Hales Group Limited

Hales Group Limited - Leicester

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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Hales Group Leicester on 4 and 5 July 2017 and our visit was announced. We spoke with people who used the service on the telephone on 11 and 12 July 2017 to seek their feedback. We gave the provider of the service 48 hours' notice of the inspection. This was because the location provides a domiciliary care service. We need to be sure that the registered manager would be available to speak with us.

At our last inspection on 5, 6 and 7 December 2016 we found seven breaches of legal requirements. After this inspection the provider wrote to us to say what they would do to meet legal requirements in relation to a breach in Person centred care, Need for consent, Safe care and treatment, Safeguarding service users from abuse and improper treatment, Good governance and Staffing. The service was also in breach of the registration regulations failing to notify the Commission of events affecting people. At this inspection we found that provider had made some of the required improvements. However, we found that further improvements were required and three continuing breaches of the Regulations.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

Hales Group Leicester provides personal care for people aged 18 years or over who need care or support at home. At the time of the inspection there were 44 people using the service. The majority of people who used the service had their care funded by the local authority.

There was a registered manager at the service. There was also a branch manager in post who had submitted an application to become the registered manager to take over this role from the current registered manager. 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.

People were not consistently protected from risks relating to their health and safety. Assessments of people's needs had not been completed fully. There was a lack of consistency in the information that had been recorded in assessments of need, care plans and risk assessments. We found that risks associated with some people's care needs had not been assessed. Where people had risk assessments these were not always specific to the person and their individual needs. Guidance for staff was not detailed enough to ensure that staff knew how to meet people's needs safely.

Staff could identify the potential signs of abuse and knew how to report any concerns. Where incidents had

occurred that may cause concern these had been reported appropriately.

People told us that there were usually enough staff to meet their needs. However they told us that the staff were still sometimes late for calls. There was a system in place to record if staff were late or missed a care call. This had not consistently identified where a person's call had been missed except for when an alert had been put on the system. Alerts were used when people had received a high number of missed calls or needed their care at a specific time. This is a significant reduction from the amount that had happened at the time of our last visit. However this is still a high number of missed calls.

People were at risk of not receiving their medicines as prescribed. The medicine administration record charts were handwritten and the information recorded in these was not always consistent with the prescriber's instructions. Where people had medicines to take as and when required there was no guidance as to when these could be given. People's care plans did not always give staff guidance on how people should be given their medicines.

People received care from staff who had not always undergone the appropriate pre-employment checks. We found that appropriately robust references were not always sought to show that staff had displayed good character in previous employment.

The service was not working within the principles of the Mental Capacity Act 2005. People had been recorded as having the capacity to make decisions by the member of staff who had completed the assessment. However the assessment had identified that the person may not have the capacity. We also found that assessments were not carried out in relation to specific decisions that people may need to make. Relatives were recorded as being able to make decisions on behalf of someone without evidence having been seen of their legal right to do so.

Staff received support through an induction to the service and supervision. There was an on-going training programme to provide staff with guidance and update them on safe ways of working.

People were supported to access healthcare services. People had been referred to health professionals for assessments where this was needed. People were usually supported to maintain a balanced diet. Where someone needed to follow a specific diet such as low sugar there was no guidance in the care plan for staff on how to provide this.

People were asked to make choices about their care and staff asked people for consent before they supported them.

People told us that staff were caring. However, some people felt that there was a lack of consistency in the staff who supported them. This impacted on people's experience of the support that they received. Where people had the same staff regularly they felt they had built a good relationship with the staff and thought the staff understood their needs.

People were usually treated with dignity and respect. They felt that staff asked them before carrying out any tasks. However, one person felt that staff let themselves in without knocking or using the bell despite them asking that this did not happen.

People had been involved in reviews of their care plans to make sure information about them was current. We found that care plans contained some information about what people liked, disliked and what was important to them. However, for some people this information was limited. People felt that staff did not

always have the time to provide all of their support.

There was a complaints procedure in place. People and their relatives had used this. Most people had received a response to their complaints. Some people felt that they were not always listened to. Where people had raised concerns about late calls these had not always been recognised as a complaint or responded to.

People's views about the quality of the service had been sought by the provider twice and the feedback had been given to people as to what actions would be taken as a result of their feedback.

The provider had developed an action plan to address the concerns that we found. They had recorded all actions as being complete. However, there were still concerns with the care plans, risk assessments, needs assessments and medicine records. The quality of the actions had not been fully reviewed. Audits had been undertaken. However these did not always identify and address the concerns that we found as part of our inspection. Where actions had been identified these had not been fully addressed and similar errors were still happening.

There had been 17 missed calls since our last inspection. This is a significant reduction. However, it was still a high number of missed calls. The provider had identified that the calls had been missed and had reported each one to CQC and the local authority as potential neglect.

People told us that the service had improved since our last inspection. Staff agreed this and felt supported in their roles.

The service was led by a registered manager who understood their responsibilities under the Care Quality Commission (Registration) Regulations 2009.

We identified that the provider continued to be in breach of three of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see at the end of this report the action we have asked to provider to take.

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 safe.

People were not consistently protected from risks relating to their health and safety. Risk assessments were not always specific to individuals. Guidance for staff was not detailed to enable them to provide support safely.

People continued to experience missed and late calls.

There were enough staff deployed to meet people's needs safely.

