Hales Group Limited

Hales Group Limited - Ipswich

Inspection report

53 Barrack Square
Martlesham Heath Business Park
Ipswich
Suffolk
IP5 3RF

Tel: 01473732126
Website: www.halescare.co.uk

Date of inspection visit:
09 December 2022

Date of publication:
23 January 2023

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

About the service
Hales Group Limited – Ipswich is a domiciliary care service providing personal care to people living in their own homes. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of our inspection there were 45 people using the personal care service.

People's experience of using this service and what we found
At the time of the inspection, the location did not provide personal care for anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

Right Support:
Not all of the people we received feedback from felt listened to by their care workers. The manager had plans to speak with all people about their experiences and recent satisfaction surveys had been sent out. They assured us actions would be taken as a result of feedback received.

Right Care
People's care plans were not always kept up to date to guide care workers in the care required. The management team had started to improve in this area, but this was not yet fully implemented.

Right Culture
There had recently been a change of management in the service. The management team knew where they needed to make improvements, had an action plan in place, which they were working on. All improvements had not yet been fully implemented and embedded in practice.

Improvements were needed in how risks were assessed and mitigated; this includes ensuring all risk assessments were being kept up to date. There were shortages of staff, which the service was taking action to address and limit the impact on the safety of people.

We found that care plans, risk assessment and monitoring of staff had not been kept up to date. This had been identified by the service and improvements were in the process of being implemented.

There were visits which were not being undertaken for the planned time, travel time between visits was not always provided and care workers were found to be logged in to visits to multiple people at the same time. We were assured this would be addressed to limit the risks of people not receiving the care they required.

The service had systems to monitor that people received their medicines, where required. Where shortfalls were identified actions were being taken to address them. Care workers were guided in infection control and

the use of personal protective equipment (PPE). However, we received feedback that not all care workers were wearing all the PPE.

Care workers were recruited safely. There were systems in place to learn lessons when things went wrong and use them to drive improvement.

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

Rating at last inspection
The last rating for this service was good (published 3 October 2018).

Why we inspected
The inspection was prompted in part due to concerns received about lack of staff, late and short visits, the lack of travel time provided between visits, safe care, governance, systems to monitor staff not being kept up to date and care plans not being reviewed to ensure they were kept up to date. In addition, there was a recent change of management in the service. Following concerns received, we had undertaken a range of actions, including contacting the service for assurances, informed the local authority commissioners and/or raised a safeguarding referral with the local authority. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hales Group Limited - Ipswich on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment and governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Hales Group Limited - Ipswich

Detailed findings

Background to this inspection

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

Inspection team
The inspection was undertaken by one inspector.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. The previous registered manager deregistered on 5 December 2022. There was a new manager in post who told us they were in the process of submitting their application to become registered manager.

Notice of inspection
We gave a short period notice of the inspection because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 7 December 2022 and ended on 21 December 2022. We visited the location's office/service on 9 December 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with six people who used the service and nine relatives of people who used the service. We spoke with the manager, the director of East and South Region and four care workers, we also received electronic feedback from one care worker.

We reviewed eight people's care records, three staff recruitment files and a range of records relating to governance, including staff training, audits, policies and procedures, and lessons learned documents.

We fed back our findings of the inspection to the manager and director of East and South region on 21 December 2022.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● We were not assured people received safe care at all times. Records did not assure us that care workers were always undertaking the planned visits and providing the planned care. This included care workers being logged into multiple visits at the same time. The management team assured us they would look into this.

● People's care plans and risk assessments included information of how staff were to support people safely. However, these had not been kept up to date. For example, one person's records stated they used a hoist for their mobility. There was no reference to the types of slings used and their daily notes showed they also used a different piece of equipment, which was not referred to in the care plan or risk assessment.

● Care workers told us care plans were not always up to date. Care workers reported when they visited people they had not been to before they were not confident up to date information was in place on how they should be supporting the person safely. Despite receiving training in using mobilising equipment, when it had not been used for some months, they did not feel confident using it. The management team told us there was equipment in the office which staff could use to update themselves on using it safely.

● Competency checks and observations on care workers during their usual work practice had not been kept up to date to ensure care workers were supporting people safely. One person told us how they were supported with their mobility using equipment, but this varied on the staff who visited them and staff were not always clear on the support they required. They told us when staff were trying to assist them to move, they had pulled the back of their trousers to help manoeuvre them. This was an unsafe method of supporting people to mobilise.

Systems had not been established to assess and mitigate risks to people using the service. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw records which showed where care workers had concerns, they had been appropriately reported to the office. For example, care workers had identified issues with access to a person's home, this was reported and addressed.

● The management team told us they had identified that the risk assessments and care plans had not been kept up to date and were in the process of improving this.

Staffing and recruitment

● We had received concerns about staffing levels in the service prior to our inspection. We discussed the issues of staffing with the management team regarding the difficulties with recruitment in the care sector.

Whilst there were staffing issues within the service, we were assured they were taking action and were working with the local authority to reduce the risks to people.

