Hales Group Limited

Hales Group Limited - Grimsby

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

The inspection took place on 21 February, 5 March and 19 March 2018 and was announced. We gave the provider 48 hours' notice of our inspection. This was because the location provides a domiciliary care service and we needed to be sure the registered manager and staff would be available to support the inspection process.

Hales Group Limited - Grimsby is a domiciliary care agency located close to the town centre of Grimsby in North East Lincolnshire. It provides personal care to people living in their own homes in Lincolnshire and North East Lincolnshire. It provides a service to older people, people with learning disabilities, physical disabilities and people living with dementia. At the time of our inspection, the service was supporting 279 people. Not everyone using Hales Group Limited - Grimsby received a regulated activity; the Care Quality Commission only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

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

At our last inspection on 10 and 12 February 2016, the service was rated Good overall. During this inspection, we identified shortfalls throughout the service in relation to medicines management, quality monitoring of the service, records and staff support, supervision and training. These included breaches of Regulation 12 Safe Care and Treatment, Regulation 17 Good Governance and Regulation 18 Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we asked the provider to take at the back of the full version of the report.

The provider did not have effective systems to ensure risks to people were fully assessed, monitored and reviewed. Accidents and incidents were recorded, but lacked detail of any actions taken to reduce risk and prevent reoccurrences.

People did not always receive person centred care in line with their preferences as not all care plans were regularly reviewed. They did not accurately reflect the care and support people required. People's care plans did not always contain suitable guidance to ensure staff could meet their needs effectively and consistently.

Improvements were needed to ensure that staff received appropriate on going or periodic supervision in their role to make sure their competence was maintained. We saw that although a supervision plan was in place, 87 staff had only received 373 supervision sessions since our last inspection in February 2016. The provider had not always ensured competency checks were completed for all staff to evidence they had the

necessary skills to safely meet people's needs.

Staff had not always completed the necessary training to deliver the care and support the people who used the service required. People using the service expressed concerns that not all staff had the required skills to meet their needs for example; stoma care, catheter care and people receiving their nutrition through a tube directly into their stomach. People told us they had not had positive experiences with staff who were unfamiliar with their needs and on occasion had been left wet and uncomfortable, when their regular carers were not available to support their care delivery.

Improvements were needed to make sure all records maintained for people were accurate and completed to show care instructions had been followed so that people received the care and support they required in line with their individual needs. The manager did not always have access to care records completed by staff stored in people's homes and failed to ensure they had oversight of their care. This meant there could be delays in any care or treatment they required. We found some people's care plans had not been reviewed since their creation in 2015. Improvements were needed to be made in the way information was recorded in relation to people's capacity was assessed and consent recorded.

We have made a recommendation about the application of the MCA.

People were at risk of not receiving their medicines as prescribed and we found evidence that some people had not received their medicines as prescribed. This had been due to not obtaining medicines in a timely way before stock ran out. There were also issues with staff not signing medication administration records (MARS) and not recording medicines people were prescribed. Transcriptions of medicines in a monitored dosage system (MDS) tray were not completed for each individual medicine.

There was sufficient, suitably recruited staff to meet people's needs. However, the standard of records varied with some having gaps in information, others containing duplicated information and another contained information belonging to other staff members.

We have made a recommendation about the standard of staff files.

People were usually provided with a varied and balanced diet and accessed the support of other health professionals, when required. Information shared by healthcare professionals was not always documented or shared with the branch office.

People told us they had developed good relationships with their regular carers who promoted people's privacy and dignity and encouraged them to maintain their independence. They felt that staff offered explanations and asked them before carrying out any tasks. They told us staff knew them well and understood their individual needs. However, some people felt there was a lack of consistency in the staff that supported them, including new staff and staff who were not their regular carers. There had been fourteen missed calls logged between September 2017 and February 2018.

People and their relatives felt able to raise concerns and complaints, but we received a mixed response about how these were responded to. People's views were sought in the planning of the service, but changes made were not always monitored to ensure they were effective. Not all staff felt supported by the manager and the provider.