References had not always been sought from the most appropriate source to ensure staff's character in previous employment.

People's medicine records were not always completed correctly in line with the prescriber's instructions.

Is the service effective?

Requires Improvement

The service was not effective.

The service did not work in line with the Mental Capacity Act. People were recorded as having the capacity to make decisions where assessments indicated that they may not have the capacity to do so.

Staff received support through an induction to the service and supervision. Staff had completed training to enable them to meet people's needs.

People were supported to access healthcare services. They were supported to follow a balanced diet.

Is the service caring?

Good

The service was caring.

Staff knew people who they worked with regularly well and were able to tell us about their likes and dislikes. People and staff told

us about the importance to them of building a good relationship.

People told us that they received support from staff who were caring and kind.

People were treated with dignity and respect while staff were supporting them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had their needs assessed and a care plan developed from this. The information in these was not always consistent. Care plans had been reviewed with people.

People were having some of their calls at their preferred times. They told us that they did not always have the same care staff and this was important to them. Some people felt that staff did not always have time to complete all tasks.

There was a complaints procedure in place. People told us that they had raised concerns with the provider. Most people had received a response to their complaints. We found that not all concerns were recognised as complaints.

Is the service well-led?

Requires Improvement

The service was not well-led.

The provider had completed audits to review the quality of documentation that had been completed. These did not always identify or address concerns that we found during this inspection.

People had been asked for their feedback of the service and been given information about actions put in place to address any concerns that they had.

People and staff felt that improvements had been made in how the service was delivered. Staff felt supported in their role.

Hales Group Limited - Leicester

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 4 and 5 July 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. We needed to be sure that the registered manager would be available to speak with us.

The inspection was carried out by two inspectors and two experts-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. Both experts had experience of caring for someone who used this type of service.

Before our inspection, we reviewed the information we held about the service and information we had received from people, relatives and staff who had contacted us. We contacted two local authorities that had funding responsibility for some of the people who used the service. We also contacted Healthwatch (the consumer champion for health and social care) to ask them for their feedback.

We reviewed a range of records about people's care and how the service was managed. This included 10 people's plans of care and associated documents including risk assessments. We looked at eight staff files including their recruitment and training records. We also looked at documentation about the service that was given to staff and people and policies and procedures that the provider had in place. We spoke with the branch manager, the registered manager, the regional operations director, a care co-ordinator and seven care workers.

We contacted people who used the service by telephone. We spoke with 14 people who used the service and

14 relatives of other people who used the service. This was to gather their views of the service being provided.

Requires Improvement

Is the service safe?

Our findings

At our last inspection carried out on 5, 6 and 7 December 2016 we found three breaches of the regulations. Regulation 12, Safe care and treatment, Regulation 13, Safeguarding service users from abuse and improper treatment and Regulation 18, Staffing. We required the provider to make improvements and they submitted an action plan setting out what they were going to do.

At this inspection we found that the provider had made some of the required improvements. However, we continued to identify a number of areas where improvements had not been made.

People told us that the number of missed calls they had experienced had reduced, however they were still happening. A relative said, "On one Saturday they did not turn up for the evening visit. This confused [person's name]." One person told us, "They have let us down twice." Another person commented, "They have missed a call recently. They didn't say why." One person said, "They didn't arrive once. They did not ring to let me know." Records showed since our last inspection that there had been 17 missed calls. This is a significant reduction from the amount that had happened at the time of our last visit. However this is still a high number of missed calls.

People told us that staff sometimes arrived on time. Comments included, "Generally they are on time," "They are within 5 or 10 minutes," "They don't always turn up on time," Their timing is very unreliable," "They can arrive up to midnight for the evening call which should be between 8 and 9pm," and, "They are sometimes on time. I don't mind as long as they tell me but they don't always do that. Sometimes it can be up to half an hour." Staff gave us differing views about if they were able to arrive on time. Some staff told us that they did not have enough time to travel from one call to the next. They explained that if they were running late they would call the office and staff from the office should let the person know the care staff member was on their way. One staff member said, "They sometimes don't tell people if I am running late. It is only 15 – 20 minutes. I only get 5 minutes travel time. I need more. " Another staff member commented, "I am very rarely late. The office will call people and let them know." One staff member told us, "There is not always enough time between calls. We can't help it if we are late. Most of the time people are called if we are going to be late." Another staff member said, "There is not enough travel time. I have some gaps in my rota. These are needed to make it to calls on time."

We looked at the planned and actual call times for people over a three week period. We found that there were times when this information had not been recorded as staff had not contacted the office to confirm that they had arrived. The staff had been reminded of the importance of completing this task however it was not always done. Where staff had confirmed the time they arrived for the call we found that staff were still arriving more than 15 minutes early or late quite regularly. This ranged from 16% of calls for one person to 40% of calls for another. It is agreed with people that staff can arrive up to 15 minutes early or late for a call to allow for variances in traffic and the length of the call times. The earliest staff had arrived was 28 minutes before the planned call time. The latest they had arrived was 67 minutes after the planned call time. The registered manager told us that some calls were time critical and needed to take place at the agreed time. Where this was needed the scheduling system would alert staff in the office or out of hour's staff if staff had

not arrived at the correct time and someone would contact the staff to find out what was happening.

