Hales Group Limited

Hales Group Limited - Lowestoft

Inspection report

22 Beach Road
Lowestoft
Suffolk
NR32 1EA

Tel: 01502530676
Website: www.halescare.co.uk

Date of inspection visit:
18 July 2016
28 July 2016

Date of publication:
04 October 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Hales Group Limited - Lowestoft, is a domiciliary care service providing personal care to people in their own homes. When we inspected on 18 July 2016 there were 258 people using the service. Most of these people were older adults with needs associated with physical disability, dementia or long term conditions. This was an announced inspection. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to know that someone would be available on our arrival.

There was 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 Care Act 2008 and associated Regulations about how the service is run.

Staffing arrangements did not always ensure care workers were available to consistently respond to people's assessed needs, and some people experienced late or missed visits. This was in the process of being addressed by the registered manager, and we have made a recommendation.

People were not consistently provided with rotas which gave them details of who would be visiting them for their care visit, and at what time of the day. This left some people feeling anxious and unclear about arrangements. We have made a recommendation about this.

Systems and processes designed to improve the provision of care were not yet fully embedded, which impacted on people receiving care which was responsive to their assessed needs. Staff told us they felt time constraints impacted on their ability to arrive at the next visit on time. We have made a recommendation about this.

A complaints procedure was in place. People's concerns and complaints were listened to and addressed in a timely manner, however, we found one example where concerns had not been addressed, and feedback received in relation to missed and late visits suggests that this continues to be an area for on-going improvement.

Care workers were knowledgeable of the safeguarding reporting procedures and knew how to respond to any abuse. Staff recruitment systems were robust which ensured that new staff were suitable for their role.

Risk assessments were in place which identified specific risks to people and hazards in their home environment. These were regularly updated.

Care workers understood the principles of the Mental Capacity Act (MCA), and gained people's consent before they provided care. People told us they were encouraged to make choices about their daily lives.

People received the support they required to take their medicines. People were supported to maintain good

health and have access to relevant healthcare services.

People told us that care workers were kind and compassionate to them. Care workers were knowledgeable about the needs of the people they supported and helped them to be as independent as possible. They also treated people with dignity and respect.

Care workers were trained in subjects relevant to the people they were caring for, and there was an induction plan for new care workers which ensured they were confident to perform their role.

There were quality assurance systems in place which included feedback from people using the service to help the service know where improvement was required.

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.

Care workers were not always punctual and sometimes visits were late or missed.

The availability of care workers did not ensure that people received care and support as planned.

People were protected against the risk of harm by care workers who knew how to recognise and report any signs of abuse.

People were supported to manage their medicines safely.

Is the service effective?

Good

The service was effective.

People received support from care workers who had received appropriate training to give them the knowledge and skills to meet people's needs.

Care workers sought people's consent before providing care and support.

People were supported to access health care professionals when required.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect.

People and their family members were involved in making decisions about the support they received.

People's dignity and privacy was respected and maintained

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Rotas were not consistently provided to people so they knew who was visiting them and at what time.

Care plans provided care workers with clear guidance on how to meet people's individual needs. People were involved in their care planning as much as possible.

The service had involved other professionals to support people with their health and access to health care services.

There was a complaints process in place which enabled people to raise concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had systems in place to monitor the quality of the service. However, processes which were designed to improve care provision were not yet fully embedded, and this impacted on the consistency of care people received.

The service had a positive, person-centred and open culture.

There were opportunities for people and care workers to express their views about the service.

Hales Group Limited - Lowestoft

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 and 28 July 2016, and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service, and we needed to be sure that someone would be available on our arrival. The inspection was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we held about the service, such as notifications and information sent to us from other stakeholders for example the local authority and members of the public.

We spoke with 18 people who used the service and seven relatives. We spoke with the registered manager, quality assurance officer, and six care workers. We also contacted two health and social care professionals after the inspection. We looked at records in relation to 20 people's care. We also looked at records relating to the management of the service, recruitment, training, and systems for monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

We looked at the staffing arrangements for care visits. Some people and relatives expressed concerns about the punctuality of care staff. They told us that care staff sometimes arrived late, and that there were occasions when people had to telephone the office to tell them that a care worker had not turned up. One person said, "They sometimes call when they are going to be late but sometimes they don't, so I call the office and tell them to cancel the visit". Another said, "The carers are a bit more regular lately, I told them [managers] about it and it seems to be getting better". There were several complaints received by the service which related to missed visits. In November 2015, a business decision was made to transfer 42 staff into the service from another company. This led to significant errors in data which was entered onto the system which scheduled visits, and as a result, many people's visits were missed.