The concerns identified during our inspection showed us the provider did not have effective systems in place to monitor the quality and safety of the service provided and to maintain consistent standards of care

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 consistently safe.

Systems in place for the management and administration of medicines were not robust, which meant some people did not always receive their medicines as prescribed.

Staff were recruited safely and they knew how to protect people from the risk of harm or abuse and how to report concerns. Not all staff had received regular safeguarding training updates.

Staff told us there was insufficient office staff on duty at weekends to cover calls made to the Grimsby branch and the other branches they covered.

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

Accidents and incidents were recorded, but lacked detail of any actions taken to reduce risk and prevent reoccurrences.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had access to training, but this had not been planned in a way that ensured training updates did not lapse. There were some elements of training that had not been completed by all staff such as catheter care, stoma care and PEG. This meant not all staff had the required skills to support people's assessed needs.

Supervision plans were in place, but the majority of staff had not received on-going support and supervision and appraisal to ensure their competency was maintained.

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

People confirmed consent was gained before care and support was delivered. Information within care plans did not always detail how people who had been assessed as lacking capacity may be affected in their decision-making processes.

Is the service caring?

Good

The service was caring.

People who used the service were supported by small-dedicated teams who knew their needs well and understood their preferences for how care was delivered. People told us their regular staff team treated them with dignity and respect and were kind and caring.

Staff promoted people's privacy and helped them to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff were knowledgeable about people's individual needs although not all this information was included in care plans.

Care plans and risk assessments were inconsistent and did not always contain details of people's preferences to enable staff to deliver person centred care. Where there had been changes in people's needs, these were not always recorded within their care records.

The provider had a complaints policy and procedure in place. People's views on how the provider dealt with and responded to complaints was mixed, with some people being satisfied while others were still unhappy with aspects of their care package.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider's quality assurance system were used to ensure, amongst other things, people's care plans were up to date, staff training and supervision had been completed, complaints and accidents had been investigated. However improvements were required to effectively drive quality.

Audits used have not fully identified all care plans included important information or identified gaps in recruitment records. There were shortfalls in recording, which meant that there was not accurate information about people's needs, which could put them at risk of not receiving appropriate care and treatment.

Where errors and incomplete records were found these had not always been fully addressed.

The manager notified the CQC of specific events that occurred within the service as required.

Hales Group Limited - Grimsby

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.

The inspection visits took place on 21 February, 5 and 19 March 2018 and announced. The provider was given 48 hours' notice because the location is a domiciliary care service and we needed to ensure someone would be in the office

Four adult social care inspectors with a specialist advisor (SPA), whose specialist area was medication, carried out the first day of the inspection. Two experts by experience contacted people who used the service, their families and healthcare professionals during the inspection to obtain further feedback about their experience of the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. A contracts officer from North East Lincolnshire Clinical Commissioning Group was present on the first day of our inspection. Three adult social care inspectors carried out the inspection on the second day. One adult social care inspector carried out the inspection on the third day.

Prior to the inspection, the provider completed a Provider Information return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We spoke with the local authority commissioning and safeguarding teams to gain their views of the service. We also looked at the notifications we had received from the service and reviewed all the intelligence CQC held, to help inform us about the level of risk for this service.

We visited the office location on each day of the inspection to see the registered manager and office staff;

and to review care records and policies and procedures.

During our inspection, we spoke with twenty people who used the service and four of their relatives. We looked at care records for eleven people who used the service and other important documentation including; medication administration records (MARS) and monitoring charts for food and fluids and weights.

We also spoke with the registered manager, the registered manager of another branch, who had been supporting at Hales Group Limited - Grimsby, the regional operations director, three care coordinators, the care delivery trainer and two office based staff. Ten members of care staff were also spoken with. We also looked at personnel and training files for twelve members of staff, staff supervision and appraisal records, as well as other records used in the management and monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us they felt safe and they were aware of who they should speak with if they needed to raise a concern. Comments included, "I feel very safe with them, even the ones I don't know very well. They look after me. If not I would speak to my family or the management" and "I do feel safe with them, the quality of care is not a problem at all." Another person told us, "Yes I do feel very safe with the carers. They make sure I am steady on my feet before they leave me."

