upsets them."
- Most of the 45 staff who contacted us raised concerns about rotas, some describing them as unmanageable. They said rotas were planned last minute and changed constantly, even on the day. This limited their ability to be on-time and provide person-centred care. Staff members commented, "Calls are added on without any notice. On one occasion calls were added to my rota overnight, and I was not informed of these additions either by call or text. As these calls were scheduled before my first call, I was unable to fit them in and so these calls were missed."

The provider failed to ensure rotas were managed effectively so people received care when they needed it. This placed people at risk of harm. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing

- The provider had plans to help retain current staff and recruit new staff to ensure staffing levels were sufficient to provide people's care on time.
- New staff were recruited safely. The provider was updating DBS checks for staff who had transferred to the service as part of a recent change of provider.

Using medicines safely

- The provider did not manage medicines safely. Relatives gave many examples where family members had not received their medicines or received them late.
- Some people had time critical or time sensitive calls for medicines administration. These were not always fulfilled on time. For one person, a significant number of these calls for January 2021 were much earlier than planned; sometimes over two-hours early. We have asked the provider to investigate this and report back to us explaining the reasons and the action they are taking.

● The provider did not always respond quickly to medicines incidents. The provider identified through medicines checks one person was not taking their medicines as prescribed. They told us an investigation was carried out. However, they were unable to provide the investigation report when we requested it.

The provider failed to ensure medicines were managed safely. This placed people at risk of harm. The above is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

Systems and processes to safeguard people from the risk of abuse
● People were not adequately protected from the risk of abuse. There were occasions when safeguarding referrals were not made to the local authority in a timely way.
● On one occasion the provider delayed making a safeguarding referral for five days after being made aware of a risk to a person's safety. The statutory notification the provider submitted to the Commission indicated the provider had previous concerns for this person which had not been acted on at the relevant time. The provider told us they investigated the issues and took action to keep the person safe.
● The provider's safeguarding analysis identified rota management as the root cause for many safeguarding referrals. The provider had identified actions to improve rota management. We found further improvements were required to ensure these improvements were sustained.

The provider failed to ensure timely action was taken to safeguard people at risk of abuse to ensure they remained safe. This placed people at risk of harm. The above is a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment

● The provider was making progress with updating staff member's safeguarding training. 85% of care staff had completed the provider's 'upskill training' programme which included safeguarding.

Assessing risk, safety monitoring and management
● The provider did not effectively manage risks to ensure people received their care safely.
● Staff missed a crucial night-time call for one person, leaving them without their welfare check. When care staff arrived for the next call, the person was found to be very unwell.
● On another occasion staff arrived without the information about the person's care needs. This meant some tasks were not completed, including ensuring the person had eaten.
● One relative told us care staff had recently arrived extremely late to support their family member into bed. They were over three hours late and arrived in the early hours of the morning. Records showed this had happened on nine occasions in January 2021. This left the person without the support they needed to assist them to bed at a suitable time.
● The provider assessed risks to people as part of the care planning process. However, risk reduction measures were often generic statements, which did not reflect the person's specific needs.

The provider failed to ensure risks were managed robustly so people received their care safely. This placed people at risk of harm. The above is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

● The provider had recently taken over the service. They were making good progress with reviewing people's care plans and risk assessments to ensure they reflected people's actual needs.

Preventing and controlling infection

● The provider had procedures in place to promote safe infection prevention and control (IPC).
● Staff told us they had access to IPC training and were supplied with PPE they needed.

Learning lessons when things go wrong
● The provider has systems for monitoring incidents and accidents. There had been one accident logged since September 2020 which did not involve a person using the service.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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

Staff support: induction, training, skills and experience

- Staff did not receive the training and support they needed to be effective in their caring role.
- 19 out of 21 staff told us they were not well supported, and this impacted on their ability to care for people. Staff commented, "I feel I'm not supported in anyway. I have raised them [concerns] and had no support back", "I don't feel very supported in my role, as whenever I have had a problem with my rota I don't feel as though it is being listened to" and "I do not feel supported at all. The most crucial point of contact, being the office, can ignore the phone for hours."
- Although most staff had completed 'upskill training', training for more complex care was not up to date or completed. Training information provided for staff supporting people with stoma care showed only six out of 13 staff had completed specific training and this was with a previous provider. The provider told us they did not usually complete a competency assessment for this type of care.

