Harbex Limited

Harbex Nursing & Care

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 Harbex Nursing and Care on 20, 21 and 23 September 2016 and the first day of our inspection was unannounced. Harbex Nursing and Care is a domiciliary care service which provides personal care to people living in their own home. They also provide practical and domestic support such as shopping, cleaning, and financial and social support services to people. Their office is located in Urmston, Manchester and the company provides care and support to people living in Manchester and Stockport. At the time of our inspection the service was supporting about 70 people.

The previous inspection took place in July 2013. At that inspection, we found that the service had met all regulatory requirements.

The service had a registered manager who had been in post since October 2010. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found breaches in the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009. You can see what action we have told the provider to take at the end of the full report.

People told us they felt safe with the care and support they received from Harbex Nursing and Care. Staff we spoke with could tell us about the types of abuse and what action they would take if they suspected that abuse was taking place. We found that the service could not demonstrate that all staff members were up to date with safeguarding training. This meant people using the service may be at risk of harm due to lack of staff knowledge and awareness in this subject. Risk assessments were vague and lacked person-centred information to help staff minimise or control identified or potential risks. We noted that risk assessments needed to be reviewed and updated more consistently. This meant that people were still at risk because staff were either unaware of their current circumstances or did not have sufficient information to manage risk safely.

There were recruitment processes in place; these needed to be more robust to help ensure that people were supported by care staff that were suitable to work with vulnerable people. This meant that people were potentially at risk of harm because the provider had not ensured suitable staff were employed. The service did not have many missed visits. The manager credited this to the use of an electronic monitoring system. People told us however that many times their care staff were late. This meant that people were not receiving care and support at times that suited them. People were generally satisfied with the consistency of care and told us they had regular care staff supporting them.

There were systems in place to help support people to take their medication safely. Medication errors were

thoroughly investigated and staff members had to undergo refresher medication training and be assessed as competent before they could administer medicines. This should help to ensure that people received their medication safely. People told us care staff had good hygiene practices and wore personal protective equipment when carrying out their duties. This should help to ensure that people were protected from the risk of infection. Accidents and incidents were recorded and the service took appropriate action to help ensure people were kept safe.

People felt that care staff had the right skills and knowledge needed to undertake their caring role. The service had systems in place to deliver the Care Certificate induction standards to new recruits. We saw that people's consent to care and support was sought correctly. People's consent to receive care was sought appropriately. However, staff had not yet done training in the Mental Capacity Act 2005. The registered manager told us these were scheduled for later in 2016. Staff received supervisions and appraisals to help ensure they received the necessary support to carry out their roles. Records did not support that all staff had received supervision or an appraisal. The service had good relationships with two training providers. This should help to ensure staff attained ongoing learning to perform more effectively in their jobs. The service facilitated people's access to health care professionals if required. This meant people were supported to receive the right health care when they needed. People were supported and encouraged to make healthy eating and drinking choices. This should help people to maintain a balanced diet and support their wellbeing.

People told us care staff were kind and considerate to them. They gave us examples of how staff were proactive and went the extra mile. This meant people felt cared for and supported effectively by their care staff. People were treated with dignity and respect and encouraged to maintain their independence depending on their abilities. This helped to promote their continued wellbeing.

Care plans were task specific and did not always reflect people's preferences and choices. Care plans were reviewed but we did not always see records to indicate that these were taking place when they should. This meant that people may not be receiving the appropriate care and support for their current needs. There was a system of managing complaints and people told us they were aware of the complaints procedure. The service sent out an annual client questionnaire and the last one sent out was in May 2015. The results of these had not been collated as the service was making changes to its feedback mechanism. This meant that while the service had sought people's opinions on their care and support it did not demonstrate what action was taken as a result of their feedback.