When we checked care and medication records we found safe medicine practices were not always followed, which meant people were at risk of not receiving their medicines as prescribed. These included; staff not signing medication administration records (MAR) after the administration of medication. One incident where changes with anticoagulant medicine was not passed to care staff which, resulted in a carer guessing the dose of Warfarin based on previous doses, when the prescription for Warfarin medicine had been cancelled and new medication had been prescribed. Two further incidents were identified where Warfarin medicine had not been given as prescribed. Another incident involved a person not receiving their prescribed medicines for a two week period, as the care staff had not re-ordered these.

The current system for transcribing prescribed medicines in a monitored dosage system (this is where medicines are provided in pre packed trays with the date and time medicines should be taken.) not completed for each individual medicine; instead, the transcription on to the MAR chart simply stated words to the effect of 'MDS tray.' Therefore, the carer would simply give the person all of the medicines in the MDS tray for that visit, without checking what medicines were actually given, as this information was not available. This practice led to at least one incident where a person was not given their medicine for several days as the pharmacy had changed this item from being in the MDS tray to a separate box mid-month. A further incident included where a controlled medicine was not given as the prescribing pharmacy had taken this out of the person's monitored dosage system and put it into a separate box, but had not informed the service. In both cases, carers had not noticed this or followed it up.

When we spoke with the registered manager about this, they explained that they had introduced an audit system to review the completion of medication records. Initially they had found that the front sheet of care records contained a section in relation to MARs that staff were completing instead of the medication record at the back of the document. Because of this, the front section was to be removed. In addition to this, formal discussions had been held with staff, however these records did not identify how staff could be supported to prevent further mistakes being made or consider any other reason for these records not being completed, for example, whether the length of the call adequate to meet people's needs and complete the necessary documentation. Despite these discussions taking place, the introduction of competency checks and further training provided, the audits showed records for medicines were still not fully completed.

These issues meant there was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks were not always managed to ensure people's safety. Care plans failed to record all of people's

individual care needs and their log books [records of care and support that had been provided] evidenced that staff were delivering support that had not been planned for or risk assessed. For example, risk assessments were not in place for the use of bed rails, which had led to one person trapping their leg between the bed rail and mattress. Another person did not have a moving and handling risk assessment despite staff informing us the person required two staff to support them with all transfers. Their care plan failed to stipulate their moving and handling needs, to ensure transfers were completed safely. In the records for a third person we saw a risk assessment had been completed detailing they had no allergies. Further, into the care plan we saw the person had an identified allergy documented that had not been picked up in the risk assessment process.

We also found that not all people's care plans had been reviewed in the last twelve months, with some not having been reviewed since 2015, which meant the provider was not aware of their current care and support needs and had subsequently failed to mitigate risks in relation to their care. This meant we could not be assured the service delivered safe care and treatment.

We reviewed accident and incident records and saw that the provider had failed to consistently investigate accidents and incidents, meaning that effective learning was not taking place and consequently preventable accidents and incidents could reoccur.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we spoke with the registered manager and staff we found they had a clear understanding of the different types of abuse and how to recognise these and what to do if they witnessed any poor practice. They told us there were comprehensive safeguarding and whistleblowing policies in place and the training provided them with the information they needed to understand the safeguarding processes.

We found improvements needed to be made to staff recruitment files to ensure these were complete and to address inconsistencies in staff recruitment records. In the majority of cases, staff were recruited safely and full employment checks completed prior to new staff starting work with the service. These included an application form to assess gaps in employment history, obtaining written references, a disclosure and barring service (DBS) check, which would highlight any criminal record and an interview. In other records for staff, we found gaps in employment history, duplication of references from the same referee, missing dates of employment appointment and records relating to other staff members in the incorrect file.