The registered manager told us how these had been managed, which included changes in the staff responsible for scheduling the visits. They were aware of the shortfalls that had caused this to happen and they had worked with the local authority and had developed systems to try and reduce the risk of this happening again, such as keeping a log of late and missed visits so they could monitor the frequency, identify trends and try to reduce incidents. This was on-going work, and needed further review and improvement to ensure that people's individual needs were being met consistently. People living alone or those who lack capacity may be particularly vulnerable if visits are missed or late. Though the registered manager told us that they had since improved the systems, feedback we received suggests this remains an on-going issue.

We recommend that the service explores current guidance from a reputable source in managing risk associated with missed or late visits, planning for these incidents, to mitigate potential serious implications on people's health and well-being.

Systems were in place which protected people from avoidable harm and abuse. Care workers had been provided with training in safeguarding people from abuse. They understood their roles and responsibilities regarding safeguarding, including the different types of abuse and how to report concerns. There were systems in place which guided care workers on the actions that they should take if they suspected a person was being abused. A care worker told us, "Issues I have reported previously have been dealt with quickly". Notifications from the service showed that they took actions when concerns were identified. They had made referrals and worked with the local authority, who were responsible for investigating safeguarding concerns, when care workers had been concerned about people's safety.

People commented on the safety of the service. One person told us, "I feel very safe with them [care workers] in my home". Another said, "I have a key safe and they are really good about making sure the house is all locked up at night. They leave the hall light on for me as well which makes me feel safe".People were protected by the procedures for the recruitment of staff. Staff we spoke to, and records we reviewed, confirmed that reference checks and Disclosure and Barring Service (DBS) checks [which provide information about people's criminal records] had been undertaken before new staff started work. This ensured they were suitable for their role.

People's care records included assessments and guidance for care workers on the actions that they should take to minimise risks. These included moving and handling and risks that may arise in people's own homes. One person told us, "They've taken up all the rugs so that I don't trip on anything. They [care workers] fuss about me being safe". We saw that some records relating to moving and handling could be more detailed to ensure guidance was always clear to the care workers providing support. We brought this to the attention of the registered manager who said they would review these plans promptly. Reviews of care with people and their representatives, where appropriate, were undertaken to ensure that risk assessments were up to date and reflected people's needs.

Care workers were provided with training and had undergone medicines competency tests. People's records provided guidance to care workers on the level of support each person required with their medicines. One person told us, "My carer is really careful about my tablets. Everything gets written down including the time and if they need to, they leave a note for my family". Another said, "Very good with the pills, they sort them all out for me". Records showed that, where people required support, they were provided with their medicines as and when they needed them. Where issues had happened with medicines, appropriate action was taken to reduce the risks of similar incidents happening and to safeguard people. This showed that the service's medicines procedures and processes were safe and effective.

Good

Is the service effective?

Our findings

People and relatives commented on the skills and experience of the staff providing care. One person told us, "They [care workers] are very good, very experienced, and know what they are doing. Some of the younger carers aren't so good, but they all have to learn". A relative told us, "My [relative] couldn't have better care. They are brilliant. They always check the care plan".

Care workers were provided with up to date training on how to meet people's needs in a safe and effective manner. This included an induction before they started working in the service. This consisted of mandatory training such as moving and handling and safeguarding, updated on an annual basis. One care worker told us, "I hadn't worked in the care industry previously, but the induction told me everything I needed to know, it prepared me for things that I might come across". There was a full time training officer who organised and provided training to care workers and were available to answer any questions regarding the care they provided to people. The training provided reflected the needs of the people using the service, and there were also more specialist training opportunities offered to meet the more diverse needs of people, for example, Parkinson's disease, Huntingdons disease and end of life care.

Prior to new care workers starting work in the service they were provided with a training programme which incorporated the Care Certificate. This is a set of standards that care workers are assessed on to ensure they are providing good quality care. This included carrying out observations to ensure staff were competent. There was a training room in the service with equipment such as a hoist and a bed where care workers received practical training in meeting people's needs. A relative told us, "My [relative] has to be moved by hoist and there are always two carers. I know they are well trained and they use slide sheets [equipment to move people comfortably] as well. My [relative] has very delicate skin as well as a lot of other problems but they are so careful about handling [relative] and they use special silky slings which are less harsh on the skin. They are really good. It's down to them that [relative] is able to stay at home or otherwise [relative] would need residential care".

Records showed that care workers were provided with one to one supervision meetings. This gave them the opportunity to discuss the way that they were working, identify training needs, and receive feedback on their work practice. Quarterly staff meetings were also held, which provided a forum for staff to raise concerns with the management team and share relevant information and updates. One care worker said, "The staff meetings are good, you can raise any issues you want to". Records showed that care worker meetings were held which updated them on any changes in the service and where they could discuss the service provided and any concerns they had.