The provider failed to ensure staff received good support and all of the training they needed. This placed people at risk. The above is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing

- Following our visit to the service, the provider updated the quality improvement plan to include plans to update stoma training for all staff.

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

- People were not always supported in a timely way to have enough to eat and drink.
- Relatives gave mixed feedback about how well people were supported with eating and drinking. This was mostly due to call times not being attended as planned. These were often early or late which impacted on people's mealtimes.
- One relative commented, "Ensuring that [family member] eats is paramount to their care, and there have been times when food is left for [family member] but no encouragement to eat."
- Care plan and daily logs showed people's preferences were recorded about what they liked to eat and drink.

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

- Care plans included information about the other agencies involved in people's care. This included a range of health and social care professionals.

● Health and social care professionals were supporting some people to address concerns that had about their care.

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

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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.
● The provider's care planning documents contained a section covering capacity issues. People whose care plans we reviewed had been assessed as having capacity to make decisions about their care.
● People's needs were assessed as part of the provider's care planning process. This included information about religious, spiritual and cultural needs.
● The provider was reviewing every person using the service to ensure the care provided met their needs. This was due to be completed by the end of February 2021.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

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

Respecting and promoting people's privacy, dignity and independence

- People were not always treated with dignity and respect because they did not always receive essential care when they needed it. This often impacted negatively on people's wellbeing.
- People described how care staff were often late or did not stay for the full length of the call. This meant they often had to wait for long periods of time or try and provide their own care. People and relatives commented, "It's not as consistent as it could be, sometimes the morning is 6:45, sometimes 9:30" and "The morning one [care staff] was quite late, but not a problem as I did it myself."
- One person raised concerns about how lack of training in a specific area meant they did not feel their care was provided in a dignified way.

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

- People and relatives had significant concerns about rotas and how this impacted on people's care.
- People generally felt care staff were kind and considerate. Most people and relatives told us the concerns they had about the care provided were about poor organisation and communication, rather than the staff providing care. People and relatives commented, "The girls [care staff] are doing their job. There's unhappiness, the carers don't feel appreciated … I've seen a deterioration in the care; management is the problem."

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

- Relatives were actively involved in some people's care and advocated on behalf of them, depending on their needs.
- Care plans identified where people had an independent advocate.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- The provider was not effective in using learning from complaints to drive through sustained improvement in people's care. Rota management was identified as a root cause of 45 out of 98 complaints. The provider had identified actions to improve rota management. Further improvements were required to ensure these improvements were sustained.
- Individual complaints had been investigated and actions identified to resolve issues.
- A significant number of people and relatives told us they had complained about the service. Although some saw some improvement at first, this was not sustained. They also told us they had raised the same issues numerous times without improvement. One relative described how this was a daily issue they had to contend with.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans required further development to ensure they were personalised to meet people's needs.
- The provider used an electronic care planning system to plan people's care. The care plans developed contained a large amount of generic information which was not always relevant to each person. The provider had recently taken over the service. They were making good progress with reviewing people's care plans and risk assessments to ensure they reflected people's actual needs.
- Care staff completed daily logs of what they had done at each visit; these varied in quality. Some care staff recorded in detail what care they had provided, whilst others recorded general statements, such as 'all care tasks completed.'