We recommend the provider ensures a protocol is developed, which stipulates the documentation required to be held on staff files and audits done to ensure these files are complete.

The manager explained the service's safety management system and provided us with the extensive lone working policy that ensured staff were safe whilst working independently. An out of hours on call facility, where people using the service and staff could access support and advice was also in place.

We looked at the staffing levels and we saw there were suitable numbers of staff employed at the service. Staff we spoke with told us that overall staffing levels were adequate but additional office staff were needed to provide cover at weekends and evenings. They explained they not only covered their own branch but also for two other branches, which they were finding difficult to manage and were, worried that something may be missed.

When we spoke to the branch manager they told us 14 calls had been missed in the previous six months.

During the month of February, there were no missed calls. Each missed call was investigated by the registered manager and the majority were the result of communication errors, for example the service being unaware of people's discharge from hospital. The registered manager told us they had been trying to recruit additional senior staff, but had been unsuccessful. The recruitment to these roles continued.

Requires Improvement

Is the service effective?

Our findings

When we asked people if staff had the necessary skills to meet their needs, we received mixed responses. Comments included, "The regular carer is excellent, but the problems are when she's on holiday or not available. Then they send anybody and half the time they do not know what needs doing. I have a stoma and I need help with emptying the bag but the young ones haven't a clue and I end up being left wet and uncomfortable." Another told us, "I think the carers are marvellous. They never do anything without asking me if it is all right, even though they do the same things nearly every time they come. I try to be as independent as I can and I think they encourage that." Other people told us, "There is a problem going on at the moment which they are supposed to be dealing with. It's one of the carers they've been sending who is not very good" and "Overall they are good. Some individuals are not so good as the others though."

Staff training records confirmed that the majority of staff employed at the service had received mandatory training in line with the organisation's expectations. This included fire training, moving and handling, infection control, mental capacity legislation, pressure damage and safeguarding people from abuse.

We reviewed training records and found a concerted effort had been made from July 2017 to ensure that all staff received training updates. Prior to this staff had not always received regular training updates of mandatory training. For example, we found that only a small percentage of staff had received more specialist training for example, diabetes, stroke, epilepsy, stoma care, catheter care and the support of people receiving their nutrition through a tube directly into their stomach. Records did not show regular competency checks had been completed with staff working with people with more specialist requirements.

Staff who administered medicines had completed training. However, since our last inspection in February 2016, concerns have been raised with the local safeguarding team about a number medication errors and omissions. We spoke with the registered manager about this; they told us that the usual procedure in cases where errors were made, the staff member involved would be stopped from any further medication administration duties until such times they were re-trained and their competency re-assessed. When we looked at records of where errors had been made we saw that this process had not been followed with all staff. When we asked why, the registered manager confirmed that this would have led to staff shortages in one area. This meant that when staff made a medicine error, not all staff were provided with further support to ensure they had the necessary skills and were competent to continue to administer medicines.

When we asked staff if they received regular supervision or competency checks, they told us they did not receive regular supervision, appraisal or competency checks. Comments included, "I haven't had one" and "If there is an issue they will bring us in." When we spoke with the registered manager about this they told us that a matrix for staff supervision, appraisal and competency checks had been put in place from the beginning of 2018. We reviewed the matrix and saw this process had started in December 2017, but were unable to see that staff had received regular supervision and competency checks prior to this date. Records showed 86 staff had received only 373 individual sessions since our last inspection in February 2016.

During the inspection we spoke with the registered manager who told us that staff wouldn't attend staff

meetings but had requested additional training. Therefore topics were being trialled for example, an end of life care session had been planned for February. Throughout 2017 the organisation operated a "Learning Weeks" structure where quarterly focus was placed on a particular area of learning. However,the learning weeks described had only just been introduced by the Grimsby Branch at the time of our inspection .

