Hales Group Limited

Hales Group Limited - Thetford

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

This was an announced inspection that took place on 15, 16, 17 and 25 November 2016. On 15 November 2016 we visited the provider's office. On 16, 17 and 25 November 2016 we contacted people who used the service, their relatives and staff who worked for Hales.

Hales provides domiciliary care services to people in their own homes. At the time of the inspection, the service provided care and support to 186 people.

We last inspected Hales Group Thetford in October 2015 where we rated the service as 'good' overall however we rated it as 'requires improvement' in well-led due to there being failure in the provider's systems to make sure that there were always enough staff to meet people's needs.

We re-inspected the service in November 2016 as we received a number of concerns about people not receiving their care as planned and a high number of late and missed care calls. This meant that people were not receiving the care they required.

There was no registered manager in post in day-to-day charge of the service as required by the provider's registration conditions. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service did not employ enough staff to meet people's needs. This meant some people had not always received their planned visits or visits were late. This resulted in risks to people's dignity, welfare and safety. Some people who needed two care staff at each visit had only one staff member arrive. This meant care could not be carried out as required, or safely; or relatives were supporting the care staff to deliver care. This placed people and staff at risk of injury or harm.

There were robust recruitment processes in operation, which contributed to protecting people from the employment of staff who were unsuitable to work in care.

Medicine administration records were not always completed accurately and medicines were not always administered as the prescriber intended.

Risks to people were assessed and there was guidance for staff about how they should minimise these risks while they were delivering care.

People and their relatives were not always positive about the skills, experience and abilities of staff who worked in their homes. Care was not provided in a way that always promoted people's dignity and respected their privacy. Not all people received personalised care and support that met their changing

needs and took account of their preferences.

Staff had received suitable levels of initial training but their competence had not always been checked in the delivery of care and support. Supervision and observation of practice had not been completed routinely. Staff did not always receive appropriate support.

The company had a suitable complaints procedure. The procedure had not always been followed but the regional manager was ensuring that any outstanding responses were dealt with.

The staff understood their legal obligations when making decisions on behalf of people who could not make them for themselves. They were also knowledgeable in recognising signs of abuse and were aware of the procedures to follow to safeguard people from harm.

People were complimentary about their regular care workers but felt the care provided by new workers did not always meet their needs.

Management arrangements at the service were inconsistent. There had been a number of management changes meaning a lack of consistent leadership and support. This had affected staff morale and the quality of the care being provided to people who used the service.

We found the service was in breach of four regulations 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not sufficient numbers of staff to meet people's needs at the times they requested.

Staff underwent the necessary checks before they were employed

People were protected by a staff team who could recognise signs of potential abuse and harm.

Medicine administration records were not always accurate and people did not always receive their medicines appropriately.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not being regularly supported and developed.

Staff adhered to the Mental Capacity Act 2005 code of practice and obtained people's consent prior to providing care.

People were supported to maintain their day to day health needs.

Is the service caring?

Requires Improvement

The service was not always caring.

The lack of consistent care workers to support people impacted negatively on the relationships between people and their care worker.

People were supported by staff that were caring and that treated them with respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not receive care that was responsive to their needs and respectful of their preferences.

People knew how to raise concerns however they were not confident these would be dealt with in a prompt and positive way.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A lack of leadership, governance and managerial oversight led to the service being poorly managed.

The provider had not ensured that effective quality assurance procedures were in place to assess and monitor the quality and safety of the service people received.

Communication from the office staff to people and care staff was not effective in keeping people up to date with changes.

Hales Group Limited - Thetford

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 at the provider's office on 15 November 2016 and was announced. On 16, 17 and 25 November 2016 we contacted people who used the service, their relatives and staff who worked for Hales. The provider was given 48 hours' notice before we visited the office because the service provides care to people within their own homes. The provider and staff operated from a central office and we needed to be sure that they would be on the premises so we could speak with them during the inspection.

The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we requested that the provider complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was received from the provider. We also reviewed other information that we held about the service. We had requested feedback before the inspection from the local authority safeguarding and quality assurance teams.