The registered manager had reported each missed call to CQC and ensured that people had received the care that had been missed as a result of the call. At our previous inspection we were told that the scheduling system was able to alert a member of staff in the office if a call had not taken place. The system that was in use was still not alerting staff in the office to missed calls. Most of the times that a call was missed this had been identified by the person, a relative or a member of staff picking this up and contacting the office, except where a call was classed as time critical. We discussed this with the registered manager. They told us that they had asked the Information Technology department to review this. Analysis of the system was being undertaken to see if this could be resolved. An upgrade was planned to be rolled out to all services within the next month which was hoped would resolve the issue.

People who used the service had an assessment of their needs in place. Some of these had been completed after people had started to use the service. Some assessments contained very limited information. The regional operations director told us that a number of assessments were completed at the same time as the care plan and the information had been recorded in the care plan instead of the assessment. The information in the assessment was often different to the care plan and in some cases information had not been included when it was something that staff needed to know about the person. For example, in one person's assessment it said that the person used incontinence aids. This was not included in their care plan. One person had a specific care plan that identified that they were living with diabetes. This information was not included within their assessment or the full care plan. Another person's assessment strongly reflected that they liked to be independent and this was to be encouraged. This information was not found in their care plan. There was a risk staff would not know how or what was important to the person and how to meet their needs.

Information was also not always updated when a change had happened to a person. For example, one person's care plan identified that they had suffered from seizures in the past. The person had been admitted to hospital following a significant seizure two weeks before our inspection. The care plan had not been updated to reflect this change. It is important that staff have up to date details about a person's needs and how to support them safely.

Risk assessments were not always completed for areas where there may be risks to the person or to staff when they were receiving support. For example, one person was at risk of developing areas of skin that were damaged due to pressure. They did not have a risk assessment for this; even though their care plan identified that there should be one in place. Another person was cared for in bed. They had a risk assessment in place around how staff supported the person with moving. This said that there were no risks with moving as the person was cared for in bed. The risk assessment did not identify that the person was supported with turning or being repositioned on the bed, the risks that are associated with this and the equipment that is used. We found information in the care plan that said the person required support from two staff at all times and had specific equipment that was needed to move them safely. This was not included in their risk assessment. Information about risk was not recorded consistently. Three people were at risk of falls. One person had information about them being at risk of falls included in a risk assessment around moving and handling. Another person had a risk assessment in place around them being at risk of falls. It was not identified in their care plan that they were at risk. A third person was at risk of falls. This was identified in their care plan but there was no risk assessment around this. Staff may not be aware of the risks to people of them receiving care and how to reduce them.

Risk assessment's had been completed however, we found that the control measures were not always specific to the individual or their needs and did not always provide staff with guidance on how to support

the person safely. For example, one person had a risk assessment about how to safely support them if they showed behaviour that was challenging, such as hitting out at staff. This had the person's name on it but did not identify what behaviour they may show and how staff should support the person to reduce this. The risk assessment said, 'Try to access as much information as possible about the person and their trigger points.' Staff were at risk of not knowing what behaviour the person would show and how to support them safely to reduce this.

People's records around medicines were not completed correctly so they may not always receive their medicines safely. We looked at medication administration records (MAR) charts for people from January to June 2017. These had been audited by a member of the management team. However, we found concerns about the information in the MAR charts that had not been identified as part of the audit. For example, the guidance for staff as to how and when to administer medicine was not clear. One person had a medicine recorded as Tazoome 100mg capsules. Purple and yellow oblong capsules. This gave the staff no guidance as to how many capsules should be given, or what time of the day. The medicine had been given at the same time once a day but we were not able to confirm that this was the correct dose or time. We found this had happened on three MAR charts we reviewed. Another person had tablets that were different doses. The instructions said one tablet if 800mg, or two tablets if 400mg. Staff had to check the size of the tablet they were giving to ensure they were giving the correct dose. This should have been identified with the pharmacist so that only one size tablet was available to reduce the chance of mistakes.

The directions were not clear if people needed to take medicines on an as and when basis instead of regularly. One person had paracetamol prescribed for them to be taken when required. The guidance for staff said, 'given as required.' There was no information to say when it would be appropriate for the person to take paracetamol or the dose that they needed to take. This information is important to make sure that people take the correct dose and do not take the medicine more frequently than is necessary.

People and their relatives told us that they were supported with their medicines. One person said, "They help me with my dosset box for my tablets." A relative told us, "They put cream on [person's name] and give her minor meds. I have no concerns." Staff told us that they had completed training in medicine administration and been observed giving medicines to check they were competent at doing this. One staff member said, "I had a medication supervision and was observed giving meds. It was quite thorough."

The branch manager had been in post for one month at the time of our inspection. They had identified that there were concerns with the MAR charts and medicine procedures. They had undertaken a review of medicines and were working with each person, their GP and pharmacist to ensure that appropriate guidance was in place. They were implementing a new process where MAR charts would be typed to ensure that guidance was clear for staff. Processes were being undertaken to address the concerns. However, this had only been done recently despite these concerns dating back to January 2017. However, concerns remained that people could not be sure that they had taken their medicines as prescribed. One person had missed their medicines 15 times in a five week period. This had been identified and considered as a complaint. However, actions taken to address the potential impact of these omissions had not been recorded. The registered manager told us that the previous manager had dealt with this investigation.