People were happy with the service they received from Harbex Nursing and Care. Staff were positive about the agency and were supported by their managers. We found that quality assurance processes in place were not robust and did not give the registered manager and provider effective oversight of the quality and safety of service. This meant that people's care and support was not adequately monitored to ensure their safety and wellbeing. We saw that the provider had a suite of policies and procedures in place; this should help to ensure staff had appropriate guidance to carry out their roles. The service did not always meet the legal requirements of notifying the CQC of safeguarding incidents.

We did not see evidence that regular staff meetings were held. We noted a meeting had been held in February 2016 but that only senior care staff and managers were in attendance. Staff meetings should help all staff to feel supported in their roles and give them the opportunity to discuss concerns they may have about their work. The registered manager told us that communication amongst staff and management was good. Care workers confirmed this, saying that there was an open door policy at the service.

The service had developed good partnerships with local authorities and other providers in the sector. This

should help Harbex to keep up to date with good practice and discuss challenges within the care sector.

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.

People told us they felt safe with the service and that they generally received consistent care. Recruitment processes were not robust and did not provide strong assurances that appropriate care staff were employed.

Staff we spoke with were aware of safeguarding principles and said they would report any suspected abuse to their manager. From records we reviewed, we were unable to verify that all staff had received safeguarding training and were up to date in this area.

Medicines were administered safely and effectively. Medicine errors were investigated thoroughly and staff had to undergo refresher training prior to attending any medication visits.

Is the service effective?

Requires Improvement

The service was not always effective.

People had confidence in care staff's abilities and felt they were equipped to do their jobs.

The service failed to demonstrate that all staff received induction, mandatory training and ongoing professional support to help them carry out their duties safely and effectively.

People were assisted to access healthcare professionals as appropriate and when required.

Is the service caring?

Good

The service was caring.

People felt cared for and respected by their care staff. Many people and their relatives told us they had developed good relationships with their care workers.

The service ensured that people and their relatives, when required, were involved in the care planning process.

People told us they were treated with dignity and respect and supported to maintain their independence according to their abilities. Care staff were able to give us examples of how they did this.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were task-oriented and did not contain information about people's history, preferences or social interests. However staff had access to initial assessments which contained information about people's social and religious interests.

People knew how to make a complaint. However the service did not operate an effective system of managing complaints.

The service sent out an annual client questionnaire to get people's feedback on the service they received. However results of these had not been collated to help the service identify what areas needed improvement.

Is the service well-led?

Requires Improvement

The service was not always well led.

People and relatives told us they were happy with the service they received and would recommend the agency.

The provider had developed a set of policies and procedures to help ensure that care staff were effectively supported to understand their role and carry out their responsibilities effectively. Some of these required review.

Quality assurance systems were not robust and did not effectively monitor the quality and safety of the service provided.

Harbex Nursing & Care

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 20, 21 and 23 September 2016 and was unannounced. The inspection was conducted by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We contacted Trafford Council Commissioning team and Trafford Council safeguarding team for information; they both told us they had no concerns with the service. We also contacted Trafford Healthwatch who told us that they had not received any feedback about this service so far. Healthwatch is an organisation responsible for ensuring the voice of users of health and care services are heard by those commissioning, delivering and regulating services.

During the inspection, with their prior consent, we visited three people in their homes and spoke with two people and one relative by telephone. We also spoke with the nominated individual, the senior field coordinator, the registered manager and two care assistants. A nominated individual is a person employed as a director, manager or secretary of an organisation with responsibility for supervising the management of the regulated activity. We were unable to speak with the registered manager until the third day of our inspection as they were on annual leave when we first visited.

We contacted and spoke with two training providers who had involvement with the service. We reviewed nine people's care records including three records kept in people's homes (with their permission) and six staff recruitment records and training files. We looked at the service's statement of purpose, policies and

procedures, and other operational documentation.

Requires Improvement

Is the service safe?

Our findings

People using the service told us they felt safe with the care and support they received. One person said, "I'm really well looked after and (I) feel more secure since I've started using Harbex." Another person told us, "Yes, I feel safe with the carers."

