Hales Group Limited

Hales Group Limited - Leeds

Inspection report

First Floor, Unit 6
Hepton Court, York Road
Leeds
LS9 6PW

Tel: 01132083346
Website: www.halescare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of this service in June 2017. After that inspection we received concerns in relation to safeguarding, staffing and governance arrangements at the service. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hales Group Limited - Leeds on our website at www.cqc.org.uk

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults. At the time of our inspection there were 139 people using the service.

Not everyone using Hales Group Limited - Leeds receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There was a registered manager in post at the time of the inspection. 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.

Systems and processes in place to support people to take their medicines were not robust, and there had been a number of safeguarding alerts raised where people had not received medicines. The provider told us after the inspection that they had identified the majority of these safeguarding concerns themselves through auditing of medicines practices, but quality assurance systems and processes needed to be improved to ensure they were robust, identified all shortfalls, and that they were used to drive improvements within the service.

Risk assessments were not always robust. They were incomplete or did not have enough detailed information on how to mitigate risks to people.

There were not enough staff to provide care effectively and we identified a number of people experienced missed calls. The staff team told us there was a high turnover of staff and the registered manager reflected that they had approximately 20 vacancies for extra staff to which they were actively recruiting. The provider told us following our inspection that missed calls were related to poor communication, poor management and poor staff practice, as opposed to a lack of staff. Nonetheless, poor deployment and monitoring of staff practice had led to numerous missed care visits, which meant people had not received the care they needed.

The service's quality monitoring systems were not robust. The service was unable to analyse information such as medication administration records (MARs), care notes and safeguarding alerts for trends and

themes.

The service did not have the capacity to carry out audits in a planned and thorough way, and where audits were carried out, they did not always identify and act upon issues found.

The service had action plans in place to integrate the newly acquired Bradford service into the Leeds team and tackle issues identified under previous management, however, there were no timescales in place for when actions had to be completed and the plan would have benefited from this. The plan had been shared regularly with relevant stakeholders since December 2017 and was used to monitor progress against the improvement areas needed

Staff were recruited safely, and had been trained in safeguarding vulnerable adults. Staff were able to describe how they would use the service's safeguarding and whistleblowing procedures to protect people from harm.

There were contingency plans in place in the event of a significant disruption to the service such as a flood or communications failure. We saw these operate effectively during our inspection.

Staff told us the manager was approachable and honest, and we saw they had made efforts to improve staff engagement.

Some people we spoke with told us they did not recall receiving an annual survey, and other people said they had received a questionnaire which asked them about some aspects of their care. Records showed that annual surveys had been issued to people using the service and these were due to be administered again imminently in the Leeds area. The provider also made available in people's homes on a monthly basis a survey called 'Are we caring' via which people could feedback their views regularly.

Notifications such as safeguarding incidents and expected deaths of people who used the service had been sent to the CQC as required.

We found that the service was continuing to breach Regulation 17 (Good Governance) of the Health and Social Care Act 2008 and that there were two further breaches in Regulations 12 (Safe Care and Treatment) and 18 (Staffing) found at this inspection. 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 enough staff to provide care effectively. People told us they had experienced missed visits and that staff were frequently late.

Medicines management was not robust and the provider had needed to make numerous safeguarding alerts where people had missed their medicines.

Risks to people were not always assessed in sufficient detail.

Staff were recruited safely, and staff understood how to raise safeguarding alerts appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality monitoring systems were not robust in identifying and acting upon concerns, and no analysis of trends and themes took place.

People told us they felt the service was not organised well, and that communication and feedback could be improved.

The registered manager had made efforts to improve communication and transparency, and staff told us this had a positive impact.

Hales Group Limited - Leeds

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 checked 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.

We undertook an announced focused inspection of Hales Group Limited – Leeds on 7 and 22 February 2018. This inspection was done to check that improvements to meet legal requirements planned by the provider after our June 2017 inspection had been made and also we had received a number of concerns about medicines management and leadership at the service. The team inspected the service against two of the five questions we ask about services: is the service safe, and is the service well-led.