During this inspection, we spoke with seven people who used the service and eight relatives of people who received care from Hales Group Thetford. We also spoke with the regional manager and had contact with 14 care staff and two care co-ordinators.

We looked at care plans and risk assessments, medicine administration records and communication logs of ten people who used the service. Communication logs are records that staff complete in people's homes

following their visit. We also viewed eight staff recruitment records and information in relation to staff training. We also looked at how the provider monitored the quality and safety of the service.

Before we carried out this inspection, we also reviewed the information we held about this service including notifications. A notification is information about events that registered persons are required, by law, to tell us about.

Requires Improvement

Is the service safe?

Our findings

Before our inspection, we had received concerns that some care visits had been missed. This had resulted in some people not receiving the care they needed. We had received feedback from the local authority that they were working with the branch to monitor the number of late and missed calls. Both the local authority and the regional manager told us that there had been improvements made however we could see from the monitoring in place that there were still a number of people who had late or missed calls.

There were not always sufficient numbers of care staff deployed to consistently provide people with safe care and sufficient support to meet their needs in a timely way. This had at times impacted upon people's care and wellbeing. These concerns were reflected in our conversations with people. For example one person said, "Once they [office care-coordinators] rang up and said that they couldn't get anybody out to see me and I'd have to find somebody myself. Recently they didn't come out to get my tea - they didn't even ring me to say and didn't even ring me the next day. It was really difficult but I had to try and get myself something. They are an absolute disgrace. I've never known a firm like this." Another person said, "They are often late. For example, they should have been here around 8am this morning and they came at 10.20am. We have had several missed calls. For example about six weeks ago at the weekend they didn't turn up at all. It means my [family member] has to help me which they find difficult.

One person's relative told us, "They are supposed to come in the morning. Some of them [care staff] can be very late. Sometimes they don't turn up at all so I have to help my [relative] myself which is not easy. On one occasion I phoned and they said [care staff] would be there in a few minutes but they weren't." A relative told us, "If I need to I can wash my [relative] but some people don't have anybody else to help them."

Staff told us there were not enough staff to meet people's care needs in a timely manner. Staff told us they often worked additional hours to try and help although this meant at times they were working very long hours sometimes with no breaks. One care staff member for example said they had worked over 60 hours in one week as there was no staff cover. Another member of staff told us that they felt pressured to still work even if they were unwell, "They have told me I cannot phone in sick if I am unwell, and they insist that you still work."

Staff told us that if they were unwell or on a day off they were still asked to come into work. Whilst some staff were happy to work additional hours some told us they found the pressure to work extra hours too much. One member of staff said, "Even on our days off they pester us all the time. They phone and phone us. They don't leave us alone, asking us to come into work and work extra shifts. To be honest staff end up switching their phones off."

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The regional manager told us that the provider was actively trying to address their recruitment of care staff and increase the numbers of staff working for them. We were told that they had recently employed a

member of staff to recruit new staff and that this had seen some benefit already as a number of new staff had been recruited. Office co-ordinators were responsible for organising the schedules for the staff for their care visits to people. Despite this people told us that they often had missed or late care calls. This meant that their allocated care worker was either running late or did not turn up at all. This resulted in the person not receiving any care, having to manage alone or being reliant on another family member to help them.

Some people who used the service relied on staff to help and support them when taking their medicines. The systems in place to ensure that people received their medicines safely were not robust to ensure that people received their medicines as per the prescriber's instructions. People did not always get their medicines at the time they needed them. We looked at a number of people's medication administration record (MAR) charts and found errors had been made and not identified by office or care staff.

Staff were routinely responsible for completing the MAR chart with the list of the medicines the person was taking. This information should be based on the medicines and instructions for administration as provided by the persons prescriber. One person had been prescribed antibiotics that were to be taken three times a day. Information about the length of time of the course of treatment had not been recorded on the MAR chart. We found that the same antibiotics had also been recorded in the 'as required' section of the MAR chart. This meant that they were recorded twice. We saw that recording of the medicines being administered was inconsistent. Some staff had signed in both places on the MAR chart for the same time of administration. This meant that the person may have received the medicine twice in error. We saw that on a number of days the staff had failed to sign the chart at all indicating that the medicine may not have been given. We could not be confident that the person had received their medicines as their doctor intended to address their health concern. We also found that where some people had been prescribed a medicine four times a day, this had only been signed for once a day for several weeks and this error had not been identified by staff or the office staff auditing the MAR chart.