People who required support with medicines had this identified in their care plan. It was not always clear what support people needed. For example, one person's care plan said they needed support with taking medicines but there was no further guidance for the staff about what support was required. We found a risk assessment that identified that the person may refuse their medicines. This was not included in the care plan and there was limited guidance on what staff should do if this happened. Staff did not have information about how to support the person to take their medicines safely.

These matters constituted a continued breach of Regulation 12, Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that people had not been protected from the risk of abuse or improper treatment. People were at risk of neglect, degrading treatment and their needs were disregarded. At this inspection we found that the provider had made the required improvements.

People still have times when calls were missed or late. However, these were now recognised by the provider as potential abuse. Each missed call and details of any missed care had been recorded. Where people had missed medicines, meals or personal care the provider had identified ways to make sure that this was picked up and completed either at the next call or by a relative. All missed calls had been reported to CQC and to the local authority. This meant that people were protected as there was oversight by external bodies of what was taking place and what had been done to ensure people's needs were met.

People were protected from abuse and discrimination because they were supported by staff who knew their responsibilities to keep people safe from avoidable harm and abuse. The provider had guidance available to staff to advise them on how to report any concerns about people's safety. Staff we spoke with had an understanding of types of abuse and what action they would take if they had concerns. All staff we spoke with told us that they would report any suspected abuse immediately to the manager or external professionals if necessary. One staff member said, "I would report it and document what was said. If I needed to I would go to higher management or to the local authority." The actions staff described were in line with the provider's guidance. Staff told us they had received training around safeguarding adults. Records we saw confirmed this.

At our last inspection carried out on 5, 6 and 7 December 2016 we found that sufficient staff were not deployed to meet people's needs safely. We saw that staff were regularly asked to cover additional calls and these were fitted in when staff were available and not at people's planned call times. There were not enough staff available and this meant people regularly had missed and late calls.

These matters constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing. We required the provider to make improvements and they submitted an action plan setting out what they were going to do. At this inspection we found that the provider had made the required improvements.

People told us that there were generally enough staff to meet their needs. One person said, "They always seem to have enough to cover." Another person told us, "It is okay through the week, but can be a mess at weekends." A relative commented, "We get different staff every day so probably not." Another relative said, "We get the same group of carers and we have got to know them." Staff told us that they felt there were enough staff to meet people's needs. One staff member said, "I have gaps on my rota as I don't have enough work to do." Another staff member told us, "We have our rota now and it is more settled. I have never had a time when a second member of staff has not turned up." The registered manager told us that staff were given a contracted number of hours and then could pick up extra work if needed. This meant that work was shared between staff and that they had flexibility to cover additional calls if needed or if they wanted to. The call monitoring records showed that staff were deployed to cover the calls that the branch were providing.

Pre-employment checks had taken place before staff started to work with people. The process included obtaining references, checking people's right to work documentation and undertaking a Disclosure and Barring Service (DBS) check. The DBS check helps employers make safer recruitment decisions and aims to

stop those people who are not suitable from working with people who receive care and support. We found that references were not always from the most recent or relevant employer. References provide evidence of staff conduct in their previous employment. The branch manager told us that they would check all pre-employment checks had been completed fully before staff started work.

People told us that they usually felt safe when receiving care from the staff. One person said, "I feel safe with them." Another person told us, "I feel safe with carers, but I feel safer with some than others." A relative commented, "[Person's name] feels safe with her carers." People's home environment had been assessed to make sure it was safe for the person and staff. This included checking that there were no slip or trip hazards. We saw that there were plans available in case of an emergency, for example, a flu outbreak in the staff team or a fire in the office. These included plans for how the service would continue to operate. The provider had considered people's safety should an incident have occurred.

Requires Improvement

Is the service effective?

Our findings

At our last inspection carried out on 5, 6 and 7 December 2016 we found a number of breaches of the regulations. Regulation 11 Need for consent. People were not supported in line with the Mental Capacity Act 2005 (MCA) and Regulation 18, Staffing. Staff had not received the support, training and supervision that they required. We required the provider to make improvements and they submitted an action plan setting out what they were going to do.

At this inspection we found that the provider had made some of the required improvements. However, we continued to identify a number of areas where improvements had not been made.

Three people's care plans had details of other people who said they had the legal authority to make decisions on behalf of the person. We asked to see evidence of the documentation for this. It is important that the documentation has been seen as the legal authority can be granted for people to make decisions in relation to health and welfare, finances or both areas. Some people ask a relative or friend to make decisions on their behalf but this can only be done legally where it has been agreed by a court. The provider had not seen the evidence for what decisions people could legally make. The branch manager said that they had asked the named people for this on more than one occasion but it had not been provided. Without evidence of the legal agreement a person can be consulted as part of a decision but cannot be asked to make decisions on behalf of someone. The provider's paperwork prompted staff to ensure that any legal agreements are seen to check that the information they have is correct. This had not been done. The branch manager agreed to follow this up and get copies of the paperwork.

The provider's paperwork was not correct to support the staff with assessing capacity. The paperwork asked three of the four questions that must be asked as part of the capacity assessment. The person completing the assessment was not asked to consider if the person could weigh up or use the information. The test being completed was not being carried out fully in line with the MCA. We also found that when considering capacity this was being done on a general basis. Under the MCA a person's capacity to make a decision should only be considered in relation to a specific decision. For example, can the person consent to their personal care. Where capacity had been assessed it had not been identified what area of the person's care this was being considered for. We just found a capacity assessment had been completed for the person's capacity to make all decisions. This is not in line with the guidance for the MCA.