Meeting people's communication needs

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

- Information could be made available in different formats, if needed.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care

- The provider had systems to learn from people's experiences. Although actions had been identified as a result, these had not always been successful in delivering sustained improvement to some people's care.
- The provider's analysis of complaints and safeguarding referrals identified rota planning and management as a major contributing factor. The provider acted to address these concerns. However, further improvement was needed to ensure sustained improvements were delivered.
- People and relatives told us they had significant concerns about the care Hales Group South Tyneside provided. They had raised the same concerns continuously with little improvement seen. People and relatives told us, "[Family member] did have conversations with Hales about what was required for [family member] … but since that conversation, assurances have not been met. We still have problems with timings of visits and inconsistency of staff, who sometimes aren't aware of [family member's] needs."
- There was a high level of dissatisfaction with the service from people, relatives and staff. 27 people and relatives contacted the commission between 25 September 2020 and 8 February 2021 with complaints about the service. The majority of the 45 staff who gave feedback also raised concerns about the service.

The provider had failed to use learning and take decisive action to improve the care people received. This placed people at risk of harm. The above is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

- The provider and registered manager were committed to making significant, long-term improvements to people's care. They had experienced unexpected difficulties in making as much progress as they would like. In particular, the COVID-19 pandemic had a serious impact in the availability of staff, which affected their ability to deliver care on-time. The provider had also encountered problems during the transfer of services from another care provider and cultural issues. The provider sent us information to show the situation was improving, such as the number of calls provided within 30 minutes of the planned time had improved from 61% in October to 80% at the end of December. Also the number of complaints received had fallen in January 2021.
- The provider had developed an overall quality improvement plan which identified actions to help improve people's experience. Following our visit, this was updated with additional actions to increase the capacity to improve communication with people, relatives and staff. Office based staff were starting customer service training to improve people's experience of contacting the provider.

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

characteristics
● The provider did not effectively engage with people and staff to ensure their feedback was encouraged, valued and used to drive improvements. They were carrying out an extensive review to improve engagement with people, relatives and staff.
● Some people and relatives told us they had raised concerns about rotas several times. They said their concerns had not been addressed. They commented, "Things haven't really improved, as you know we were assured things would get better and sorted out but really there is still lots to be sorted out" and "When I was sending emails for explanations they said all the right things but didn't really improve."
● Staff told us their views were not valued or listened to. They commented, "I am able to make them but I do not believe they are listened to" and "I always raise my issues on behalf of my service users but these changes are never made."
● People, relatives and staff described communication generally as poor. People and relatives said the provider was not proactive in ensuring changes to calls were communicated in advance of the change happening.

The provider had failed to learn lessons from previous feedback and improve people's care. This placed people at risk of harm. The above is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The culture of the organisation did not promote a person-centred approach to delivering care or an openness which empowered staff.
● Most people and relatives told us care was not provided when people wanted or needed it. People did not know in advance the planned times for their care and which staff would be attending. Relatives told us they had been promised rotas on many occasions, but this had not happened.
● Many staff told us they could not easily approach management. When they did, they felt their views were not valued or not always listened to. They told us this affected how well they were able to care for people.
● Most staff felt morale was extremely low. Staff commented, "Staff morale is very low. We just don't seem very supported from the office, there are always problems with the rotas and also the attitude that you get from a few of the office staff."

The provider had failed to promote a culture where the views of people and staff were actively encouraged and acted on. This placed people at risk of harm. The above is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

● Following our inspection the provider updated the quality improvement plan with additional measures to improve staff morale.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● The registered manager had not been proactive in making timely notifications to the Commission. Most notifications were submitted more than a week after the incident had occurred. We are dealing with this matter separately.

Working in partnership with others
● The provider was working with the local authority commissioners to improve performance and outcomes

for people using the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks were managed robustly to ensure people received safe care. The provider also failed to ensure people received their medicines when they were due.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure timely action was taken to safeguard people at risk of abuse to ensure they remained safe.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to have in place robust systems for checking and mitigating risks, quality and safety within the service. The provider had also failed to learn lessons from previous feedback and improve people's care.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure rotas were managed effectively so people received care when they needed it.