Some other people also had incorrect information recorded on their MAR charts. Some staff had failed to record the names of some people's medicines accurately on their MAR chart. This meant that there was risk that they could receive the wrong medicines. We also found that there were a number of gaps with missing care staff signatures on various people's MAR charts with no explanation as to why the administration of the medicine had not been recorded. When we viewed audits of the MAR charts carried out, we saw that staff had failed to pick up all of the errors that we identified.

These concerns about the safety and management of people's medicines meant that we could not be confident that people were receiving their medicines as their prescriber intended.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us they felt safe receiving care in their homes and that they trusted the staff that arrived to see them. One person said, "We trust [staff member] completely. They are reliable and know what they are doing." Another person said, "I do generally feel safe with the carers themselves although the training definitely needs looking at." Relatives also told us that they felt their family member was safe when they knew the care staff were in their home and that they were reliable. One relative said, "The carers themselves are always helpful and I feel that my [family member] is very safe with them."

Staff we spoke with had a good understanding of how to identify abuse and act on any suspicion of abuse to help keep people safe. Staff also knew the principles of whistleblowing, the duty by a staff member to raise concerns about unsafe work practices or lack of care by other care staff and professionals.

Before commencing work all new staff had appropriate checks carried out to make sure they were suitable to work for the service, delivering care to people. These checks included seeking references from previous employers and carrying out a disclosure and barring service (DBS) check. The DBS checks people's criminal record history and their suitability to work with people in a care setting. We asked staff if the appropriate checks had been carried out before they started work. They all confirmed they had not started to work for Hales until their DBS check and references had been satisfactorily received.

There were personalised risk assessments in place for people who used the service. These identified the risks relating to people's care, health or wellbeing and detailed the measures put in place to reduce the risks. Risk assessments covered areas such as mobility and environmental risks in the person's home which may affect them and / or visiting care staff. We looked at eight people's risk assessments and found that they had been reviewed regularly to ensure the level of risk was still appropriate for them.

Requires Improvement

Is the service effective?

Our findings

People told us that they did not feel staff had the appropriate training to deliver their care effectively. One person said, "I feel that the training is null and void. A young [care staff] had just started. They were with another carer one day and was then left on their own. Another carer came to us and said that they had been called in. They had only started the other day. They said it was a good job that they had had training at their previous job." Another person told us, "The training definitely needs looking at."

Relatives we spoke with were equally concerned about the training staff received in order to care for their family member. One relative said, "I don't think that the training they [care staff] get prepares them for the job or that they are adequately qualified. I think this firm [Hales] will take anybody on." Another relative said, "I think they need more training and I don't think they get much training or updates. Hales don't seem to do this. There was one carer who had been in the job for a couple of weeks and they came to my [family member]. They were not shadowing but as the second carer and [care staff] had never seen a hoist before and had no idea or how to turn my [family member]."

The regional manager told us that new staff completed a five day training course when they first commenced employment with Hales. This covered key health and safety areas such as moving and handling, infection control, safeguarding and fire safety. New staff shadowed more experienced staff to help them to understand their role and responsibilities. We received mixed feedback from staff about the levels and type of support they received. One member of staff said, "I had a good five days training. It was thorough training, very good." Another member of staff said, "I was pleasantly surprised by the training. It was good, five days training which was thorough."

Other staff however told us that they had not always received the level of training or opportunities to 'shadow' experienced staff when they started that they needed to do their job effectively. One staff said "They [office staff] told me I would have three 'shadow shifts' when I started the job. After one they assumed that I would be okay to go off and work on my own. No one asked me. I would have preferred them to ask me if I was okay to work on my own. Actually I wasn't okay so I told them and they let me have another shadow shift." Another member of staff told us that they had been left alone to care for someone who needed the use of a hoist to get out of bed. The member of staff told us that they had been asked to care for this person despite having no hoist training.