Staff we spoke with told us they had completed a full induction prior to commencing their role. Staff who were in the process of completing their induction, were allocated a care coach who supported them through the induction process and assessed their skills development until they were confident and competent in their role. The trainer confirmed newly appointed staff completed a comprehensive induction and shadowed experienced staff before working independently. We found that not all inductions had been signed off by the person or their mentor, or evidenced new staff continued to be supported and assessed in their role, following the completion of their induction,

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with confirmed consent was gained before care and support was delivered. They told us, "They are caring and kind and always ask permission to help me first" and "They always ask if they can come in and explain what they are going to do and ask if that's okay with me."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who lack the mental capacity to do this for themselves. The Act requires, as far as possible, people make their own decisions and are helped to do so when this needed. When they lack capacity to take particular decisions, any made on their behalf must be made in their best interest and as least restrictive as possible. Improvements were needed to be made in the way information was recorded in relation to people's capacity was assessed and consent recorded. Information within care plans did not always detail how people who had been assessed as lacking capacity may be affected in their decision-making processes. We found consent to care and support was not always recorded within people's care records.

We recommend that the provider seeks advice on best practice, to assess people's capacity in relation to specific decisions for people living in their own homes.

People we spoke with confirmed consent was gained before care and support was delivered. The registered manager and staff we spoke with were able to demonstrate a good understanding of how they supported people to make their own decisions. They described offering people choices and gaining their consent before they delivered any support. Staff told us that if they had any concerns about any changes in people's capacity, they would share this information with the office. They told us, "Any concerns we have or changes in people we share with the office and they can make a referral to their GP."

People we spoke with and their relatives confirmed people were supported in line with their preferences in relation to their nutritional needs. Comments included, "My relative forgets to eat and drink unless somebody is with him and the carers are really careful to make sure he does eat. They leave him cold drinks between visiting times and note down whether he has had them or not", "Yes they will heat a frozen meal for my lunch and do a snack for tea. My son does the shopping for me, so I choose whatever I fancy" and "They do get my lunch ready for me, I have what I fancy. They always make sure I have a drink left for me."

When we spoke with the registered manager and the branch manager they confirmed people's nutrition and weights were monitored and where needed other professionals were involved, for example; speech and language team and dietician. Evidence of health appointments were detailed in people's care and support

plans and showed people had access to a number of healthcare professionals including; GP's, district nurses and specialist nurses. Records showed necessary referrals were made in a timely manner when this had been required.

Each person accessing the service had an individual log book that staff used to record information and details of care and support given. Any identified concerns were recorded or reported to the senior staff for further advice and action. Examples of this included, people appearing unwell, declining their medication and any changes to their skin integrity or food and fluid intake.

The registered manager told us they felt supported by the provider and senior managers and attended regular management meetings, where best practice and changes to legislation were discussed.

Good

Is the service caring?

Our findings

People who used the service told us they were supported by kind and caring staff that knew their needs and understood their preferences for how their care and support was delivered. The majority of the people we spoke with were complimentary about the care they received. Comments included, "I can't fault any of them, they are very good to me", "They are the nicest, best carers anyone could have", "They are all very kind and caring ladies" and "The majority are very kind, just the odd one has a bit of an attitude problem."

When we spoke with the registered and branch manager they told us they wanted people to have a service they were happy with and use the service because they wanted to not because they had to. The branch manager commented, "People have chosen to stay in their own homes, so we should be able to provide the care they want – a good service. The same as we would want for our own family."

People told us staff were caring and respected their privacy and dignity, supported them to be independent and delivered care that met their individual needs. One person said, "They listen to me and to my wife as well, which is good as she is obviously involved in my care." Another person told us, "I like how respectful they are. They have to do some unpleasant things, like putting cream on me but they always keep me as covered and make sure the curtains are closed. They do their best to make me feel comfortable about what they are doing." Further comments included, "My carer needs some kind of award. They are just brilliant. When I have a shower, they are gentle and dry me well. I feel right fresh and clean", "The carers really go the extra mile all the time. I look forward to seeing them. It's nice to have somebody to talk to" and "I try to do as much as I can for myself to try and be a bit independent but it's good to know they're there if I need them." A relative we spoke with told us, "My family member always has a bit of a laugh with the carers. You can tell they are dedicated to their job. It's the chatting that is as important as everything else."