● There had been several staff leave the service. To address this, the management team were actively recruiting to the vacant posts, office staff and management covered some visits and agency staff were being used. To retain care workers and make the service attractive to work for, the hourly rate for pay had been increased. The director of the east and south region told us they were attending a meeting the week after our inspection with a view to participate in a local initiative to attract people into care work.

● When visits could not be accommodated due to the shortage of care workers, people and relatives were contacted and asked if relatives could assist or if the person could manage without the visit. One relative told us they were advised by telephone if there was no staff available for visits and received requests if the family could support the person, they said this had increased recently. Another relative told us the same, saying the calls for no care workers being available had increased in the last, "Few weeks."

● However, the management team told us they had now had agency staff in place and all visits were now rostered for completion.

● Care workers told us they felt under pressure to undertake more visits and there were not enough care workers to cover the visits. One care worker said, "I do not feel that there are enough care workers. There are far too many calls put on a carer and in my opinion, given an impossible task to get round to everyone and spend the time needed to carry out tasks required."

● We reviewed six care worker's personnel files and found recruitment was undertaken safely. This included Disclosure and Barring Service (DBS) checks which provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection

● The provider had an infection control policy and procedure in place and staff had been trained. There was also a COVID-19 pandemic management policy in place.

● Staff told us there were sufficient stock of PPE (personal protective equipment), which was confirmed when we visited the service.

● Staff told us they were aware of the PPE they should be wearing during visits to people, this was also identified in people's care plans. However, we received feedback from some people that care workers did not always wear aprons. This was a risk of cross infection when care workers went from one person's home to another. In addition, we saw that a person had raised this with the service in their review. We did see one person's personnel records which advised them of ensuring they wore PPE as guided, but there was no follow up in their records.

● Spot checks on staff had not been kept up to date to ensure staff were practicing good infection control procedures. We were assured these were now planned and checks on care workers wearing PPE would be undertaken.

Using medicines safely

● Audits of medicine administration records were undertaken by the manager and actions were taken where any discrepancies were identified. People's daily records and medicines administration records showed when people had received support with their medicines.

● We had received information of concern from the local authority, regarding support provided to specific people relating to their medicines. The service was investigating and feeding back to the local authority.

● Two care workers told us they felt that changes in people's medicines were not always uploaded onto the electronic system, so they were aware of what people needed support with. One told us they had recently searched for a person's medicine, which they could not find and when the called the office they were told the person no longer took them. The management team told us the systems for medicines were always

updated when there were changes and an alert on the system of changes, which required care workers to synchronise their electronic device. This was also communicated via email to care workers.
● We received mixed views about the safe support provided with medicines. One relative told us that when there had been changes to the dosage of medicines, it was not always fed back to staff on their electronic devices promptly, they said they thought it was to do with the, "Synching of the system."
● The relative had identified where their family member had been given their medicines twice, which they reported to the manager and it was addressed. Another relative told us the care workers were, "Conscientious," with supporting their family member with their medicines.
● Staff had received training in supporting people with their medicines, as required, safely. However, we reviewed six staff personnel files and found two had received a medicine competency check in 2022 and four in 2021. The management team had identified this and had started making improvements.

Systems and processes to safeguard people from the risk of abuse
● There were systems in place designed to reduce the risks of abuse, this included staff training and policies and procedures. In addition, staff were provided with a handbook which identified actions staff should take if there were any concerns of abuse.
● Care workers told us they would have no hesitation reporting concerns of abuse.
● We saw records which evidenced where safeguarding referrals had been made by the service when there were safeguarding concerns. Where requested, the service investigated concerns and fed back their findings to the local authority.

Learning lessons when things go wrong
● The service had systems to learn lessons from, for example complaints and incidents. This included disciplinary action and providing training for staff.
● Lessons learned were disseminated to staff in for example, correspondence to advise staff of their role and responsibilities and providing updated policies and procedures to read.
● The service maintained a lessons learned log for each quarter, which detailed the actions taken and improvement made.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- We had identified shortfalls in the service, which the majority had been identified by the management team prior to our inspection. There was an action plan in place and some improvements had started. However, these had not yet been fully implemented and embedded in practice.
- We checked the visits log, people's daily notes and the rotas of four staff for October and November 2022. We found people were not always receiving the full time for their visits, care workers were logged in to more than one person's home at the same time and care workers were not always logging out of visits. We also found there were times when people had their lunch visit between one and two hours after their morning visit. Evening visits, when people were being assisted to bed, were undertaken over an hour prior to the planned time.
- We had received feedback from a person which confirmed their bedtime visits were sometimes two hours prior to their planned visit. The person did not wish to go to bed at this time but had no choice as they needed assistance. They told us they and their relatives had contacted the office with their concerns and for a short time improvements were made but then went back to being early visits. They also told us that their morning and lunch visit were close together, so they had not wanted lunch because they had just had breakfast.
- One care worker told us that people had raised concerns with them about colleagues attending to their evening visits too early and sometimes care workers arrived to support people to bed when they were eating dinner.
- Some care workers said they received travel time between visits, some said they did not. The management team told us this was provided when required, as some people lived close to each other. However, from staff rotas reviewed travel time was not always provided, we found that 43% of visits undertaken in October and November 2022 did not provide travel time. This meant care workers would have to cut visits short or miss their breaks to ensure all people received their visits as planned.
- People did tell us sometimes they felt rushed by the care workers, this was also identified in a review undertaken by the service with a person, who said a care worker rushed. Care workers also told us they had received feedback from people about other colleagues who rushed and did not stay for the allocated time.
- People's care plans were not always kept up to date to show their current care needs. Care workers confirmed they felt care plans were not being updated. One care worker told us, "I feel that there is not enough information in the care plans to explain thoroughly their care needs. For example, I know that a service user wears one type of pad during the day, and a different one for night-time. If someone that is not [their] regular carer came in, they wouldn't know this as it is not documented on the care plan." They added

