Hales Group Limited

Hales Group Limited - Thetford

Inspection report

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11 May 2021

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Hales Thetford is a Domiciliary Care Agency supporting approximately 100 people living in the community. Hales provides personal care support to people to enable them to remain as independent as possible. At the time of the inspection approximately 75% of those supported were supported with their personal care.

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.

People's experience of using this service and what we found
People told us there were not enough staff to ensure they received their care at a time which suited them and met their needs. This included at times they were required to take their medicines. One person said, "My medication is always late, because they are never on time." Risks to people's health and wellbeing including their medicines were poorly managed and people were not suitably safeguarded from poor care. Infection prevention and control procedures specific to the management of the current pandemic were not implemented and monitored to ensure appropriate action was being taken by staff and the people supported. The provider's recruitment procedures were not followed to ensure the suitably of staff was kept under review.

The provider did not have an effective system of quality audit to assure themselves the service delivered was safe and what people wanted. People were not as involved as they would like in how their support was delivered. One person told us, "I have shared my concerns, called and written to them, 28 days, not heard from them, two hours late every time is not acceptable." Staff told us they 'loved' the job, but they were poorly supported, they could not deliver the Rota in the way it was presented to them as it did not contain enough travel time and sensible breaks. CQC did not receive notifications for all incidents of concern, but the provider's last report was available on their website.

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

Rating at last inspection and update –
The last rating for this service was Requires improvement (7 November 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about missed and late calls to people in receipt of services. A decision was made for us to inspect and examine those risks. We received concerns in relation to the management of medicines and people's needs not being met. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well led key question sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

The provider told us both prior and throughout the inspection that they had taken steps to mitigate concerns raised by staff and people using the service. However, on inspection, we did not find the steps taken had been effective in mitigating the risks to people in receipt of services.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to staffing and recruitment, medicines management and the management of risk including safeguarding people from the risk of abuse, a lack of suitable audit and quality assurance and oversight at this inspection. We also found we had not received notifications of incidents as required.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Hales Group Limited - Thetford

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 Care Act 2014.

Inspection team
One inspector led the inspection remotely for the duration of the inspection and two inspectors attended the site on the first day. An Expert by Experience spoke with agreed people via telephone over two days. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in the community.

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short period of notice to the inspection because we needed to ensure someone would be in the office available to support the inspection. Inspection activity started on 28 April 2021 and ended on 11 May 2021. We visited the office location on 28 April 2021.

What we did before the inspection
Prior to the inspection we had been working with the local authority, quality monitoring and safeguarding team to assure ourselves the service was safe. We reviewed feedback from professionals, people in receipt of

services and staff working at the service to determine the need to inspect.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all this information to plan our inspection.

During the inspection
We spoke with or had email communication with 22 staff. This included the area and regional manager and quality director. We spoke with carers, a care coordinator and quality officers, we also spoke with staff from different provider services who were supporting the service at Thetford. We spoke with or had email communication with 17 people using the service or their family members. We spoke with seven professionals who were supporting the service during the inspection.

We had email communication with the office of the nominated individual to share concerns as the inspection progressed. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a large number of records, including 12 care plans, incident reports, medicine records and records used by the provider to monitor the performance of the service. We also looked at personnel records including information for recruitment, supervision and training.

After the inspection
People using the service and staff continued to contact us to share concerns and we shared this information to support the provider to improve. We continued to seek clarification around the evidence reviewed as part of the inspection up to writing the report and we met with stakeholders of the service to ensure the service was supported to keep people safe.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

At our last inspection the provider had failed to have robust systems in place to manage risks to people in receipt of support. Medicines were also unsafely managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider was still in breach of regulation 12.

● Where risks to people's health and wellbeing were identified by staff or shared with staff by people they supported, appropriate action was not taken to ensure risks were mitigated. Where people were supported by the service with their medicines, action was not taken to ensure people received their medicines as prescribed. We were told, "All the staff have terrible timing, something needs to be done about that."
● One person had fallen and had their leg dressed by paramedics. No information was added to the person's care plan or risk assessment, a body map was not completed. Concerns were noted the wound could have become infected over 10 days later and information was still not added to the person's file to give staff the information they needed to support them.
● Risk assessments were not completed for people's serious health care needs, including diabetes, COPD, Sepsis and major organ failure. This meant staff did not have the associated information they needed to support people if it was needed.
● Staff completed information of concern notes, reviewed by office staff to take action, but these were not reviewed in a timely way and when they were, records were not updated to inform all staff of any changes to the support to be provided.
● People's medicines were not managed effectively, and people did not receive the support needed to ensure medicines were administered as prescribed.
●Where people had medicines that should be taken at a specific time, including before meals or every four hours, the provider did not ensure rotas and scheduled visits corelated with the time the medicine was required. This put people at risk of not receiving their medicines as required to treat their health needs.
● When medicines were prescribed, they were not immediately recorded on the MAR chart resulting in a potential delay in people receiving required medicines. MAR charts did not include all the detail of the prescription and there were times when they had been completed incorrectly.
● Medicines to be administered as required (PRN) did not have dedicated protocols in place to inform staff when and if they should be administered. This put people at risk of receiving medicines unsafely or

inappropriately.
● Staff had not received the training or support to ensure they were competent in administering medicines. More competent senior staff did not oversee staff administering medicines to ensure they were safe to do so.