No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

The inspection team consisted of two adult social care 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. Before the inspection we reviewed information we held about the service such as notifications, and information from external agencies such as the local authority. We reviewed a range of records relating to people's care, such as medicines administration records, quality monitoring reports and meeting minutes.

We spoke with eight staff, including care staff, the registered manager and coordinators. We spoke with 26 people who used the service and nine relatives of people who used the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in June 2017 we found that there were shortfalls in staffing, management of medicines and timeliness of safeguarding referrals. At this inspection, although the timeliness of safeguarding referrals had improved, there were outstanding concerns in other areas where the service had not made the required improvements.

We reviewed the management of medicines at the service. We looked at 12 Medicine Administration Records (MARs) and found that in 11 of them, there were signatures missing or other errors in the recording. For example, in one MAR there was no signature to indicate that two different medicines had been given to a person on seven separate occasions and there was no explanation given in the space available as to why. In another MAR, a person had been prescribed a topical medicine to be given four times a day but this was not always signed for as administered with no explanation provided.

The MAR document had a separate Topical Medicine Administration Record (TMAR) which included a body map to indicate where the medicine should be applied and space to record that it had been applied. However, this medicine was still recorded in the regular MAR with no information on where the medicine should be applied and why. Topical medicines are creams and ointments that are applied externally to the skin. In another MAR we found an entry had been redacted using correctional fluid with no explanation. In some MARs we reviewed staff had indicated why a signature was missing, for example, a person had either refused their medicine or taken it themselves, however, on other occasions this explanation was absent. This meant people were at risk of not receiving their medicines.

We were informed that the type of MAR we saw was a new document that had been introduced in September 2017. However staff had not received adequate training on how to use the new document. This was being addressed by the Registered Manager who had organised a team meeting in January, prior to the inspection, to provide additional training.

We looked at a MAR which had been audited and signed off as having no missed doses; however, upon review we found a dose of Amoxicillin was missing a signature to evidence administration without explanation by the member of staff as to why.

We reviewed the service's safeguarding incidents in Leeds since August 2017 and found that of 17 safeguarding investigations, 10 involved medicines errors or missed visits where people were due to have medicine administered. We saw that where this was the case, a GP was alerted, professional advice sought and an appropriate investigation was completed by the registered manager. We saw evidence that staff had been given extra supervisions and training or a disciplinary investigation was carried out as a result of errors.

We found information about the risks people were exposed to in their daily lives within their care files but risk assessments were not always completed to the standards required by the service and the provider had not identified this as an issue through their quality monitoring. This meant there was a risk that staff did not

have all of the detailed information that they might need during care delivery or in an emergency situation.

For example, in one fire risk assessment which also contained a social worker's fire risk assessment, we saw that a daily routine/care plan had been developed. There was limited detail for staff to follow. The person whom this related to had not signed this plan. Areas of the assessment document were not completed. This included; no surname, no date of birth, no age, no mobile number and the full address was not entered. Inside the support assessment document further details of GP were missing. One part of the assessment stated, 'Each property must have two emergency escape routes in the event of a fire', however this was not completed. We found in another person's care plan, where there was evidence in their bathing and washing risk assessment, and also their falls risk assessment that the person needed support with their mobility, no moving and handling risk assessment was present. We found a medicines risk assessment which did not identify potential side effects, and there was no evidence it had been reviewed or signed as completed. We found in risk assessments where there was equipment listed such as a hoist, walking frame or wheelchair, there was no information about the make, model and date of last service. This meant that staff could not identify who was responsible for the safe maintenance of equipment in people's homes or who to contact in the event of equipment failure. When we raised these issues with the registered manager they told us these would be completed urgently.

Following our inspection the provider told us that care record documentation was being reviewed for people supported in the Bradford area.

We concluded the above evidence demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe Care and Treatment.