that the person did not verbally communicate so would not be able to advise the staff.
● We identified from a person's daily notes that they had been supported by care workers on one visit, which was not dignified or demonstrated the person was being listened to, nor that the care plan was being followed. We fed this back to the manager who assured us it would be investigated.
● One of the care plans reviewed used the term, "Suffering with dementia," this is not a widely recognised form of referring to people who were living with dementia.
● The system for monitoring and supporting staff had not been kept up to date. This included supervisions, spot checks and competency checks, which were observations of care workers whilst they were working to ensure they were providing good quality care.

Systems were not robust to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The management team told us they had identified when care workers had not spent the planned time at visits. As a result, staff had been advised of their responsibilities and the ways care workers were being paid was reviewed.
● The management team were aware that the care plans needed reviewing and updating, this was included in their improvement plan and they were in the process of addressing this.
● We saw records which showed some care reviews had been undertaken in November 2022 and arrangements had been made for a person's relatives to attend the office to review their family member's care plan. One person's relative told us their family member's care plan had not been reviewed for a year, however, they said they had recently received a telephone call advising someone would be visiting them in the next two weeks to discuss the care plan and if there were any changes.
● Care worker spot checks and supervisions were being planned to provide support and ensure they were working to the expected standards.
● People and relatives gave positive feedback on their regular care workers, who they felt were caring. One person said, "They [regular care workers] are absolutely marvellous."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● There was a duty of candour policy and procedure in place which was understood.
● We were told of an example where details of a recent investigation, actions taken, and an apology was sent to a person's relatives.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● Since our last inspection the previous registered manager had left the service and deregistered with us on 5 December 2022. There was a new manager in post, seven weeks prior to our inspection. They were being supported by two members of the senior regional management team who were present in the service two to three days each week. The management team understood the improvements they needed to make and had a plan in place to address shortfalls.
● There had been changes in the office staff, several office staff had left. The management team told us as of the week of our inspection visit, the office was fully staffed including a full and part time care coordinator, quality assurance officer, administrator, and recruiter.
● Care workers told us it was difficult to say if the service was well-led, due to the manager being new. One care worker told us that the new manager seemed willing to listen and were hopeful improvements would be made. The management team told us they were working to improve the culture in the service, as some

care workers had not liked the changes brought in by the new management.
● We received mixed views from care workers about the communication with the office, one care worker said in parts it is positive, when they have raised concerns communication has been sent to all care workers, however, when a person was in hospital they had not been informed.
● Care workers, they told us they loved their jobs and were passionate about providing good quality care. They spoke about people they supported and cared for in a caring and compassionate way. Some care workers gave us examples of how they supported people to ensure they had positive experiences of their interactions.
● A range of audits were in place, which was supporting the provider and management team to identify shortfalls and put plans in place to address them. This included audits on staff files, medicine administration records and daily notes.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Recent satisfaction surveys had been sent out to staff and people using the service. Responses had been received, but these had not yet been analysed and actions taken as a result of people's comments. The manager assured us this would be competed, an action plan developed, and feedback sent to people and staff which identified the actions taken as a result of their comments.
● One care worker told us they had recently received a gift from the new manager, such as a badge and some sweets. They told us this was a nice gesture. We saw certificates of appreciation in a care worker's records which showed positive feedback had been received from people using the service.
● We saw records of communication sent to the care staff team in 2022, including cold weather updates and advising staff not to speak with people using the service about their pay and cancelled calls. Staff were advised in November 2022 that the service had identified interesting information about visit cutting, staff were advised they must stay for the full time of planned visits.
● The minutes from a staff meeting held in November 2022 showed staff were kept updated with events in the service and issues with staffing and covering visits.
● Some people and relatives told us they did not receive a rota so were not sure when their care visits were to be and by whom. One person said, "I just have to lie here and wait." One relative told us, "It is difficult to say if they are late or stay the right amount of time because we do not have a rota." The management team told us people could have a rota when requested.
● Relatives told us they could call the office if there were any concerns.
● Staff received an induction and handbook when they started working for the service. The handbook provided information on the requirements of their role, including uniform and dress code and health and safety.

Working in partnership with others
● The manager told us they felt that they had positive working relationships with other professionals involved in people's care including commissioners, allocated workers, district nurses and occupational therapists.
● We saw compliments had been received by the service, one was from a health professional in December 2021, who commented on how the service had worked alongside them.

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 Systems had not been established to assess and mitigate risks to people using the service. This placed people at risk of harm.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not robust to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm.