Hales Group Limited

# Hales Group Limited - Peterborough

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

Hales Group Limited – Peterborough is a domiciliary care agency which provides personal care to people living in their own homes in Peterborough and surrounding areas. At the time of our inspection there were 85 people being supported with the regulated activity of personal care.

This inspection was carried out on the 3rd, 4th, 5th and 6th July 2017 and was an announced inspection. At the last inspection on 4th and 5th August 2016, the service was rated as 'requires improvement.' We found that the service had made improvements since the last inspection; and was now rated good.

People were looked after by enough, suitably qualified staff to support them with their individual needs. However, some people experienced late care calls or an inconsistent group of staff to support them.

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

The CQC is required by law to monitor the operation of the mental Capacity Act 2005 (MCA) and report on what we find. The registered manager had an understanding that people being supported by the service who lacked mental capacity to make day-to-day decisions should have an application to the Court of Protection made on their behalf. Staff were able to demonstrate a basic understanding of the MCA. Any decisions made on people's behalf by staff were done in their best interest and as least restrictive as possible.

Staff demonstrated their knowledge of how to report incidents of poor care and harm. Staff helped people in a way that maintained their safety and people were looked after by staff in a caring manner. Staff supported and encouraged people to make their own choices and live as independently as possible. People were treated with respect and people's dignity were promoted by staff.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff enjoyed their work and understood their roles and responsibilities in meeting people's needs They were trained to provide effective and safe care. Staff were supported to maintain their skills by way of supervision, spot checks, competency checks, and appraisals.

The provider had a process in place to make sure that staff were only employed to look after people once all pre-employment checks had been completed and were found to be satisfactory. However, this process was not always followed.

People's care arrangements took account of people's wishes and aspirations, including any likes and dislikes and how they wanted to be supported. People's care plans recorded their individual assessed needs and any assistance they required from staff. Risks to people were identified, and plans were put into place by staff to monitor and minimise these risks, as far as possible, without limiting people's independence.

People were supported to take their medicines as prescribed and medicines were safely managed by staff who were trained, and whose competency had been assessed. Where there had been any errors in the administration of people's medicines, these had been identified and dealt with to reduce the risk of recurrence.

People were supported to eat and drink sufficient amounts of food and fluids. People's choice about what they wished to eat and drink was promoted and supported. Staff monitored people's health and well-being needs. They acted upon issues identified by referring people to access a range of external health care services.

There was a process in place to manage any concerns and complaints received. The registered manager had identified areas for improvement with this process and had implemented improvements so that people and their relatives felt listened to and their concerns resolved to their satisfaction.

Arrangements were in place to ensure the quality of the service provided for people was regularly monitored. People and staff were encouraged to share their views and feedback about the quality of the care and support provided. Actions were taken as a result to drive forward any improvements 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 not always safe.

People's support and care needs were met by a sufficient number of staff. However, some people had experienced care calls that were later than the agreed care call time tolerance.

Recruitment checks were in place to make sure that only staff that were suitable to provide care for people were recruited. Safe recruitment checks were not always followed.

Peoples medicines were administered and managed as prescribed.

Staff were aware of their duty to report suspicions of poor care and/or harm.

### Is the service effective?

**Good**

The service was effective.

Staff had a basic understanding of the key requirements of the Mental Capacity Act 2005.

People's choices were respected by staff.

People's nutritional and hydration needs were met.

Staff were trained to deliver effective care and support.

Where needed, people were assisted with external healthcare referrals.

### Is the service caring?

**Good**

The service was caring.

Staff were caring and respectful in the manner they supported and engaged with people.

People's dignity was promoted by staff.

Staff assisted people to maintain their independence.

## Is the service responsive?

Good

The service was responsive.

There was a system in place and actions taken to receive and manage people's concerns and complaints and to resolve them to people's satisfaction..

People's care and support needs were planned and reviewed to make sure they met people's current needs.

## Is the service well-led?

Good

The service was well-led.

There was a registered manager in post.

People and their relatives were able to contact the service and feedback on the quality of the service provided.

Audits were carried out as part of the on-going quality monitoring process to identify and make the necessary improvements. Improvements had been identified and actions taken were on-going.

# Hales Group Limited - Peterborough

**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 the 3rd, 4th, 5th and 6th July 2017 and was announced. This was so that staff would be available during the inspection. The inspection was carried out by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience or experience of caring for someone who uses this type of service. Their area of expertise was in relation to adult social care; domiciliary care agency – telephone trained; family carer of person with dementia; older people / family carers of older people, and end of life care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at this and other information we hold about the service. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. Before the inspection we asked for information from representatives of the local authority contracts monitoring team, the local authority safeguarding team, and Health watch to aid us with planning this inspection.