● The provider has not taken effective and decisive action to ensure the requirements of the regulation had been met.

The provider continued to have ineffective systems in place to safely manage and mitigate risks to the people they supported. Medicines continued to be poorly managed. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The provider did not have enough competent staff, suitably allocated to meet the needs of the people in receipt of a service. One person said, "The carers are ok, it is the company who have to sort themselves out in terms of staff and keeping their promises of actually sending them and then checking on them."
●The Care Quality Commission had been sharing concerns with the provider for approximately four months prior to the inspection about issues raised with the commission from staff. Concerns primarily focused around the development of the rota, the lack of travel time between calls and staff cutting calls short, in attempt to ensure everyone was in receipt of support. We found that during the inspection concerns were still noted and calls were often missed or cancelled due to the non-attendance of staff at the scheduled time of the call to provide support.
● The provider had told us steps had been taken to improve this and it was happening less. This was not the case. More senior staff left during the inspection leaving the rota to be completed by another service without the knowledge of the people supported and the circumstances of staff. Staff told us the rota had gotten worse.
● People supported by the service continued to share concerns with CQC about missed and late calls, these impacted on medicines, meals and the receipt of support with personal hygiene and continence needs. People and their family commented that medications and some meals were being missed because the carers turn up late. People were not receiving the assessed support to meet their needs.

People did not receive the care they needed as there were not enough suitably allocated staff to meet their needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some staff were not recorded as having a DBS check but were working independently on the rota and others had been in post for over 10 years but only had one DBS check in that time.
● Staff recruited by the service primarily had checks made with the Disclosure and Barring Service (DBS) to ensure they were safe to work with vulnerable people prior to doing so alone. However, when information of concern was identified on these checks, formal risk assessment was not completed to ensure any associated risks could be mitigated by the service.
● Where application forms identified anomalies in previous employment these were not questioned or discussed to ensure all risks were managed. For example, one staff member said they had been in one role for nine years, yet their recruitment history did not confirm this and registrations with the CQC showed different information.
● We found the provider did not complete due diligence checks on recruitment information to ensure all staff in post held the appropriate skills and knowledge for the role they were applying for. We saw applications for one role, yet staff were recruited to a different one. The provider's recruitment procedures

had not been followed.
● The provider had not taken steps to implement effective systems to ensure staff were competent in the role they were working. This included in the administration of medicines, moving and handling and procedures to reduce risks associated with the COVID-19 pandemic.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate recruitment was effectively managed. This placed people at risk of potential harm. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● There were not effective systems in place to ensure people were protected from abuse including neglect.
● In 2021 the Care Quality Commission has received 20 notifications of abuse or allegations of abuse from the service. Over 75% of these were about missed calls or calls that should be completed by two staff being completed by only one. People were not getting the support defined in their assessments of need.
● When speaking with staff and people in receipt of support, we were told that they feel when they raise concerns they are not listened to. We were told the out of hours number is simply not answered or calls not returned, answer machines are full so staff cannot leave messages. One person told us," If you speak to the company it's like speaking to a brick wall."
● These concerns have all been shared with the provider and yet they continued throughout the inspection. The inspector themselves had difficulty contacting the office, to share concerns staff had raised with them, as they couldn't get hold of the office, whilst working to complete calls to support people.
● Concerns were raised by staff, professionals and people themselves which required reporting under safeguarding procedures which the service had failed to do.

People are not protected from abuse because effective systems are not in place. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff have not received quality training in safeguarding for some time but when talking with them it was clear they were aware of what they should be doing and clear about the service they wanted to deliver. They did not feel supported by the provider to do this.

Preventing and controlling infection
● The provider was supporting approximately 75 people in the community with the regulated activity personal care. Staff had been provided with written information on changing infection prevention and control (IPC) guidance through email. But staff had not had any additional training, any additional competency checks nor any additional meetings to support them on implementing the changing procedures through the pandemic.
● We were told by some staff that others were not wearing appropriate personal protective equipment (PPE). We saw a supervision for one staff member who was not happy wearing the correct PPE. They had been asked to source a different mask but there was no conclusion recorded. Records did not say whether this staff member was wearing correct PPE moving forward. Staff had arrived at houses where people had recently been discharged from hospitals and they had not known. Consequently, they did not have the additional PPE required, to ensure procedures were followed.
● In December 2020 government guidance changed to advise that staff in domiciliary care agencies were tested weekly for COVID-19. The provider did not purchase the required tests until February 2021. The implementation of the testing programme has not been effective, and few staff are aware of the importance

of weekly testing and do not see it as a requirement.