Staff had different experiences in respect of support received. Some staff told us that they had received supervision although not consistently. Other staff said they hadn't received supervision at all. This meant that support was inconsistent and not all staff felt supported by the management.

We viewed the staff training matrix supplied by the regional manager and saw that there were a number of staff who had not yet refreshed their training as per the provider's policy.

The regional manager told us that the field care supervisor undertook spot checks in people's homes to check that staff had arrived on time, were wearing their ID badge and were observed to be competent in the

delivery of care. However not all of the staff we spoke with said that they had received a spot check at people's home. We also saw in some staff files for both existing and new staff that they had not had a spot check carried out. This meant that there were inconsistencies in the checking of staff competencies. Following our visit the provider told us their usual practice was to carry out spot checks after staff had completed the care certificate and not prior to providing care to people.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The regional manager told us they were aware that there had been gaps in staff receiving supervision and spot checks of their performance. They also told us that this was something that they were addressing. The actions being taken by the regional manager were acknowledged by some staff when we spoke with them.

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 decisions made on their behalf must be in their best interests and be as least restrictive as possible.

The majority of people who used the service were able to consent to their own care. We saw that people had been asked for their consent as part of their care planning and had signed to say they agreed to their care plans. Staff were aware of their responsibilities in seeking people's consent before providing any care or support.

People told us that where it was part of their plan of care that staff prepared their food and drinks, this was to their liking. One person said, "The carers are all helpful and friendly and they come in and get my food. They always ask me which meal I fancy." We saw from care records it was part of some people's care that staff should leave snacks and drinks available for them. Staff we spoke with confirmed that this happened.

All of the people we spoke with managed their own referrals and contacts with healthcare professionals. However people told us that staff did respond when there was an emergency situation. One person told us about how a staff member had telephoned for ambulance for them when they had been unwell and had waited with them until it arrived.

Requires Improvement

Is the service caring?

Our findings

People did not always receive the care and support that they needed. One person told us that there was an occasion when their care staff did not turn up to help them for two days. They told us that this had resulted in them not being able to access the toilet. They told us that as a last resort they had to rely on a personal friend to help them. They told us that they were never told by Hales why this happened. They said, "The only communication from the managers in this organisation is when I get a letter about the manager changing yet again. It really is terrible." Another person told us, "When I've phoned before about a missed call they [office staff] said we had cancelled the call which we hadn't. They lie and then we get a letter of apology." Another person said, "We pay for 45 minutes but only get 30 minutes but when I phone to tell them they don't believe me as the agency staff tells them they are here for 45 minutes."

Some people also told us that Hales were unable to meet their preferences for a particular gender of care staff. One person said, "They sent a male carer at the weekend and I've said that I didn't want a man in the mornings as there is a lot of personal care but they still sent him - it's unkind." Staff also told us that people's preferences were not always met. One staff member said, "Some of our people we care for ask for females to care for them, they get sent males and vice versa." A relative told us, "It's been put on the form but they [office staff] take no notice. [Person] wants a male carer to wash them in the mornings but they [office staff] take no notice. The usual carer is good and tries to help us but when they are off work they send women and my [family member] won't let them wash them." Another relative said, "I have rung the office to say [person] doesn't want women to wash him and they just say they haven't got enough men." This compromised people's dignity.

People and their relatives told us that changes in their regular care workers were impacting on the relationships and rapport people had built with them. They informed us it was harder to build a rapport with the number of new care workers they had. One person said, "My more regular carer is good and kind. [Carer] makes my bed and checks that I've taken my tablets. We have a chat. Some of the others are impersonal. They just come in, do the job and rush out." Another person said, "One day I didn't have anyone turn up. They phoned as they couldn't find anyone to come and see me." Staff also reiterated people's concerns. One staff member told us about their frustrations about the number of different care staff people received and the resulting lack of consistency in their care. They said, "One person I go to see had 20 different carers in 10 days. They are so fed up with the changes. They never know who is turning up."