Decisions about a person's ability to make a specific decision had not been completed correctly. For example, for two people the staff member completing the assessment had said that they were not able to retain information. When carrying out a capacity assessment there are four areas to be considered; can the person understand, retain, use or weigh up the information and communicate it. If the answer to any of these questions is no then the person may not have the capacity to make that decision. In both of the files we looked at the person was deemed to have capacity despite them being assessed as being unable to retain the information.

These matters constituted a continued breach of Regulation 11, Need for consent, of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff asked for consent. One person said, "They always say is it okay". Relatives confirmed that this happened. A relative told us, "They always ask [person's name] when they do any personal care for her." Staff had an understanding of the need to ask for consent from people before supporting them with care, and involving people in making their own choices. One staff member said, "I bring [person's name] choices. She picks what she wants. I give her time to answer." Another staff member said, "It is important that we give people choices. They are a human being and can make decisions. I always ask people and make them aware of what I am doing. You can't force anyone to do anything they don't want to." Staff told us that they had completed training in the MCA. Records confirmed this.

At our last inspection carried out on 5, 6 and 7 December 2016 we found that staff had not received the support, training and supervision they required to provide care effectively to people. At this inspection we found that the provider had made the required improvements.

People received support from staff with the appropriate skills and knowledge. One person said, "They appear to know what they are doing. The carers now are much better trained." A relative told us, "They are all well trained." Staff told us that they had completed training courses and felt that they had completed courses that were relevant to their role. One staff member said, "The training was very useful. I think everything was covered. I am confident with what I am doing." Another staff member told us, "I am always on training. We learn new things. It is good to be updated. Things are always changing". Some staff told us that they did not feel that training online was effective for them. One staff member said, "My only gripe is the online training. I have not got time to do it. I like to come in and do a classroom course." Another staff member commented, "The training is not compatible with my phone and I don't have a computer. I will have to make time to come into the office to do it. I like training with the other staff so we can talk through scenarios. You get more from it." We discussed this with the branch manager and the regional operations director. They said they would discuss staff concerns with them to try and resolve worries about on-line training. Training records showed that staff had completed a range of training and that for most staff this was in date. Where staff needed to refresh their knowledge this training had been arranged.

The branch manager told us that the provider had introduced a new way of training called a footsteps programme. As part of this staff would attend interactive staff meetings, had the opportunity to complete distance learning courses, and to complete a level 2 or 3 qualification in health and social care. As part of this development weeks were held four times a year with a focus on specific areas. In May 2017 a week had been held that aimed to develop staff skills and understanding in end of life care. This had involved a talk by staff from LOROS who are a local organisation who specialise in end of life care. As part of the week staff completed a two hour classroom session about the topic and were assigned electronic learning to help develop their knowledge.

Staff told us that they had an induction when they started work. They described how they had been given time to complete training, get to know the service and the policies and procedures. Staff told us that they had spent time shadowing more experienced staff before working alone with people. One staff member said, "I did all of my training and some shadow shifts. It was useful as I was completely new to care." We saw that staff completed the Care Certificate. The Care Certificate was introduced in April 2015 and is a benchmark for staff induction. It provides staff with a set of skills and knowledge that prepares them for their role as a care worker.

Staff received support and supervision. One staff member said, "I had supervision not long ago. I can talk to my manager when I want to." Another staff member told us, "I had a spot check on Monday. They are

happening frequently." A spot check is when a member of staff's practice is observed when they are providing care. Records confirmed that staff had completed a supervision meeting, a spot check and were in the process of completing appraisals to review their performance overall.

Some people were supported with preparing food and drinks and eating when it had been assessed that they needed this support. One person said, "They prepare my food for me which is a special diet of soft food. They give me a good selection." Another person told us, "They do me a cooked breakfast." However a relative said, "They are not always preparing [person's name] meals." We discussed this with the registered manager. They told us that there had been occasions where staff had not prepared the correct number of meals for one person. This had been raised with the staff who supported this person and guidance recorded in their care plan. We saw that where people had specific diets they needed to follow information about this was not clear in the care plan. For example, one person was diabetic and their care plan said to follow a diabetic diet. There was no guidance for staff about what a diabetic diet was within the care plan. The registered manager agreed to provide more details for staff. The provider told us staff received training on diabetic care during their induction.

People who we spoke with told us that either they or their family arranged their health appointments. Care plans contained contact details of people's relatives, GP, or other involved health professionals so that staff were able to contact them when they needed to. Staff were aware of their responsibility for dealing with illness or injury. They told us they would contact the GP or an ambulance if needed. We saw that care records tracked all actions that had been taken if staff had thought that someone was unwell.

Good

Is the service caring?

Our findings

People told us that staff acted in a caring manner towards them. One person said, "They treat me very well." Another person told us, "[Staff member] is kind and encouraging." One person commented, "The girls who come to see me are very caring and nothing is too much trouble."

People told us that when they had regular staff they had built a good relationship with them and this was important to them. One person said, "Having the same carer's means I have got to know them." A relative told us, "Having a couple of regular carers makes a difference." However, some people and their relatives felt that staff members who were not part of the regular staff team did not always have the same approach. One person said, "Some carers are better than others." Another person commented, "When I had regular carers I had confidence in them. Now I am getting lots of different carers I am not so sure." A relative said, "We have different staff and [person's name] can get stressed with people she does not know." Another relative commented, "The care [person's name] gets is good in parts. Some are better than others." Staff told us that they felt it was important to get to know the people who they supported. One staff member said, "I have built up a working friendship with people. It is important to do this. People recognise you and it makes them and us feel comfortable."

People were usually supported in a dignified and respectful manner by the staff. One person said, "They help me have a wash and make sure I am not uncovered. They definitely are respectful." A relative commented, "The carers are very respectful." However, one relative explained that they had asked staff to knock on the door and not use the keys in the key safe to let themselves in. They said, "Some still let themselves in. I leave big signs all over but they still don't knock on the door or ring the bell." Staff told us that they promoted people's privacy and dignity. One staff member said, "Make sure people are in a private room such as the bathroom or bedroom. Do not expose people. I would treat people how I would want to be treated." Another staff member told us, "I talk people through what I am doing so they know what to expect."

People were encouraged to maintain as much independence as possible. A relative told us, "They encourage [person's name] to do what they can themselves." Staff told us that they tried to encourage people to be involved where they could be and wanted to be as this maintained their independence. One staff member said, "I promote independence. I ask people to help with washing so that they know they can do it." We saw that care plans included information about what the person could do for themselves. However, sometimes this was not clear. For example, we read in one care plan, '[Person] can wash some of their body.' The care plan did not identify which part of their body the person could do themselves. A staff member told us that they would just ask the person. This meant that staff were encouraging people to maintain the skills they had instead of doing things for people that they could do for themselves.

People were involved in making some decisions about their care. One person said, "I choose which meal I want." A relative told us, "[Person's name] will choose if she wants the care or not." Records showed that people had been involved in decisions about their support. For example, people were asked about routines that they liked to follow and how staff should support them.

The provider had made information on advocacy services available to people. An advocate is a trained professional who can support people to speak up for themselves. We saw that there was information in the service users guide that referred people to office staff if they needed an advocate. There was information available in the office about advocacy.

People's sensitive information was being handled carefully. We saw that the provider had secure lockable cabinets for the storage of records. When information about people was shared between staff this was done discreetly and in a sensitive way so that conversations were not overheard. The provider had policies about confidentiality and data protection. This meant that people's privacy was being protected.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection carried out on 5, 6 and 7 December 2016 we found a breach of Regulation 9, Person centred care. People were not receiving their calls on time and their wishes had not been taken into account by the provider. Regular reviews were not taking place to ensure that it was correct and still relevant to the person. We required the provider to make improvements and they submitted an action plan setting out what they were going to do. At this inspection we found that the provider had made most of the required improvements.

These matters constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person centred care. We required the provider to make improvements and they submitted an action plan setting out what they were going to do. At this inspection we found that the provider had made most of the required improvements.

People told us that they were told which staff would be coming and when. One person told us, "I get a list each week with who is coming." However, people said that the rota could be changed. One person said, "They just show up. I don't know who is coming and they are not introduced beforehand." A relative told us, "The rota's can change. It can be different carers." Another relative commented, "I have asked for photos of the carers so [person's name] knows who they are." They told us that these had not been provided.

People told us that they did have some calls at their preferred time. One person told us, "They stick to the times in my care plan." However other people told us that they still did not get calls at their preferred time. One person said, "My morning visit is supposed to be between 8 and 8:30. They started to come at 9 and now it is closer to 10. They gave my carer another client which makes her run late." Another person told us, "I would like to get my one visit a day between 8 and 8:30 which is what I had when they first started. They don't stick to it and are turning up anytime up until 10." Staff told us that they usually get to see people regularly. One staff member said, "I do a regular run now. I am working with people I used to work with. People were pleased to see me back." Another staff member commented, "At first I didn't have much consistency. It has got better now. I don't know what I will get each week. I work with people more regularly then before." Daily records we looked at showed that the same staff did attend calls regularly for people with some staff supporting people less regularly. The registered manager told us that they were continuing to review people's care with them and were trying to make sure that where possible people had their calls at their preferred times.

People told us that they had been involved with their care plans and assessments. One person said, "We have had a lot of discussions [about my care plan] recently." Another person commented, "I rang the office to plan my care." A relative told us, "We have been involved in the care plan." However, one person said, "It took a year to get my care plan." Staff told us that care plans had improved. One staff member said, "The care plans are getting better." Another staff member told us, "The care plan does reflect the person. If something changes I let the office know and they will change it." Care plans we looked at included some information about the person or their wishes as to how their care should be provided. For example, we saw in one care plan that the person had a body wash and only required assistance with their legs. The care plan

guided staff to ask the person what they wanted for their lunch and identified that they preferred a hot meal and a hot drink.

People told us that staff knew their likes and dislikes. One person said, "The staff understand what I like and what I don't like." Staff confirmed that information about what the person liked and disliked had been included in the care plans. People's history, background, likes, dislikes and preferences had been recorded. The amount of detail that had been recorded varied from one person to the next. For example, in one person's care plan there was very specific details about what they liked. This included guidance for the staff on exactly how to cook the person's breakfast to their liking and where to find all the tools to do this. However, in another care plan there was limited information that said to support the person to get their breakfast. This information is important for staff to help them to understand the person and how to support them in their preferred way.