● As part of the inspection we requested details of the testing and vaccination position at the service. We found approximately 50% of staff had no COVID-19 test results available.

● The provider had developed a contingency plan to support people in the event the pandemic had an adverse effect on the service provision. This included a risk rating applied to each person supported. We discussed the risk rating with the person who developed it and were told they had not completed the information in an informed way other than their own knowledge of people they supported. Consent had not been acquired from people using the service.

We were not assured the provider had implemented an effective programme of preventative IPC measures as a result of the pandemic. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the provider did not have a system of quality audit and procedures were not developed for improvement. Contemporaneous notes were not kept of the service delivered to people which made effective audit more difficult. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider was still in breach of regulation 17.

● Staff told us the service was not managed professionally or effectively. We were told the rotas were always given to them last minute and were often changed. They worked long hours without breaks. The only way they could fit care calls in and get a break for something to eat was to cut calls short. One person told us, "I am not happy with the hours, I have set days on and off. It seems since new management has taken over these have been ignored. I never got more than a couple of days' notice for the rota but now it's a day or a few hours' notice."
● We had discussed this with the provider prior to the inspection and an organisational safeguarding alert was raised by the local authority in February 2021 to investigate this and other concerns raised with CQC about the standard and quality of the service.
● The provider had assured key stakeholders and CQC that processes had been implemented to reduce risks at the service but we found these were not effective when we inspected.
● A live view of the care calls to be completed was available electronically. We were told, staff in the office were part of a rota to watch this and ensure when calls were running late, people in receipt of services were contacted. This had not happened to any of the people we spoke with, who had late or missed calls.
● People had previously complained about not knowing which staff were coming to support them. They had requested rotas from the service to keep them informed of who to expect. The provider had assured us people that wanted rotas had received them. We found this was not the case during the inspection.
● An effective system of quality audit of daily records, Medicine Administration Record (MAR) charts and care records had not been implemented. We looked at the audits completed for the records we reviewed and saw the audits consistently identified no issues. When we looked at the associated records, we saw concerns in the information which required action to improve.
● Medicine administration record (MAR) charts showed medicines not administered, they also showed

medicines administered when they were not available or had been stopped. This led to concerns in the validity and accuracy of the records kept. These concerns were not identified in the audits.
● Audits were routinely completed on the same people's records, meaning some people's records had not been audited for some time. The quality of the service provided to these people was unknown. Audits completed monthly often identified the same issues which had not been effectively addressed from the month before.
● Action plans were not developed and consequently actions were not signed and dated once completed. This did not provide assurance or accountability of required actions.
● The provider had been in breach of regulations since 2015. At each inspection an action plan has been provided which when tested at the next inspection had not been fully implemented and applied.

The provider had not implemented an effective system of quality audit to assure themselves the quality of provision met the requirements of the regulations. Contemporaneous records to support the management of the service were not kept. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us; they loved their job but wanted to complete it to a higher standard. People in receipt of support told us the carers were excellent, but they felt they were put under too much pressure to complete long days and support too many people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● People in receipt of services told us they did not feel involved with reviewing their care plan. When they requested changes to how their care was delivered, we were told it was not implemented. This included the time of the call, the support delivered and the staff attending.
● One person told us they requested only female carers but were regularly sent male carers. Another told us, they routinely asked for their tea and bedtime call to be further apart, but this had rarely happened.
● We saw reviews had recently been completed on the system which included a small questionnaire completed with people in receipt of services. As at the last inspection we noted the primary concern was late or missed calls.
● We reviewed the last survey completed by people in receipt of services and again noted, primarily concerns were around the times care calls were delivered.

The provider had not taken effective action to address concerns raised consistently in feedback from the people in receipt of support. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candor, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had not sent notifications to the commission in all the required occasions. This included incidents of other events including allegations of abuse, police incidents and events that stop the service from running smoothly.
● When we reviewed incident records, safeguarding and complaints information we noted additional information of which we should have been notified. We were made of aware of other concerns from staff members and family members, of which we should also have been notified.

The provider had failed to send notifications of other incidents to the commission as required as part of their registration. This was a breach of regulation 18 (notifying of other incidents) of the Health and Social Care Act 2008 (Registration) Regulations 2009.

- The last inspection report was available on the providers website.

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 provider had failed to send notifications of other incidents to the commission as required as part of their registration. Regulation 18 Registration

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Systems were either not in place or robust enough to demonstrate recruitment was effectively managed. Regulation 19 (1) a, b, c (2) a

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People did not receive the care they needed as there were not enough suitably allocated staff to meet their needs. Regulation 18(1) (2) a