People and their relatives were complimentary about the permanent care workers who had been consistently supporting them. Most people told us that whilst they did not hold the provider organisation Hales in good regard, they had developed good relationships with their regular care staff. One person said, "My regular carers are wonderful to me and I like them very much." Another person said, "Nobody can beat my [care staff]. They are worth their weight in gold. They are so kind to me and we have a great chat and a laugh."

Most relatives were also complimentary about care staff and the care their family member was receiving. This was particularly the case where their family member received continuity of care with the same staff

visiting consistently. One relative said, "We haven't had any contact with the office people but the carer who comes out and is our regular carer is perfect. [Particular care staff] is so kind and knows how to handle my [relative]. They [staff] are always cheerful and always on time and never rushes. You can't get any better than perfect can you?"

The staff we spoke with showed a great deal of warmth about the people that they were providing care to. One staff member said, "I love the care side of my job. I love learning about people. I put everything into my job. People like to talk to me about the war and that's fine, I talk to them. I make sure they are happy and they have a cup of tea if they want one. They are happy and we have a laugh." Another staff member said, "One person we help with lunch but when we get there they have already had it. I make sure I still give them their full time. I will vacuum for them and do the little extras."

A relative told us, "[Particular carer] talks to [relative] nicely and asks them if they need anything. They are very respectful and friendly and have a joke with us" A third relative was also enthusiastic about a particular carer saying, "[Care staff] is brilliant. They'll have a joke with you. They talk to us. [Care staff] doesn't just come in and go through the motions. [Care staff] has got to know my relative and built a rapport. This one [care staff] doesn't just come in wash [family member] and go like some of the other carers."

Staff understood the actions they needed to take to ensure a person's dignity and privacy were respected. People we spoke with were complimentary about staff and told us that they felt the staff were 'respectful' and treated them with dignity. Staff said they were mindful to ensure people were comfortable when receiving care. This included ensuring their privacy by drawing their curtains and closing doors, and ensuring their dignity through covering them up as much as possible whilst personal care was delivered.

Office staff told us that people were involved in the development and review of their care plans; however this was not always demonstrated through feedback obtained from people. One person told us, "They told me about six months ago that they were going to redo my care plan but they have never got round to doing it." Reviewing a person's care plan is important in ensuring that care staff have the correct information needed to provide a person with the care they need and would like.

Requires Improvement

Is the service responsive?

Our findings

People told us that the service was not always responsive to their needs. People also told us they did not always know who was coming to provide their care. People did not routinely receive a rota so they did not know which staff would be visiting them. We found and staff confirmed that staff changes were often made at short notice. People we spoke with were not happy with the arrangements for the timings of their care calls and how many changes were made. One person said, "We never get a rota. We never knew what time or who will be coming." Another person told us, "Sometimes they are in and out and don't stay for the time they are supposed to."

People's needs or preferences in relation to the timing and duration of their care visit were not always respected. People told us care staff did not always stay for the allocated time and their care was sometimes rushed. One person's relative told us, "They are supposed to come at about 8.45am to 9.15am and my usual carer is usually on time. Some of the others can be very late. I've waited until 11.30am and then phoned. They said there had been a misunderstanding and that they'd been told not to come. A few weeks ago they didn't turn up at all so I had to help my [relative] which is not easy."

One person said, "We gave them [office staff] a list of the carers we had been happy with and were assured that we would receive care from them but it didn't work out that way. The carers changed and several of the ones we knew left as they were unhappy with Hales." Staff we spoke with confirmed this saying, "I received four different rotas in one day. People don't receive any information about who is turning up. It's a ridiculous company. Carers miss calls, double ups [care where people require two carers to attend] don't show up. People are really unhappy. There have been no improvements in the past six weeks." Another staff member told us, "I went to someone and when I got there they told me the office had changed the time of their call and they were not expecting me. Another person should have had an early morning call and they sent me at lunchtime."