During the inspection we spoke with six people who used the service, and 10 relatives of people using the service. We also spoke with, the registered manager and the quality and compliance manager. Their role was to monitor and analyse the quality of the service delivered at each of the provider's locations. They were also involved in the setting up and monitoring of the provider's policies, procedures and quality systems. We also spoke with the trainer; a field co-ordinator and four support staff.

We looked at five people's care records and records in relation to the management of the service; quality monitoring records; management of staff; management of people's medicines; compliments and complaints, staff training certificates, and four staff files. We also received additional evidence including, survey results, an action plan and a copy of the last report template poster from the provider on the 6th July 2017.

Requires Improvement

# Is the service safe?

## Our findings

During this inspection we noted that there was a mixed opinion to the timeliness of people's care calls. Staff punctuality was still a concern for some people and their relatives. The quality and compliance manager told us that the local authority contract allowed staff 30 minutes either side of the agreed care call time. Although they said that the organisation Hales Group Limited had an expectation that staff arrived within 15 minutes of the agreed care call time and were working towards improving this standard with some staff. One person said, "They [staff] will phone the day before to let me know what time the carer is coming. He is always on time and has never let me down." A relative told us, "They are usually on time within a minute or two. I have never known them to be overly late." However, another relative said, "Sometimes they [staff] are not on time. It has been three or four times in the last four to five weeks, where they have come too early. It has been as early as 7.05am when it should be about 8.30am. Sometimes it gets to 10.30am and they [staff] don't always ring, you have to ring them."

Care records showed that each person's care and support needs had been assessed and this information helped determine how many suitably skilled staff were required to assist them. Records also showed the time of each care call. However, records showed that these times were not always adhered to by staff. We saw in one person's daily notes that in March 2017, staff documented for an 8.15am care call, arrival times of between 7:36am to 7:50am over that month. A staff member told us that they were asked to cover care calls at times of short term staff absences, but were not made to feel 'guilty' if they couldn't. Documentation we saw showed that there were enough staff to meet the number of care hours contracted/commissioned.

The registered manager told us that one of their biggest challenges as a manager new to the service was honouring staff approved annual leave and managing staff sickness. This had meant that people did not always receive a regular group of consistent care staff to support them. People and their relatives had mixed opinions on whether they/ or their family member had consistent staff attending their care calls. One person said, "I have had the same one [staff member] for a while now and have got to know her." However, another person told us, "I don't have a regular carer. I have no idea who is coming as I don't get a list [roster of staff and care call times]. I phone up sometimes and they tell me but they never phone me." The registered manager told us that rosters were available to people on request, although they also confirmed that this was an area they had identified as requiring improvement.

Records showed that pre-employment checks were carried out to determine that the proposed new staff member was of a good character. These included, but were not limited to; references from previous employment, a criminal records check from the disclosure and barring service and proof of identity. However, one out of four staff recruitment files seen showed that the staff member started work before their criminal record check had been received. This showed that although, there was a process in place to make sure that staff were deemed suitable to work with the people they supported, this was not always robustly followed.

People and their relatives told us they felt safe using the service. One person said, "They [staff] come in and make sure I am alright and check if I need anything." Another person told us, "Just them [staff] being there

makes me feel more at ease." A relative confirmed to us, "I am happy [family member] is safe. I know they [staff] know what they are doing. I trust them to do the right thing."

Staff told us that they had undertaken safeguarding training and records confirmed this. Staff were able to demonstrate they knew how to recognise any signs of poor care or suspicions of harm. They described to us the action they would take in reporting such incidents, internally, or to external agencies. One staff member told us, "You can normally notice a change in behaviour; I would report it [concern] straight away and record it." Another staff member said, "I'm confident that it [safeguarding concern] would be dealt with if reported to the office [staff]." This showed that staff knew the processes in place to reduce the risk of poor care and harm occurring.

People had individual care and support plans and risk assessments in place in relation to their assessed needs. Risks included, moving and handling; poor skin integrity; the use of bedrails; prescribed medication; being at risk of choking and any environmental considerations, including a person having a pet. These records gave guidance to staff to make sure the risk was minimised.

Staff who used moving and handling equipment to mobilise people, also had their competency to do this checked by a more senior staff member. This demonstrated that processes were in place to help assist people to live a safe and independent life as possible, and reduce the risk of people receiving unsafe care and support.

There was also a business contingency plan in place in the event of a foreseeable emergency such as severe winter weather. This showed that there was guidance for staff on how to assist people in the event of a foreseeable emergency.

People we spoke with either managed their prescribed medicines themselves or had a relative help them with this. Records recorded who was responsible for the collection and disposal of these medicines. Records of the management of people's medicines were maintained. Staff told us, and records confirmed, that staff were trained to administer medicines and that their competency to do this was checked by a more senior staff member. Audits were carried out so that people could be assured that they would be administered medicines as prescribed by staff if necessary. Where there had been any errors in the administration of people's medicines, for example, gaps in the recording of this support, these had been identified and dealt with to reduce the risk of recurrence.