We looked at the service's recruitment processes and we found these could be more robust to help ensure safe staff recruitment. We reviewed six employee files and we saw they contained interview checklists, application forms, written references, identification including photographic identification, eligibility to work in the UK and confirmation of Disclosure and Barring Service (DBS) checks. The DBS keeps a record of criminal convictions and cautions which helps employers make safer recruitment decisions and is intended to prevent unsuitable people from working with vulnerable groups. However, we found gaps in employment and education history that had not been explained and documented at interview, and unverified references. In one record, we found no DBS check and in another record, we saw a caution on a DBS record but no evidence that the service had considered any potential risks and taken appropriate steps to mitigate these. We spoke with the registered manager and nominated individual about these gaps. They told us they would check to see why the DBS was not on file and rectify this. In the case of the DBS containing a caution, the service told us they had not considered doing a risk assessment but saw the benefit of this practice and would put this in place. Because of these issues we identified, the recruitment process did not provide assurances that pre-employment checks had been satisfactorily done and appropriate staff employed. This was a breach of Regulation 19(1)(a) and 19(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at nine people's care plans to see what considerations had been made for assessing risks. Risk assessments should provide clear and person-specific guidance to staff and ensure that control measures are in place to manage the risks an individual may be exposed to. Where applicable, we found risk assessments, for example, for moving and handling, falls, and kitchen hygiene, were completed. However we found that risk assessments were generic and contained no guidance about what actions needed to be taken to reduce or remove the risk. We noted there was a risk score for all assessments but that these had not been completed unless the risk related to falls. For example, in one person's risk assessment regarding kitchen hygiene, we saw a note of "Yes but cluttered" but there was no clear reference to the risk posed and how this risk should be reduced or removed. This meant that staff did not have the necessary guidance to help ensure people's safety from harm. Another person's risk assessments were dated April 2015 and we saw no record that these had been reviewed. In a third person's care records, we saw that they used bedrails but we saw no record that the service had considered any risks associated with their use. This meant that people were potentially still at risk because there was no evidence to support that their current condition had been reviewed, and because care staff did not have up to date and accurate information to support them safely and appropriately. During our review of the provider's policies and procedures we noted that the policy relating to risk assessments was dated June 2013 and we saw no indication that it had been reviewed recently. This meant that the provider had not ensured that operational guidance for staff was up to date. The examples described above constituted a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with demonstrated that they knew how to keep people safe and gave us examples of how they did this such as making sure the person's environment was free from trip hazards and ensuring people's homes were secure when they left. Care assistants we spoke with were able to give examples of the types of abuse and knew what steps to take to report any instance of abuse. We saw that the provider had a safeguarding policy which had been revised in April 2016; however we noted it contained incomplete contact details and outdated procedures for one of the local authorities they would need to contact. We raised this during our feedback with the nominated individual and registered manager who assured us that this information would be updated. Staff we spoke with told us they had done safeguarding training. However we were unable to confirm this since the service could not provide an updated training matrix and not all staff training files we reviewed contained safeguarding training records. This training should help to ensure care staff have the necessary awareness and knowledge needed to support people safely and not exposed them to risk of harm.

We asked to see how the service recorded and investigated safeguarding incidents. The senior field coordinator told us safeguarding incidents were recorded and kept in people's care files. This was confirmed when we reviewed two people's care records. We found that the service also kept a record of incidents such as missed visits and medication errors in a record book called the Complaints controlled procedures and accidents system (CCP). However we did not see the two examples of safeguarding documents found in people's files recorded in the CCP. This meant the service had no systematic way of knowing the number of safeguarding referrals they raised, and would have difficulty in identifying patterns or trends because the information was not collated in one place. We pointed out to the registered manager that upon reviewing the CCP it was not initially clear whether the concern raised was a complaint, accident or safeguarding concern. Following our visit, we received evidence from the registered manager that they had addressed this issue.

We noted from the service's incident records and safeguarding referrals we received from the local authority for the period January to September 2016 that Harbex Nursing and Care had three missed visits. People we spoke with confirmed they had not experienced any missed visits and they told us staffing levels were "okay". The registered manager told us that Electronic Call Monitoring (ECM) helped the service to ensure that visits were not missed or late. ECM is a way in which a service can monitor care staff's visit/call attendance. However, four out of five people we spoke with said their care staff did not always come at the times they preferred. Generally people told us they were understanding if care staff arrived later than scheduled. One person told us, "I can understand that timing won't always be accurate but it's a big difference from (my) preferred times. But I would like to know about it (when times will vary)." Another person told us, "They phone to say if carers are coming a bit late but it does not usually affect us." A third person said, "I don't blame the carers. It's the manager who can't sort out the rotas properly." We looked at the daily record sheets for two people we visited and we compared the times recorded with those that people had agreed to. We found that times care staff arrived varied from being 30 minutes early to over one hour late. This meant that potentially people were not receiving the care and support when they needed it and it did not demonstrate a person centred approach.

People told us, in the main, they had consistent care staff. One person however told us they no longer had a regular care worker but a different person at each visit. A relative told us their relation had two main care staff but that they were supplemented by "new ones". Some of the other comments people told us about consistency of care staff included: "I have the same carer except when she's on leave – [Carer's name]; mostly I get her. That's very useful because she knows where everything is", "I would call the office to see who was coming but I do have a regular carer who helps me with the shopping" and "I have a group of different carers but it's mainly the same ones (carers) that come."

The registered manager told us the use of ECM helped them when reviewing the rotas to ensure that people wherever possible had the same care staff attending to them; this meant that people were usually attended to by the same care worker or group of care workers which ensured that care was consistently delivered.

People told us that care workers demonstrated good hygiene practices by using personal protective equipment (PPE) such as gloves and aprons, and washing their hands as required. We observed care staff collecting PPE at the offices. The senior field coordinator told us that care staff's hygiene practices were monitored at spot checks. This should help to ensure that effective infection control practice and appropriate quality checks were in place to keep people safe from harm of infection.

We received information from the local authority about safeguarding referrals made regarding four medication errors that occurred between February 2016 and May 2016. During inspection we checked to see how the service had dealt with these. We saw that the service investigated medication errors thoroughly. We noted the registered manager took appropriate disciplinary action; staff members were removed from calls requiring medication administration until they were deemed competent following medication refresher training. This should help to ensure that people were protected from harm due to medication being administered incorrectly. Where applicable, people told us they were supported appropriately with taking their medicines. We saw from medical administration records (MARs) that care staff recorded what medicines had been given as well as when a person refused to take the medicines. This meant that there were appropriate systems in place to help support people to take their medication safely.

As mentioned previously, we found the CCP contained information about accidents. Over the period, February to September 2016, we noted there was only one accident recorded; this accident related to a person having a fall in their own home. From the documentation, we found the service had dealt with the incident appropriately and taken the necessary steps to ensure the person's continued safety. This meant the service had an effective system of monitoring the wellbeing of people to help ensure they received appropriate care and support.

Requires Improvement

Is the service effective?

Our findings

We asked people if they felt the care staff that attended to them were competent and trained to do their role. One person told us "Some seem better trained than others though it could be down to experience." Another person said, "They're very good." One relative told us, "I have confidence (in the carers' abilities) but feel the agency needs to continuously educate staff to have the knowledge about who they are looking after and their ongoing conditions."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Care assistants we spoke with did not know about the MCA. This meant that care workers were not aware what this legislation meant for the people who may be affected by it. The registered manager and senior field coordinator told us that training in MCA was scheduled in the next few months.

Staff we spoke with told us they always asked for people's consent before providing any care or support. People and relatives confirmed this. In the main, we saw from people's care records kept in the office and in their homes that they had consented to receive care and support. However, we saw in one person's care records that their next of kin had signed on their behalf but we did not see any assessments to indicate the individual lacked capacity. We discussed with the registered manager and the nominated individual that this practice was not in accordance with the MCA. In another person's care records, we noted that the new care plan, dated August 2016, had not yet been signed. But we saw that their previous consent forms had been signed. We received verbal assurance that these issues would be addressed. We will check at our next inspection to see what improvements the service has made regarding compliance with the MCA.