Staff raised concerns with us about the length of care calls that people were receiving. One member of staff said, "The office staff say to us if they are short staffed, if you can do the job in 15 minutes instead of 30 then do it and get on your way. They want us to rush. They say, go in and give medication and get out again. I don't like rushing as I am likely to forget something."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout our inspection concerns were raised about communication between the provider, staff and people who used the service. One person told us, "There are a lot of problems with the office staff. One of the [office staff] always raises [their] voice when I'm on the phone to them and they have called me a liar. They tell me the carer will be there in 10 minutes and then when the carer eventually turns up much later they show me that I am on their rota for much later. It wouldn't matter if they would only tell me the truth."

Relatives were also concerned that the communication from the office staff was not effective and the

recurring theme from those relatives that we spoke with was that they needed good communication. A relative said, "Different people answer the phone all the time. You never know who will be there or who has left." Another relative said, "Last weekend our regular carer told us [they] would be off work. When I phoned the office they said another carer would be coming. However nobody turned up. That carer was unwell but I had to phone them as usual to find out. They never phone us to tell us. They told me another carer would come. They didn't come so I phoned again and was told he'll be there in a minute; I phoned again at half an hour later again was told they'll be there in five minutes. They turned up eventually, however the carer showed us that we were on their rota for this time anyway."

We were told by the regional manager that there had been improvements to the way care staff were receiving their rotas of who they were visiting and when. They told us that all care staff were emailed copies of their rotas which was followed up by confirmation that the rota's had been received. We were aware that the organisation was working with the local authority and that the missed and late care calls were being closely monitored. From data provided to us we could see that whilst there were still a number of late and missed care calls, improvements had been made in the previous three months.

Staff were required to complete communication logs detailing the care provided to people at each appointment. On the whole we saw that these provided detailed information about the care given. In addition to communication logs we were told by the regional manager that each person had a care plan in their home that staff could reference. Staff we spoke with however told us that not all people had care plans and sometimes they were asked to care for people where there was no care plan in place. One member of staff said, "A lot of people don't have a care plan at their home. One person has been receiving a service for four months now and they still don't have a care plan. All they have is the comms log." Another staff member said, "Some care plans are just not completed. We get to someone and all they have is a communication log. We don't then always know how to support the person." This lack of care plan and detail meant there was a risk that the person would not receive appropriate support for their individual needs. When we looked at the care plans we found that they contained assessments of people's care needs and were consistent with healthcare professional's assessments.

People told us they knew how to raise complaints and concerns however they did not feel confident that their concerns would be appropriately addressed. One person said, "I've phoned them several times. I can't remember exactly when, but over the last few months. I have said that I want this as an official complaint, particularly around the lateness but I doubt they record it as a complaint and I've never heard anything back." Another person told us, I have never put in an official complaint but I have asked to speak to the manager but this has never happened." Another person was confident that they would complain if they felt they needed to, "I'd be happy to complain if there was a problem. I'd tell the carer first as they are young and need to learn but then I'd tell the boss." We spoke to the regional manager about how complaints were being managed. We also viewed records of complaints received. The regional manager told us that they were 'passionate' about ensuring any complaints received were dealt with appropriately and to the required detail. When we looked at the records of complaints received we saw that the regional manager had a record of any complaints received. We saw a log was maintained of any complaints and the action that had been taken. We saw that people were asked at both their care reviews and during any telephone surveys carried out with them if they knew how to raise any concerns. People had not been assured previously that any complaints or concerns that they had raised were dealt with thoroughly or appropriately. We found that the regional manager had taken these concerns on board and was now actively monitoring and responding to concerns or complaints that people or their relatives raised. This reassured us that any complaints received were being investigated since the regional manager has been in post at the branch.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in December 2015 we were concerned that there had been a failure in the provider's systems to make sure that there were always enough staff to meet people's needs. At that inspection we saw that improvements were being made. However at this inspection we found that concerns about people receiving late and missed care calls had continued. The feedback we received and our discussions with people during this inspection indicated there were still not always enough staff to meet their needs. The improvements had not been sustained or embedded into practice and the current systems in place were not effective at making sure there were enough staff to meet people's needs and preferences. Audits were not effective in identifying concerns that we found during our inspection.