Care workers were also advised of actions they should take to ensure a good quality service. For example, the meeting minutes in June 2016 showed that care workers were advised not to swap care visits between themselves and to ensure that they wore their uniforms when visiting people. We also saw memorandums provided to care workers to advise of their responsibilities. For example, not using social media to comment about the service they worked for and to be aware of driving conditions in the winter to make sure they were safe.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA and found that they were. One person told us, "They always ask me if I want help to wash, they don't just start to do it. They ask me what I want done first". Another said, "They ask for my consent before doing anything". Care records identified people's capacity to make decisions and they were signed by the individual to show that they had consented to their planned care and terms and conditions of using the service. The care records guided care workers to ensure that they involved people in all decisions about their care.

Where people required assistance, they were supported to eat and drink enough and maintain a balanced diet. This included keeping records of their food and fluid intake when there were risks, preparing and providing food and drinks and encouragement of drinks.

People were supported to maintain good health and have access to healthcare services. Care workers were guided in care records about what actions they were required to take when they were concerned about people's wellbeing. Records showed that where concerns in people's wellbeing were identified, health and social care professionals were contacted with the consent of people. One health professional told us, "Whenever I call, they [staff] are helpful, and try to help out where they can when arranging people's care".

Good

Is the service caring?

Our findings

Despite people raising concerns about the organisational failures of the service, people and relatives told us that the direct care they received from care workers was kind and compassionate. One person told us, "I'm very happy with them [care workers]. I tell them what I need and just how I like things done and they are very obliging". Another said, "Very good carers, and very polite". A relative told us, "Excellent, don't know what we would do without them".

People using the service and their relatives told us they had good relationships with the staff that attended their care. They spoke highly of the attitude of the care workers saying they treated people with kindness and compassion. People spoke warmly of their care workers and how they looked forward to seeing them. One person said, "I look forward to seeing [name of care worker] we have a little chat and a laugh about things". We observed that care workers spoke to people respectfully and had a good rapport with the people they supported. Care workers spoken with told us how much they enjoyed their job and the people they were supporting. One care worker said, "I have a job I adore, I love what I do".

People were supported to express their views and were involved in the care and support they were provided with. Records showed that people and, where appropriate, their relatives had been involved in their care planning. Reviews were undertaken and where people's needs or preferences had changed these were reflected in their records. This told us that people's comments were listened to and respected. People told us that care workers asked if there was anything else that needed doing before they left, and people felt care workers were generally supportive of them. A relative told us, "The carers are superb. We couldn't manage without them".

We saw that people were asked if they had a preference as to whether they wanted male or female care workers to provide their personal care and their preferences were respected. One person told us, "We normally get the same person. [Carer] is lovely and has a good sense of humour. We asked if we could always have a male carer because [relative] really doesn't want ladies and they have been very good about sending only men". Another person told us that they had requested that a more 'mature' care worker supported them with their personal care needs, and that this was arranged for them.

Records guided care workers to make sure that they always respected people's privacy and dignity. People we spoke with confirmed their dignity and privacy was always upheld and respected. One person said, "Very respectful carers. I feel comfortable when they are here". We observed care workers attending to one person, and saw that they chatted with them first which provided a more relaxed atmosphere prior to attending to their intimate care. We saw that doors were closed, and the person was covered up to respect their dignity. A relative said, "The carers are very good with [relative]. They always speak to [relative] in a polite way".

People's records also provided guidance to care workers on the areas of care people could attend to independently and how this should be promoted and respected. This meant that wherever possible people's independence was facilitated and care worker support was provided where needed.

Requires Improvement

Is the service responsive?

Our findings

The service used a computer system to manage the care worker rota and allocate people's visits. This system was used to ensure that, as far as possible, people received care and support from a regular team of care workers, however, we found that some people using the service did not experience a consistent service. One person told us, "I like to know who is coming and I don't like having a lot of new people. There are too many new people. It's tiresome having to tell people what to do and where things are".

People told us they did not always know who was coming to provide their care. One person told us, "The rota runs from Tuesday to Monday, but I never get it until after it's started so I don't know who is coming". Another said, "The rota is always late. I don't even bother with it". We brought this to the attention of the registered manager who acknowledged the current systems were not effective, and told us they would look into this issue promptly and devise an improved system which would ensure people received the rotas regularly.

We recommend that the service explores current guidance from a reputable source in delivering person-centred care, taking into account the specialist needs of people and the risks/benefits of continuity when planning people's care.

People said they were aware of having a care plan in place, and that they were involved in developing it. One person said, "A lady came out yesterday from the office, and we spent a long time going over it [care plan]. It's all up to date". People's care records included care plans which guided care workers in the care that people required and preferred to meet their needs. These included people's diverse needs, such as how they communicated and mobilised. However, there was a lack of detail about people's specific conditions and warning signals that a person might be unwell associated with their condition. Making this information available to care workers would provide additional guidance should the person become unwell. The registered manager and quality assurance officer advised us that these improvements would be made. They took immediate action to print off information for a person's care records regarding a particular medicine they were taking. This included warning signs care workers should be aware of so they could take action if needed.