People told us they were involved in making some decisions about their care. One person told us, "They came to speak with me to see what I needed help with and what I could do for myself and that it is what they are providing."

Staff we spoke with told us care plans were in the process of being updated and those on the new system contained more detail about people as individuals and their preferences. All of the staff we spoke with had an in depth understanding of the people they supported, their personalities, their particular interests and their preferred routines. Care plans seen detailed what staff had told us about people's preferences. We cross-referenced the daily records maintained by staff and known as 'log books'. These evidenced staff provided planned care in line with people's preferences. Staff we spoke with told us, "The log books are really good, we can see really quickly what needs to be done and we can check so nothing is missed. Another commented, "It is really useful for when someone may be off their food for example. If another carer has left them a sandwich or something out to eat, we can check if they have eaten it and monitor it."

The registered manager told us that each person accessing the service was provided with a client handbook on admission, which provided them with general information including, rights and responsibilities, advocacy services, out of hours services, confidentiality and data protection.

We saw personal records were stored securely in the branch office.

Requires Improvement

Is the service responsive?

Our findings

We received mixed responses from people who used the service and their relatives about staff being responsive to their needs and if they were involved with the initial and on-going planning of their care. People told us, "Yes (person) has a care plan and it has been reviewed recently, it is up to date", "Yes I have a care plan and they do come to review it regularly, "They came and talked to us about the care plan. They've made it very clear that if we find we need more support they can come and review things with us at any time." Other people we spoke with were not as confident and commented, "I believe I have one, but to be honest I have never seen it" and "No I don't think I have one."

We found people had an assessment of their needs undertaken, where people or their relatives could ask questions and gain information about the service. Information was gained about people's health and well-being from relevant healthcare professionals, the local authority and from discharging hospitals. This helped the registered manager to develop care plans and risk assessments based on people's individual needs.

During our inspection, we reviewed the care and support plans for eleven people who used the service and we saw improvements were needed to be made to ensure accurate and complete records of the care and treatment provided to people were maintained. We saw people and their relatives had been involved in the development of their care and support plans, but these had not all been signed by people or their representative. Not all people had received on-going reviews and updates of their care plans; to ensure the information was up to date. For example, one person's care plan stated the person required support to mobilise with one staff member. When we spoke with staff about this and the level of support they required they told us, the person needed support from two carers. This change of need had not been reflected in the person's care plan and put the person at risk of not receiving adequate support.

Other care plans did not contain details of signs or symptoms of conditions people had, for example, how staff would recognise a hypoglycaemic attack, or how to manage catheter care and stoma management and provide appropriate support. Although staff we spoke with knew people's care needs well, the information in some care plans did not support new staff with the level of information they needed.

When we spoke with the registered manager about this they explained they were in the process of transferring all care plans onto the new format which was an electronic system and they felt this would be better for staff as they could then be accessed by mobile phones and from the office location, which would enable updates to be done more easily. The system had been trialled in other area and staff had given positive feedback. A date for the new system to be introduced had not yet been confirmed.

Records maintained showed that not all care plans were regularly reviewed. Although some people received regular reviews, other people had been receiving a service since 2013 and there were no records to show any further assessment had been completed since that date.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

The provider had a complaints procedure in place and this was available to people within the information given to them when they started to use the service. We looked at complaints received by the service since our last inspection and saw each complaint was investigated and responded to in line with the provider's policy in a timely way. When we spoke with people, who used the service the majority gave positive feedback about their experiences. People told us they knew how to complain and felt any complaint would be dealt with. Comments included, "Yes we would tell them if we had any problems. We have complained about the times and they have improved a bit." Another told us, "I would if need be, but not had to up to now" and "Yes, I would phone the office, and they are all very pleasant." Other people raised concerns they would not be able to access rotas as the office had recently made the decision to send these out electronically and some people did not have access to a computer. One person we spoke with was still awaiting an outcome from concerns they had raised. Another told us that they were disappointed in the communication via the office and messages they had left had not been responded to. One person told us they were happy with their call times but were disappointed that a carer they had asked to be excluded from their call; had still been sent.