We asked the service about the induction process for new recruits. We were told and we saw the service had a system in place to facilitate the delivery of the Care Certificate to new recruits as well as existing staff as a training update. The Care Certificate is a nationally recognised set of standards to be worked towards during the induction training of new care workers; its objective is to develop the values, behaviours and skills care workers need to provide high quality and compassionate care. From six staff training files we looked at, we saw the service provided mandatory training such as moving and handling, health and safety and safeguarding. Induction and mandatory and ongoing training should help to ensure that staff have the necessary knowledge and skills needed to support people safely and effectively. We asked to see the current training matrix for the service but this was not available. The senior field coordinator said the training system (used to record and deliver the care certificate) would also be used to record staff ongoing training, supervisions and appraisals. This meant the service could not provide us at this time of an overview of its staff training. We will check at our next inspection to see what improvements the service has made in this area.

We spoke with two training providers who facilitated ongoing training to care workers pursuing certification in health and social care. The trainers told us they had good working relationships with Harbex. One provider told us they had worked with Harbex Nursing and Care for several years; they said, "[Nominated individual's name] has used [us] for lots of courses …Harbex does all kinds of training but ensure their staff do the really important ones which directly link to (regulatory) requirements such as Safe Handling of Medicines, Dignity and Safeguarding, Infection Control as well as the essentials of good practice which includes areas such as Dementia Care, End of Life, Care Planning and Mental Health Awareness." They provided us with a record of courses completed by care workers. The other training provider told us "Harbex is one of the best employers I support. As an organisation it is proactive regarding training, regularly refer staff to training courses and keen on supporting staff (in this way). They also spoke highly about how keen staff were to learn and that they "demonstrated excellent practice" in the field. We saw certificates of achievement displayed in Harbex's offices.

This meant staff were supported to attain skills and knowledge necessary for their role. Staff we spoke with confirmed the service encouraged and supported ongoing learning and that they could approach management for additional training if they felt this would help them in their role.

We saw from staff personnel records that care staff received supervisions and appraisals. However, we did not see supervision records in every staff member's files we looked at. The registered manager showed us their record of care staff who had had their annual appraisal and those who were due one. Supervision and appraisals help to ensure staff have the necessary support and opportunity to discuss any issues or concerns they may have, and identify any professional development needed. This meant the service did not demonstrate that all staff were receiving adequate support to help ensure they carried out their roles safely and effectively.

The nominated individual and the senior field coordinator told us about future plans to introduce specialist training in areas such as Stoma Care and Percutaneous Endoscopic Gastrostomy (PEG) tube feeding. PEG tube feeding is used in people of all ages, including children and babies, who have conditions which make it hard to swallow food and fluids. They said this training would be invaluable in helping people with more complex needs stay longer in their own homes.

People and relatives told us they knew their care staff would support them to access any medical attention, if needed. One person told us when their care staff arrived for the care call and the person looked unwell that "[Care worker's name] took one look at me and phoned for an ambulance". Another person told us that their care assistants accompanied her to health appointments. Care staff confirmed that they would contact relevant health care professionals with the person's consent, where possible, if they felt that this was necessary. From daily communication records, we saw an example of a relative commending a care worker for their prompt and appropriate response to an emergency involving their relation. This showed that the service was proactive in making sure people received the right health care when they needed to.

The service sometimes assisted people with meals if required. People told us their care workers helped them to prepare their meals. One person said, "They see that I have a meal and my afters and leave a sandwich for tea." People also told us that care workers always gave them a choice of what to eat and drink. Staff we spoke with said they encouraged people to have a healthy diet but that they were free to choose what they wanted. This meant that, when required, staff encouraged people with making healthy choices to maintain good nutrition.

Good

Is the service caring?