People told us that their care plans had been reviewed with them. One person commented, "I have one and it is up to date. We reviewed it three or four weeks ago." Relatives agreed with this. One relative said, "The care plan is fine. I am involved and it was looked at recently." Another relative told us, "[Person's name] has a care plan. It has been reviewed." We found that care plans had been reviewed for all but one person who used the service. This made sure that the information was in date and still correct. One care plan was last reviewed in April 2016. This had not been updated despite significant changes in the person's needs. The registered manager told us that they planned to review this care plan. However, the person had been unwell and was currently not receiving support from Hales Group Limited – Leicester.

People told us that they sometimes felt that staff did not have the time to provide all of their care or complete all tasks. One person said, "They do everything I need doing." Another person commented, "Sometimes they leave it for the next one who comes." One person told us, "They are polite but can be in a rush." A relative told us, "They are not always fulfilling tasks like checking the bed or making meals." People told us that staff asked them if there was anything that they needed before they left. One person said, "They always ask if they can do anything for me." The registered manager told us that where calls were taking longer than planned this was monitored in case the person's needs had changed and they needed more support on a regular basis. They explained then when staff finished calls sooner than planned this was also monitored. The registered manager told us that if all tasks could be completed in a shorter time this would be discussed with the person and the funding authority to look at reducing the length of the call. However, they also told us that some staff appeared to be regularly finishing calls earlier than the planned time with most people they supported. This was being monitored and discussed with individual staff members to try and identify why this was happening.

People told us that they did know how to complain and had done so. We had mixed feedback about the provider's response to their complaints. One person said, "I have complained in the past. I haven't had to recently." Another person said, "I have complained about their poor time keeping and got very little response. They eventually did something about it." A relative told us, "We made a formal complaint and things have improved. However it's only been two weeks." Another relative commented, "When I complain things get better for a while and then things fall back,"

The provider had a complaints procedure and this was available within the information given to people when they started to use the service. We looked at the complaints that had been received. All but one of the complaints that had been recorded had been investigated and an outcome had been given to the complainant. This had been done within the timescales set by the provider in their policy. One incident where a person had missed their medicines a number of times had not been recorded as a complaint. We also found that one complaint needed a follow up action completing and this action had not been taken.

Late calls had not always been recognised as complaints and responded to as such. We discussed this with the registered manager. They agreed to review the outstanding complaints and identify if they had been resolved.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection carried out on 5, 6 and 7 December 2016 we found breaches of regulations. Regulation 17 Good governance, the systems and processes in place did not enable people to receive a quality service and resulted in a number of concerns. Regulation 18 of the Care Quality (Registration) Regulations 2009. Notifications of other incidents. We required the provider to make improvements and they submitted an action plan setting out what they were going to do.

At this inspection we found that the provider had made most of the required improvements. However, we continued to identify a number of areas where improvements had not been made.

Feedback was mixed about the service that people received. Comments included, "I am very happy with the service I get," "It is better now," "It's not really well managed," "The service is not improving at all," and, "It is much better than it was. It is frustrating sometimes." All staff who we spoke with told us that the service had improved. One staff member told us, "I left and came back. I think they are working really hard and getting there." Another staff member said, "I have noticed a lot of changes. It took time but they are doing well." The registered manager told us that they had developed a team of staff in the office to support the service and that this was working well. The branch manager explained that they would be applying to become the registered manager. This was because the current registered manager had asked to move to a care manager role and focus on developing the quality of the service that people received.

The provider had implemented an action plan to address the concerns that we found at our last inspection. This had been reviewed and actions that had been taken had been recorded. The branch manager had also put in a place an action plan within the last month to continue to drive improvements in the service. Some of the concerns we found had been identified as part of the branch action plan. However, we found that actions that had been recorded as being done had not been fully reviewed to ensure that they were complete. For example, we looked at ten care plans. In all of these we found inconsistencies between information in the assessment of need, the care plan and the risk assessments. There was very little guidance in place for staff in some care plans. Where risk assessments had been identified as being necessary these had not always been put in place. Some risk assessments were in place. However, these had not identified the specific risk to the person and were generic. They did not provide sufficient guidance for the staff. We discussed this with the branch manager, the regional operations director and the registered manager. They told us they would continue to work to improve the quality of the care plans and risk assessments to ensure that they offered staff the guidance to provide good quality care to people using the service.

There were systems in place to regularly monitor the quality and safety of the service being provided. These included checks on areas such as daily records, spot checks and medicines records. We saw that actions that were needed had been recorded and reviewed. However, we found concerns with these records that had not been identified by the audit. These dated back until January 2017. We discussed our concerns with the registered manager and the branch manager. The branch manager told us that they had identified some of the concerns as part of their recent action plan and were working to improve medicines recording

particularly. The concerns that had not been identified went back over a period of six months without being recognised. The regional operations director told us that where concerns had been identified staff had been advised of the need to rectify these through monthly staff memos. The memos had advised staff of good practice in relation to record keeping. However, they had identified this issue a number of times and the same concerns were still happening. The method of addressing the concerns was not effective. The regional manager told us that staff were given chances to improve and then continued poor record keeping may result in disciplinary action. The provider told us additional training around medication administration was being offered to all staff. Where there were repeated errors by one staff member this training was to be a mandatory course for the staff member.