The majority of people we spoke with were happy with their call times and told us their carers let them know if they were running late for any reason. Comments included, "Yes their times are good" "We don't have a big problem with times at all", "Yes they arrive on time usually" and "Yes, just about, it's not a huge problem." Other people told us they had less positive experiences with their call times. Comments included, "The times can vary greatly. I never know what time they will arrive. It can be 9.10pm, which is too early, or 11.40pm, which is too late. I know they can't help it because of the other calls they have to make" and "Their time keeping is terrible. I have rung the office and given them a telling off and it has improved for now. We will have to see."

The registered manager told us that they were continuing to review people's care with them and were trying to make sure that where possible people received their calls at their preferred times. They were aware of the issues raised with us and were using a designated staff member to meet with people on a weekly basis to identify and address people's concerns. This system had only recently been introduced and they acknowledged that this would take time to fully embed.

Staff had received training on end of life care and the provider had a policy in place to ensure people could be supported in line with their preferences. The care plans we reviewed did not contain information about people's preferences or arrangements for their end of life care.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection, Hales Group Limited - Grimsby, was undergoing changes to the structure of the management team. The registered manager had been sharing their time across Hales Group Limited - Hull, as well as the Hales Group Limited - Grimsby, with support from the registered manager from the Hales Group Limited - Scunthorpe branch. A decision had been made that the registered manager from Hales Group Limited - Scunthorpe would apply to become the registered manager of Hales Group Limited - Grimsby, and a new manager would be registered for Hales Group Limited - Scunthorpe. This would enable the new registered manager to spend all of their time there and focus on the Grimsby branch and to drive the required improvements. The registered manager explained that calls for the Lincolnshire area were managed from the Grimsby office, but arrangements had been made for this to be transferred across to the Scunthorpe office from the end of February, this would reduce the workload of the Grimsby branch.

We received mixed feedback about the service people received. Comments included, "No I don't know the manager. I have to say they do not keep me informed of who is coming to me", "No we have never met the manager but the people in the office are helpful, when you tell them there is a problem. They act on it" and "Not personally, we just deal with people in the office, they never reply to any communication we send." Further comments included, "No, I just ring the office. It is usually the answer phone, so I don't get to speak to them. They are not quick to call back" and "I have spoken on the phone, they are very pleasant. I did cancel a visit recently but the carer did not get the message and turned up." Other people told us, "No I just call the office generally. They are the world's worst for passing messages on. I cancelled a carer and they let them know five minutes before she should have come, she was on her way." We received more positive comments from two people who told us, "I have not met her but spoken to her on the phone. She seems ok" and "People in the office are all very polite."

The provider utilised a number of methods to ensure care and support was delivered safely and effectively in line with best practice guidance. This included audits, checks, observational assessments, questionnaires and care reviews. However, further improvements were required to ensure the governance systems could effectively and consistently drive improvements across the service. The registered manager told us, "We have worked hard to develop what we have but know that we are not where we want to be yet. What we need to do from here is look at what care audits are telling us and see what can be done to improve them."

The service did not have sufficient systems in place to review all aspects of service delivery and ensure a focus on continuous improvement. There was evidence the management team had been focusing on meeting the day-to-day service demands in recent months and had less capacity to develop the management and administration systems. Whilst we saw audits were undertaken on medicines records and the completion of log books to review the quality of support staff provided, these were limited, as it was reliant on care staff returning documents to the office for review. Despite audits being carried out and actions being put in place to address issues, we found these were not fully effective in addressing issues, for example, audits had identified that staff were not completing medication administration records as required but we found that errors continued to be made.