Our findings

People using the service and their relatives were complimentary about the quality of care and support from the care workers. Some of the comments they told us included: "They [Harbex] are very good…carers are very nice", "On the whole, carers are caring, some more so than others" and "carers do have a chat and I get on with them." "They are brilliant; they are angels in training. They keep me fed, dressed and look after me well." "All the carers are lovely."

People told us their care workers knew what they liked or did not like. One care staff told us, "I like to find out a bit about the person before I go on a visit. So I read their care plan or speak to someone in the office but I also talk to them and find out more." People gave us examples of care staff's approach and how they showed caring and kindness. For example, one person told us they were pleased that "if they (care staff) use the stove they always wipe it down no matter which staff come to me". Another person told us, "[Care worker's name] took (my pet) to the vet as it was on their way to the shops to save me travel money. A third person said, "Carers always make sure that I have my pendant on and always ask if there's anything else I'd like them to do before they leave." One relative told us, "They (the carers) have a chat with [Person's name], telling (them) what they're going to do. They take their time with (them) and never rush."

People told us some care workers were proactive and took the initiative. One person told us, "some go the extra mile and can see what needs doing and get it done, for example if I'm running low on milk, they would pick some up from the nearby shop". Another person said, "[Carer's name] will always take my rubbish down without me having to ask her to do this." These examples showed that people felt cared for and supported by care workers.

People and their relatives told us they were involved in planning their care and support. They said information about what they required was gathered during their initial assessment. This was confirmed in the care records we reviewed. People we spoke with said if they had any concerns about their care they would telephone the office to discuss them. This meant that people and relatives felt included and were consulted in making decisions about the care they received.

We asked people if they were treated with dignity and respect. One person told us, "It's okay but I don't like to be called 'darling'." One care worker told us, "I treat people how I would like my mum or relative to be treated." Care staff were able to demonstrate to us how they maintained people's dignity. They told us they made sure curtains and doors were closed, would ask relatives to leave the room if that is what the person preferred and also how they spoke with the person. One care staff told us their training in dementia has raised their awareness and has helped them to provide better support to people living with this condition.

From the care plans we looked at we noted that people were encouraged to be independent depending on their abilities. For example, in one person's care records it stated, "[Person's name] can wash (their) face and brush their teeth."

Requires Improvement

Is the service responsive?

Our findings

People told us the care they received was responsive to their needs. One person said, "(I) can't fault the staff they do what they should (in the care plan)."

We looked at care records for nine people who used the service; three of these care records were viewed during our visits to people's homes. The senior field coordinator told us and we saw from people's records that they had an initial assessment of their needs. This should help to determine whether or not the service could provide the care and support needed. We noted that care plans were task-oriented and in some cases provided detailed guidance to care staff to meet people's needs but this was not always the case. For example, in one person's care plan there was very detailed information on how the person was to be supported in the shower. However in another person's care plan there was no reference to the fact they slept downstairs. We spoke with this person and they told us that new care staff always went upstairs looking for them. In another person's initial assessment we noted they preferred shaving on alternate days but this was not mentioned in their care plan. This meant that these care plans did not fully describe people's care needs.

We found that people's desired outcomes were generic and the same across the nine care plans we looked at. For example, to remain safe within own home, to ensure personal hygiene is kept to a high standard, and to ensure medicines taken.

Care plans we reviewed did not contain people's personal histories, interests, likes and dislikes apart from what they liked to have for breakfast and how they took their drinks for example, a bowl of cereal and cup of tea with one sugar. We noted that the service's initial assessments gathered information, for example, about people's social interests and religious and cultural practices; while these were also not recorded on their care plans care staff did have access to them.

The senior field coordinator told us that care plans were reviewed about six weeks after the care package started and then annually, unless there was a change in an individual's circumstance. We looked at nine care plans. In three people's files, we saw records of 6-weekly and annual reviews done in 2013, 2014 and 2015; however we did not see that reviews that were due in 2016 had been done. In one person's care file, we noted a support plan dated August 2016 but did not see a recent review to support this new plan. In the care files for five people who had started the service in 2016, we saw no record that they had been reviewed after six weeks of starting their service. In one person's files however we noted a change in the number of visits they received each week; this indicated that a review should have been done but this had not been recorded. We found the service did not demonstrate clearly that people's care needs were being reassessed according to the service's policy to help ensure their care was still appropriate. This was a breach of Regulation 9(1)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2004.