Seventeen missed calls had taken place since our last inspection. These had been identified and reported to us. However, in a number of cases these had only been picked up because a relative had called to ask where the staff were, or the member of staff at the next call had identified a missed call. The provider had told us that the system in place could identify all missed calls so that action could be taken to address any missed care. The system was not doing this. The registered manager explained that where a person had suffered from a number of missed calls, or had specific needs that meant that they needed their call to take place at a certain time an alarm had been set up to alert staff in the office if their call did not take place. However, this was not in place for all people. People therefore remained at risk of missed calls. The registered manager and branch manager had asked the information technology department to carry out an investigation to see what could be done to resolve this. We also found that where people's calls had been more than 15 minutes late and they had raised concerns about this it had not been identified that this was a complaint about the service and responded to. Actions had been taken to monitor and resolve lateness. However, the provider had not considered that these concerns should be considered as a complaint.

We reviewed the recruitment process and found that staff who had been recruited since our last inspection had a Disclosure and Barring Service (DBS) check completed before they had started work. However, we found that in four of the files we looked at references that had been sought were not from people's most recent employers, or were not detailed enough to provide evidence of good character. The provider had a recruitment policy that identified that references should be sought to show evidence of a prospective staff members conduct. This had not been followed fully. We discussed this with the regional operations director and registered manager. They told us that they would review the recruitment system to ensure that all checks were in place and completed fully before staff started work.

These matters constituted a continued breach of Regulation 17 Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that the provider had failed to provide statutory notifications that they had a duty to report to CQC. At this inspection we found that missed calls had been identified and reported to CQC as potential allegations of neglect. We also found that other notifications had been completed as required. However, we did find that one person had missed medication 15 times in a five week period in December 2016. This had not been reported to CQC. The registered manager told us that they understood what incidents need to be reported to CQC. They advised that the incident relating to missed medication had been investigated by the previous branch manager. They told us that the issues had been resolved with the person.

The provider had put in place audit processes to ensure that the delivery of care that was carried out by sub contracted providers was good quality. This included regular feedback and communication with the providers, audits undertaken on their provision of service and actions set to make required improvements. We also saw that the provider had records relating to all people where care had been sub contracted to

ensure that they had information about all people who were receiving a service either directly from Hales Group Limited-Leicester or indirectly through a sub-contractor.

People told us that they had been asked for their opinion of the service. One person said, "I put comments on a survey about the amount of different carers we have. I have had no feedback from it." Another person told us, "We had a survey. I put black marks on it about reliability." A relative commented, "They send out a questionnaire but I don't think they read them." Following our last inspection a letter had been sent to people who used the service to explain what had happened and to apologise. Since then two surveys had been sent to people to seek their views on the service that they received. Following each survey a letter had been sent out to tell people what actions would be put in place to address the findings. These had been sent in January 2017 and May 2017. The results had improved in the most recent survey although areas to improve had still been identified.

Staff told us that they attended regular team meetings and felt supported. One staff member said, "I have attended a team meeting. We get sent all of the dates in advance. The last one [branch manager] introduced themselves. They were very open and honest, listened to what we had to say and let us have our say." Another staff member told us, "I have received support from work. They helped me with a personal matter as well. The support was amazing. I have hope." Team meetings provided the staff team with the opportunity to be given feedback on how the service was run. We saw minutes from the last three team meetings. Topics discussed included good practice, training, professional boundaries, health and safety and changes in paperwork. A staff survey had been completed in June 2017. The feedback from this was sent to staff in a letter to tell them what actions would be taken to address areas that had been raised.

The provider had recruited a team of staff to support the running of the office. This included a branch manager, a care manager, field care supervisors, a branch administrator and recruiter. The branch was supported by a compliance and quality manager, an operations manager and a learning and development manager. This meant that there were people in positions to support the provision of care and to continue to drive the improvement in the delivery of care.

The service had up to date operational policies and procedures in place which covered all aspects of service delivery including safeguarding, medication, whistleblowing, recruitment, complaints and equality and diversity. Those which were relevant to staff were also contained within the staff handbook.

The registered manager was aware of their registration responsibilities. Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. The registered manager had informed us about incidents that had happened. During our inspection we saw that the ratings poster from the previous inspection had been displayed in the office and on their website. The display of the poster is required by us to ensure the provider is open and transparent with people who use the services, their relatives and visitors.

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 11 HSCA RA Regulations 2014 Need for consent Regulation 11 (1) (2) Care and treatment was not always provided with the consent of the relevant person.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) (g) Care and treatment was not provided in a safe way. Risks to the health and safety of service users of receiving the care or treatment had not been assessed. The provider had not done all that was reasonably practicable to mitigate any such risks. The provider did not manage medicines properly and safely.

The enforcement action we took:

We issued a warning notice to ask the provider to be compliant with the regulation by 30 September 2017.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (e) (f) Systems and processes had not been operated effectively to ensure compliance with the regulation. The provider had assessed and monitored the action plan that had been put in place to improve the quality and safety of the service that had been provided. However, we found that there were continuing concerns despite the actions being recorded as completed. Feedback had not all been listened to or responded to as appropriate.

Audit and governance systems were not always effective.

The enforcement action we took:

We issued a warning notice asking the provider to be compliant with the regulation by 30 September 2017.