There were not enough staff deployed to effectively provide care. People told us there were frequent issues with time keeping and missed visits. Comments from people included, "Yes, I've had a few missed calls. Two weeks ago I didn't get a carer for the morning visit and the same week a male carer came for the lunch call at between 2pm and 3pm when it should have been 12 O'clock", "I've had a few missed calls over the five months, last week it happened twice. A relative said, "Yes there have been missed calls and I have had to phone the office who then sent out a carer." We spoke to 13 people in the Bradford area, and 11 people told us they had experienced missed calls or consistently late visits. In the Leeds area, we spoke to 13 people and eight told us they had experience missed visits.

Staff we spoke with told us they were frequently required to cover shifts for staff who were sick and that there was a high turnover of staff within the service. One member of staff told us, "We are asked to pick up shifts all the time, I've done two double up rounds in one" and another member of staff said, "I don't think there are ever enough staff. Nobody has intentionally missed a call that I know of." One staff member said, "Staffing is limited at the moment, people just ring in sick or don't communicate. We pick up shifts when we can. People do get the care; I just cover for people where I can."

The service's call monitoring system was not robust as it did not identify missed calls or late visits. One of member of staff commented, "There is no system, I think sometimes staff on single shifts think they can get away with it." The service did have a monitoring system where carers were supposed to use a person's landline telephone to check in to the office; however, the registered manager and staff told us this was not effective in practice, as some people did not want staff to use their landline telephones or did not have landline telephones, and staff did not make regular use of the system.

At our last inspection in June 2017, we were informed that an electronic monitoring system had been commissioned to enable care staff visits to be monitored more effectively; however this had not been

implemented at the time of the inspection, and the only way the office was able to determine if a visit had been missed or late was if a person complained to the office or another member of staff raised it. The service recorded that there were 22 missed visits between July 2017 and January 2018. Where a visit was missed and the service was informed, appropriate action was taken. For example, on the weekend prior to our visit there were two missed calls where a person did not receive medicines or personal care in a timely way. The provider responded by suspending staff involved and conducting an investigation in line with their disciplinary policy.

The registered manager told us they were around 20 staff short and were making efforts to recruit. They told us the key issues they faced were unplanned staff absences and changes to people's needs. In response to these staffing pressures, the provider had voluntarily taken the step of refusing all new care packages in the Bradford area, whilst all existing packages were reviewed and care delivery in the service as a whole was analysed.

We concluded the above evidence demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

Where new staff were recruited into the service, this was conducted in a safe way. We reviewed staff personnel files and found records of interview questions, verification of identity and professional references. The service also utilised the Disclosure and Barring Service (DBS) to carry out background checks. The DBS is an agency which accesses the police national database to help employers make safe recruitment choices when considering staff who will be working with vulnerable people.

Staff had been trained in safeguarding vulnerable adults. Staff were able to describe different types of abuse such as financial, physical and emotional abuse, and told us they were confident they understood how to raise safeguarding alerts. Staff also told us they were aware of a whistleblowing line where they could raise concerns in confidence.

Staff were trained in infection control, and the Leeds office was well stocked with personal protective equipment (PPE) such as gloves and disposable aprons. However, in the Bradford service, staff under previous management did not have access to PPE when stocks depleted which resulted in a complaint from a person's relative about the use of gloves. The registered manager had ensured this would not happen again by taking stock to an office near Bradford for staff to collect every week.

The provider had a business continuity plan to mitigate the effects of a large event that would disrupt the service, for example a natural disaster or power failure. We saw this work effectively during our inspection when the office was affected by water damage and power failure. The operations team moved to another regional office and the service was able to continue providing care.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in June 2017 we found shortfalls in quality monitoring at the service. For example, we found that MARs and care notes were not always handed in to the office for audit and review. We also found there were shortfalls in the analysis of concerns for trends and themes. We concluded that this was a breach of Regulation 17 of the Health and Social Care Act (2008) Regulated Activities (Regulations 2014), Good Governance. At this inspection, although we noted some improvements in the overall management of the service, the service was continuing to breach the legal requirements of this same regulation.