We mentioned previously the service had a system in place to collate complaints and incidents. This system is called the complaints controlled procedures and accidents system (CCP). Our review of these records

demonstrated that the service had a system of considering and investigating complaints. We saw from the CCP the complainant received either verbal or written feedback to acknowledge receipt of the complaint and the final outcome. However we found this system was not complete in that we found examples of complaints in people's care records that were not recorded in the CCP. This meant that the service was not operating an effective system for managing complaints and we could not be sure that all complaints had been investigated and appropriate actions taken where appropriate.

People we spoke with told us they knew how to make a complaint. The registered manager and the senior field coordinator told us the complaints procedure was discussed with people at their initial assessment. Most people told us they had not made a formal complaint but had telephoned the office to raise a concern, for example, issues with timing of care visits. We noted the service user guide which we saw in people's care records, contained the agency's complaints procedure.

People we spoke with told us they had not been sent a questionnaire seeking their opinions about the service or they could not remember if one had been sent. One person told us they would phone the office to raise their concerns. We asked the service how they ensured that people were able to give feedback on the service they received. The nominated individual told us the last client service questionnaire was sent out in May 2015 and there had been a 31 per cent response rate. We noted issues raised on individual surveys had been actioned or comments made by the service. For example, a person commented, "limit number of carers that visit. Should be regular." We saw that the service had made a note stating "[Person's name] has all regular carers and the times of (their) calls are very rarely changed." We did not see any record that this information had been communicated to the person. The nominated individual told me that no analysis had been done on the returned responses but that they were aware of the main issues. They said the service was currently revising how people's feedback was captured. This meant the service was not effectively monitoring the standard and quality of people's care and support and had no systematic way of identifying any improvement required. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2004.

Requires Improvement

Is the service well-led?

Our findings

Generally, everyone we spoke with had good things to say about the agency and the care staff. One person we spoke with raised their concerns about the helpfulness of office staff and registered manager in relation to rota management but they told us the care staff were competent. People and relatives told us they would recommend the service to others. They said, "I would recommend the service; they're very good", "They are nice girls; they work hard and I appreciate what they do" and "On the whole I'm getting a good service but not knowing what's happening and timing (of carers arriving). Could be improved".

Harbex Nursing and Care had a registered manager who had been in post since October 2010. The nominated individual told us all levels of staff, managers and office staff, were trained in care so they could empathise with and help out front line staff in crisis situations. They said, "There is integrated activity and coordination between management and workforce. [Name of senior field coordinator] is a manager but goes out (on calls) with care assistants as does the registered manager." The registered manager and senior field coordinator both confirmed this. The senior field coordinator told us, "I am able to monitor practice and share knowledge with workers. Service users can (provide) feedback as well." They told us this was good practice because managers were able to see what was happening on the front line and be better able to support care workers.

During our inspection, we observed an open management culture that was approachable and helpful. Care staff told us Harbex Nursing and Care was a good service to work for and we observed an easy camaraderie amongst care workers, office staff, and managers. Care workers told us, "I think it's (the service) great. The people are nice; they help you and there's always someone to cheer you on" and "It's a good company because of the people and the training. I would recommend the service."