Systems in place to review key data including spot checks, supervision and training had only recently been re-established and needed further embedding to demonstrate the plans in place could be met and maintained. Although accidents and incidents were recorded, these were not reviewed to identify trends, mitigate risks or to identify any learning and areas for service improvement. We also saw the current systems to review the quality of care records were not robust enough to identify the concerns we found. This was especially in regards to identifying and mitigating risks to people's safety and ensuring care plan records were accurate and sufficiently detailed. Timescales for the completion of this piece of work had been identified within the action plan for October 2017; at the time of our inspection, this work was still on-going.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they attended operational management team meetings and directors meetings, which looked at service provision throughout the organisation and shared action plans in relation to how they planned to address issues, for example the introduction of learning weeks to look at palliative themes, including the provision of training, inviting families to talk about bereavement, bite size workshops and support for carers who may experience difficulties following the death of a service user. A monthly report covering all aspects of service provision and updates of the branch action plan was also submitted to the regional manager for further review.

The registered manager had considered ways in which more staff could be encouraged to attend staff meetings and had introduced learning sets on various subjects that would be covered at each staff meeting, the first one of this type of meeting was planned for March 2018.

There were systems in place to seek people's views and opinions about the running of the service. These were sought through meetings or telephone conversations, Responses to surveys about carers treating people with and being caring were positive. However, responses in relation to people being informed of changes to visit times, changes to regular carers and overall service provided were negative. The registered manager had recently introduced a weekly courtesy call for people who had raised issues about their service delivery in an attempt to address these.

We received mixed responses from people about whether they received surveys or were asked about their experience of the service. Comments included, "I can't recall having one, no", "I don't think we have had one, no", "Yes we have had one and sent it back, we never had any feedback from it" and "They did come out for an assessment and asked me questions then." Another person commented, "Yes, I said they could improve, overall."

The registered manager and branch manager were open and transparent about the difficulties experienced by the service in recent months and the on-going work still required to achieve the standards they wanted to provide for people. They were positive and enthusiastic about the on-going challenges they faced and demonstrated a clear commitment to developing the management systems in place, which would support improvements to the quality of service.

We received mixed responses from staff with some feeling supported by the branch manager but not having much input with the registered manager. All of the staff spoken with felt they would be able to approach management with any issues or problems. Information had been shared with staff about the proposed electronic system that the branch was hoping to introduce. Staff told us they saw this as a positive way of improving communication, sharing information and potentially could save them time.

Staff meetings were held but had been poorly attended. The registered manager had considered ways in which staff could be encouraged to attend and had introduced learning sets on various subjects that would be covered at each staff meeting. The first one of this type of meeting was planned for March 2018.

An anonymous suggestions area had been set up in the branch office for staff to raise issues and share ideas. Outcomes from this and from staff surveys were collated and actions agreed to address issues shared.

Throughout the inspection, the registered manager was open and honest. They listened to the feedback provided by the inspection team and made appropriate changes to systems and ways of working to develop the service. This showed that there was a learning culture within the service and that the provider embraced opportunities to improve.

During discussion with the registered manager, they were clear about their registration responsibilities regarding notifying the Care Quality Commission (CQC) about incidents which affected the health and welfare of people who used the service.

The provider had recruited a team of staff to support the running of the office. This included a branch manager, field care supervisors, care coordinators, receptionist and payroll personnel and a branch administrator. The branch was supported by a quality and compliance manager, an operations manager and a training manager. This meant there were people in positions to support and drive improvement in the delivery of care.

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

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 The provider had not ensured medicines were administered accurately and in accordance with the prescriber's instructions. The provider failed to mitigate risks in relation to the health and safety of service users receiving care, to ensure people's safety.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not always ensured there was an effective system of governance and quality monitoring in place. Effective systems and processes to assess, monitor and improve the quality and safety of the services provided and mitigate risk had not been operated fully. There were shortfalls in recording systems. The provider had not consistently ensured complete and contemporaneous records were maintained.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff received consistent training, supervision, support and appraisal as necessary to enable them to carry out the duties they are employed to perform.