Although there was a regional manager who had been deployed to oversee the branch since September 2016, there was no registered manager in post. The last registered manager for this location had deregistered in June 2016. The service had management support during this time although it was provided by different people. This meant there had not been stable management in place since the last registered manager had left. The regional manager had been brought into the service to provide management cover and was working there several days a week whilst recruitment to the branch manager's post took place.

All of the people who used the service, their relatives and staff that we spoke with or contacted told us the service was not well-led. Several people were very unhappy with the service they were receiving and the number of management changes. One person said, "They have had so many managers since I started with them but they never contact us. You never see a soul. About three weeks ago I phoned to ask if I could speak to someone senior and [office staff] put the phone down on me."

Relatives we spoke with were also unhappy with the service and told us they felt it was not well-led. One relative said, "They have had about four managers in the last three months. The office has been a shambles. Quite a lot of the good carers just leave, they can't stand it. It has got slightly better with communication over last couple of weeks."

Most of the staff we spoke with told us they hadn't felt valued over the past year. Whilst some staff told us they were happy working in their job role for the agency others told us morale was very low. They told us that the lack of a manager had resulted in too many changes and a poor relationship with the office staff. One member of staff said, "Sometimes I come home from work so stressed and it is because of the office staff." Another member of staff said, "We [care staff] have been so badly let down by the managers and office staff. They make us feel like an inconvenience."

There were ineffective systems in place to ensure audits and processes would improve the quality of the service. The regional manager informed us that they aimed for 50% of care records to be audited each month and where there were any concerns in a particular area, 100% audited was the target. We checked the quality of communication logs and medicine administration records when they were returned to the office. We viewed a number of people's medicine administration records which had been audited by both care staff and office staff. We found within these audited records a number of errors which had not been

identified by the audits already carried out. This meant that the audits were not effective and placed people at risk as concerns were not identified.

Processes in place for monitoring and improving the quality of the service were not effective. The provider did not have robust systems to audit, monitor and improve the quality of the service in a timely manner. The lack of effective systems to assess and manage risks and maintain a service that is compliant with the regulations is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One member of staff said, "The main issue is a lack of manager. In the past month or so I have seen an improvement. We have more staff on board and are recruiting." Another member of staff had also noticed a difference over the recent weeks. They said, "[Regional Manager] is brilliant but they can't be there all the time. [Regional manager] is approachable, actually I think all the office staff are really, it's just they are under so much pressure."

We did also see that some daily communication logs completed by the care staff and audited by office staff had identified some actions that needed to be taken. An email had been sent to the staff stating how the communication logs should be completed in future and identifying that improvements were needed in the accuracy of recording. Staff we spoke with confirmed that they had received this communication.

The regional manager was open and transparent throughout the inspection, seeking feedback to improve the service provided, with us and told us they were committed to making the improvements and changes necessary to improve the branch. We were told of plans in process to improve the monitoring of care calls and visit times as well as plans to improve the on call arrangements so that people had access to appropriate support. The regional manager also told us that Hales Thetford were employing more field based supervisors who were responsible for not only delivering direct care to people, but also audits of care records and spot checks of carers working with people. The aim of which was to improve the service.

Up until recently most people could not recall having been asked for feedback on the service. However two people told us that in the past two weeks they had been contacted to ask for their thoughts and feedback. One person said, "One of the carers did come out yesterday and went through questions about the service and I told her what I've told you." Another person told us, "Yesterday [staff] came out from the office to see what we think of the service." Other people told us that they had not been contacted.

Services providing regulated activities have a statutory duty to report certain incidents and accidents to the Care Quality Commission (CQC). We checked the records at the service and we found that all incidents had been recorded, investigated and reported correctly.

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 9 HSCA RA Regulations 2014 Person-centred care The service was not responsive to people's individual care and support needs.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Concerns about the safety and management of people's medicines meant that we could not be confident that people were receiving their medicines as their prescriber intended.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not operating effective systems and processes to assess and monitor their service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to support people in a person centred and responsive manner. Staff did not all receive appropriate training or support to enable them to do their jobs effectively