Care reviews were held which included consultation with people and their relatives, where appropriate. These provided people with a forum to share their views about their care and raise concerns or changes. Comments were incorporated into their care plans where their preferences and needs had changed. People were asked if they had any complaints about the service they were provided with during review. We noted that one care plan held the notes from a review where the person's family had raised concerns. There was no information in place to show how this had been followed up. The quality assurance officer told us that they would speak with the staff member who had completed the review and feedback to us their findings. It is important that information like this is monitored and tracked to ensure issues are addressed, learned from and reoccurrence is limited as far as possible. Complaints relating to missed calls and late visits had been addressed to try to improve the service and to prevent similar issues happening. There were lessons learnt logs which identified actions that the service were taking to minimise similar events happening again,

however, feedback suggests that this continues to be an area for on-going improvement.

Where people required assistance to reduce the risks of them becoming lonely or isolated, this was reflected in their care records. For example, one person's records showed care workers were to provide time to speak with the person to encourage and support an increase in their confidence and wellbeing. Another showed how the person was being supported to attend their regular day centres which was important to them.

Requires Improvement

Is the service well-led?

Our findings

The service had experienced significant issues in November 2015 following the transfer of 42 staff into the service, which resulted in an inconsistent service for people receiving care. The registered manager understood their role in providing a good quality service, was receptive to our feedback during the inspection, and recognised the need for on-going improvement. They had had in place a system for recording and monitoring missed and late visits so that trends could be identified and actions taken to prevent them continuing. The management team had worked hard to improve this, however, new systems and processes were not yet fully embedded, and we found that issues regarding missed and late visits were still a cause for concern to people using the service. In the event of staff sickness, there was no system in place which ensured people still received their visit at the time they needed, which meant the care worker was either late, or on some occasions, did not turn up. This was an area that the provider and management team needed to develop.

Care workers told us that they were clear about their roles and responsibilities, and all of the staff we spoke with told us they were committed to providing good quality care. However, care workers told us that the time allocated between visits was not always sufficient, and this impacted on their ability to arrive at the next visit on time. One care worker said, "The travel time allotted is the same whether the next visit is one mile away or five miles". Another said, "I love my job, but sometimes we feel under pressure to get to the next visit on time". The registered manager told us they could adapt the travel time if this was needed, and that they used a route planner to gauge the time needed between visits. They advised us that they would be trialling a new monitoring system which required care workers to check in and out remotely at each person's home when arriving and leaving. This would be trialled in the near future, and should help increase the level of monitoring.

We recommend that the service explores current guidance from a reputable source in relation to the importance of ensuring visits are long enough for care workers to complete their work without compromising the quality of care, including scheduling sufficient travel time between visits.

The registered manager told us that they did not have a deputy manager but was supported in their role by the quality assurance officer. In addition to this, field care supervisors supported the setting up of care plans and undertaking care reviews with people. There was a field care supervisor on each shift in each area and there were plans in place to increase these. They added that they felt supported by the provider's regional manager and other senior management who they regularly communicated with.

People and relatives we spoke with told us that they felt the service was well run and that there was a culture of caring in the organisation. One person said, "If there are any little niggles, I ring the office and they are quick to put things right". Another said, "Very good the managers, they help where they can". People were asked for their views about the service and these were used to drive improvements in the service. Records showed that quality satisfaction questionnaires were undertaken where people could share their views about the service they were provided with, anonymously if they chose to. Following these, an action plan to improve the service was developed and people were kept updated with the outcomes of the

questionnaires and actions being taken as a result of their comments. For example, for care workers to ensure that people signed records to show when they had attended visits. There was also quarterly telephone contact made with people to check that they were happy with the care and service they were provided with. The records of these included actions that had been taken, where required. For example, contacting the person if the care workers were going to be late for their visits.

Records showed that spot checks were undertaken on care workers. These included observing care workers when they were caring for people to check that they were providing a good quality service. Checks and audits were undertaken on records, including medicines and daily care records. Where shortfalls were identified action was taken to introduce changes to minimise the risks of similar issues reoccurring, such as advising care workers about good quality record keeping and ensuring that all care workers had access to medicines administration charts. This meant that the quality of care was being monitored and adapted accordingly.

The systems in place for monitoring and improving the quality of the service were sufficient to enable shortfalls to be identified and for the appropriate actions to be taken to improve the service and ensure the safety of people receiving care. However, we found that people were still experiencing an inconsistent service, and whilst the management team were addressing the issues identified by their quality assurance systems, further improvement was needed to ensure that people's experience was consistent, in line with their assessed needs, and delivered from a regular staff team.