We found the registered manager did not always report notifiable incidents to the Care Quality Commission (CQC). At inspection we reminded the registered manager that they were legally required to notify the CQC of certain changes, events and incidents affecting their service or the people who use it; these are called statutory notifications. We found five safeguarding incidents that occurred between February and September 2016 that were reported to us by the local authority and that the service had failed to inform us about. Failure to report notifiable incidents such as safeguarding was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We checked to see what systems the provider had in place to help ensure a good standard of care and support was provided and that any gaps were identified and addressed. These systems should assess, monitor and improve the quality of services provided. The senior field coordinator told us they conducted staff spot checks and monitoring visits as part of the quality assurance system. They said staff spot checks were done annually or more often if specific issues arose. Spot checks are used by the service as an assessment of the staff member while on duty; they check whether staff arrived on time, used personal protective equipment (PPE), followed the correct procedure when administering medicines and communicated with the person they were supporting. They told us they also carried out annual monitoring visits to get feedback about the quality of the support and care received. However, we did not see any

evidence or record of these. We noted audits of care plans and medication administration records were not done systematically. We found two examples of incorrect information and omissions of information in people's care plans such as inaccurate post codes and date of birth which potentially could be highlighted through a more robust audit process.

As we mentioned earlier in the report, the service used an electronic monitoring system (ECM) to arrange staff rotas and care visits. We asked the registered manager if audits of the ECM data were undertaken. They told us the system was "real time" which allowed them to monitor activity on a daily or weekly basis. This meant the manager had no overview of the call data because they did not analyse call data in a systematic way to help them plan rotas and call visits more effectively.

We noted there were some systems in place to monitor and assess the quality of the service provided such as staff spot checks and medication administration records audits. However we did not see what, if any, actions had arisen from these checks or how the service had learnt from any issues. This meant these quality assurance checks were not robust and did not provide adequate oversight of the service to help ensure it remained safe and of a good standard.

The lack of appropriate systems and processes to effectively assess, monitor and improve the quality and safety of the service provided to people was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the policies and procedures in place to guide staff in their caring role. The nominated individual told us, "Policies and procedures are working documents and not just sat on a shelf. Both staff and management refer to them all the time." They acknowledged that not all policies and procedures had been updated but prioritised depending on the need. Generally, we found most of the provider's policies and procedures were current; however we saw examples of policies that needed some update such as those relating to identifying risk and compliments and complaints. We highlighted to the registered manager and nominated individual that updating these documents would help to ensure care staff are effectively supported to understand and perform well in their caring role.

We asked if the service had regular staff meetings. The registered manager told us one meeting had been held in February 2016. One staff member told us, "They (meetings) take place but I've not been to one recently." We did not see any records to suggest other meetings had taken place. We noted from minutes of the meeting in February 2016 that there were only senior care staff (at manager level) present and it was not clear if these minutes had been distributed to the wider care staff. This meant the service did not demonstrate how care staff were given the opportunity to discuss service specific issues with each other and the manager and help develop their practice. The registered manager told us, "There was good communication between staff and the office." They told us they communicated with care staff either in person when they came into the office for supplies or on the telephone on issues such as the importance of accurate and complete recording of care provided and medication administration procedures.

The nominated individual told us they had built good working relationships with various organisations in social care such as local authorities and provider forums. We saw that the service was regularly represented at quarterly meetings of service improvement partnerships. The nominated individual told us this should help the service share and keep up to date with good practice and discuss challenges within the sector.

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 18 Registration Regulations 2009 Notifications of other incidents The service did not inform CQC about notifiable incidents such as safeguarding. Regulation 18

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service did not demonstrate clearly that people's care needs were being reassessed according to the service's policy to help ensure their care was still appropriate. Regulation 9(1)(a) and (b)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The recruitment process did not give strong assurances of ensuring that appropriate staff were employed Regulation 12(1) Risk assessments were generic and contained no guidance about what actions needed to be taken to reduce or remove the risk. Risks to people had not been considered. Risk assessments had not been reviewed and updated. Regulation 12(2)(a) and (b)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have appropriate systems to effectively assess, monitor and improve the quality and safety of the service provided to people in these areas: audit and analysis of ECM data care plan audits overview of recruitment process and, staff training and induction systematic recordkeeping of safeguarding incidents and complaints Reg 17(1) The service was not effectively monitoring the standard and quality of people's care and support through its current feedback Reg 17(2)(e)