We reviewed quality monitoring systems and processes at the service. The registered manager told us they were not able to effectively audit MARs and care notes (which were contained in the same document), and there was no designated member of staff responsible for this. The responsibility was shared across the senior leadership team. We were told by the registered manager that they had only been able to audit around 10% of records, which is in line with the provider's policy, however there were plans to improve this to around 30%. This meant the service was unable to identify the issues we found in medicines records. We saw some records where the care notes had been audited, but the MARs had not and there were identifiable gaps which could have been highlighted. We saw one MAR which had been audited, however a gap had not been identified, which meant that when audits took place they were not always effective. The registered manager told us they were aware there were issues with completion of MARs from the limited audit that had taken place, and that they had addressed this at team meetings which had recently taken place and support was offered to staff. Where issues were identified, we saw evidence staff were offered support through supervision or retraining.

We saw that where concerns had been raised or safeguarding alerts submitted, there was evidence appropriate action had been taken in response and in a timely way. However, there was no evidence that analysis of incidents, concerns, and negative audit results took place so that any trends or themes could be identified.

The service had action plans in place to integrate the newly acquired Bradford service into the Leeds team and tackle issues identified under previous management, however, there were no timescales in place for when actions had to be completed and the plan would have benefited from this. The plan had been shared regularly with relevant stakeholders since December 2017 and was used to monitor progress against the improvement areas needed.

We concluded that the above evidence demonstrated a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

The provider acknowledged that the current call monitoring system was not robust and informed us that planning was underway to procure and implement a new electronic monitoring system that would address shortfalls identified.

Staff spoke positively about the registered manager and the efforts they had made to improve the service.

One staff member said, "I have confidence in the manager to deal with issues, I feel it is getting better and communication has improved. I would recommend the service now whereas I wouldn't have done before." Prior to the staff meeting held in January 2018, there had been no staff meetings for six months. At the time of our inspection, staff meetings took place to address some of the issues at the service and improve communication. We saw that these meetings were well attended, and staff told us this was a positive change. One member of staff said, "There weren't any meetings before; communication and organisation has improved. People were talking about their issues, it needed to happen."

The registered manager had made efforts to ensure that they were transparent, open and visible to staff. For example, the Bradford team had been incorporated into the Leeds branch, and the registered manager ensured that they were visible by utilising a location near the Bradford area to facilitate face to face contact with staff and ensure that personal protective equipment and other items were available. The Bradford care staff team were also using alternative means of communication amongst themselves prior to the incorporation into the Leeds branch, due to a lack of effective leadership by the previous manager. We saw that the registered manager ensured this was stopped and that they, or the office, should always be contacted about any issues.

When people started using the service they received a service user pack which included the statement of purpose. The values and objectives of the provider stated, 'Hales will provide a caring, confidential and professional service to enable users of the service to remain living within their own home whilst enabling service users to live as independently and safely as possible, maintaining privacy and dignity at all times. The service user guide contained contact details for the local branch which stated the branch could be contacted 24 hours a day.

We received generally negative comments about the organisation and management of the service. Comments from people included, "We have had other agencies in the past which were much better than this, I don't blame the carers but the organisation is just awful" and "Some carers turned up on their first day of employment, mostly it was a nightmare, the office was incompetent and uncaring". One person did comment, "I have always found the service to be alright and I haven't had any problems."

Annual surveys had been issued to people using the service in the Bradford area prior to our inspection and people in the Leeds area were due to have these issued the month following our visit. People we spoke with were not aware of any contact from the service. One person said, "I can't remember a questionnaire, I might have had one but it would be a long time ago" and another person said, "Questionnaires, you must be joking, no never". However, we saw a number of completed monthly surveys asking the service user, 'Are we caring?' Out of the 10 we were shown, seven people had replied no to at least one of the questions. People's comments included, "Feels rushed", "Carers rush, feels ignored." At the time of our visit the registered manager had contacted five of the seven people to discuss their concerns further to see what improvements could be made and there were plans in place to contact the remaining two people as soon as practicable.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service in the form of a 'notification'. Notifications such as safeguarding incidents and expected deaths of people who used the service had been sent to the CQC as required, to ensure people were protected through sharing relevant information with the regulator.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely and risks to people were not always assessed appropriately.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality monitoring systems were not robust as they did not always identify concerns, trends and themes.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to meet people's needs and staff were not deployed effectively.