Good

# Is the service effective?

## Our findings

Staff told us they were supported with supervisions, competency checks and an annual appraisal. One staff member said, "I [have] had a supervision, it was a two-way conversation and I was asked if there was anything I wanted to report, or was there anything I wanted to add." Although records showed that some staff were overdue a spot check, supervision and appraisal. The registered manager told us that they were scheduling in these overdue checks within the next few weeks and records confirmed this.

New staff completed the care certificate as part of their induction. The care certificate is a nationally recognised induction programme that applies across health and social care. This included training and 'shadowing' a more experienced member of staff. This was until they were deemed competent and confident by the registered manager to provide effective care and support. One staff member said, "Induction. I had a weeks training and I was on three to four shadow shifts until I was comfortable to go [and deliver care]." A relative confirmed, "We sometimes have new staff that come with another member of staff. They shadow the more experienced staff."

Staff told us about the training they had undertaken to ensure they had the skills to provide effective and individual care and support people needed. Records confirmed this. Training included, but was not limited to; equality and diversity; medication administration; communication; privacy and dignity; fluids and nutrition; dementia and learning disabilities and health and safety. Other topics included, safeguarding adults and children; basic life support; catheter care; moving and handling and emergency first aid. A relative told us, "Some of the carers seem to be more confident than others." Although another relative said, "We have a hoist. Not all staff seem as confident using it, sometimes I have to show them." We spoke to the registered manager about this and they told us that they had introduced a 'moving and handling' competency check for staff. This would enable senior staff members to observe staff practice when using moving and handling equipment and assess both their competency and confidence.

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 so that they can receive care and treatment when it 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 people's capacity to make day-to-day decisions were assessed where necessary, and staff acted in people's 'best interest' where appropriate. One relative told us, "They [staff] make sure they have my [family members] consent before doing anything, otherwise they may get nowhere."

Staff we spoke with demonstrated to us a basic understanding of how they put their MCA training into practice. One staff member said, "Always ask the person [their choice] or show them [examples] when

offering choices." The registered manager told us that during this inspection no one was supported by the service who lacked the capacity to make day-to-day decisions. This meant that there had been no requirements to make applications to the Court of Protection.

People and relatives told us that they/their family member were supported by staff, when needed, with the preparation of drinks and meals. There was guidance in place for staff for people at risk of choking, and food and fluid charts, where required to monitor people's food and fluid intake each day. One relative said, "We have a soft diet delivered and staff help my [family member] with their meals. I see the staff sit and help using cutlery I have supplied. I think they do this in the most dignified manner they can." Another relative told us, "If we have a new carer arrive I will usually stay with them. My [family member] requires a soft diet and thickened fluids. I am not sure all the staff are as comfortable as others in preparing the fluids. I have noted that not all of them go to read the care plan, so I like to make sure I am happy they know what they are doing. A person confirmed to us, "I choose what I want to eat. They [staff] will always leave me a nice cup of tea." This demonstrated to us that people were assisted by staff to maintain their hydration and nutritional needs.

Records showed that people had access to external health care professionals when needed. We saw that those people assessed to be at risk were referred by staff to specialist external health care professionals when appropriate. For example an emergency service or a community nurse.

Good

# Is the service caring?

## Our findings

People and relatives made positive comments about the support and care provided by staff. One person told us, "They [staff] are kind and considerate. They treat you with respect. They know me so well now. They have become like friends." Another person said, "I don't know what I would do without them helping me. They never rush me, they are so patient. It means I can stay in my own home." A relative told us, "They are all very caring staff, very professional."

People's respect, dignity and independence were promoted by staff. One person said, "The staff are very polite, they always stand outside of the shower to help maintain some dignity. I know they are there if I need them." Another person told us, "They all treat me with respect, they don't talk down to me, [and] if they did I would soon tell them. It all works well, we work together." A relative said, "Respect is the word. They [staff] all treat [family member] with the upmost respect. Sometimes they have time to sit and chat. We all have a good relationship."

Records showed that people wanted to maintain their independence and continue to live in their own home, with support from staff. These wishes and any other aspirations a person had were then taken into account and considered when planning those aspects of their care. Guidance was then given to staff to help them understand how to support people to meet these needs.

We saw that people and their relatives continue to be involved in the setting up and agreeing the decisions about their/their family members care. Care records we also showed that staff reviewed and updated care and support plans when needed. One person said, "I do have a care plan that I signed, it has changed a bit over the years but tells the staff all they need to know. Not all staff look at it before they start, it depends on how often they have seen me. They [staff] always write in it before they go." A relative told us, "We have live in carers and they work very much to the care plan." Another relative said, "The care plan was reviewed about two or three months ago." Reviews of people's care and support needs helped make sure that people were provided with care and support by staff based upon their most up-to-date care needs.

Advocacy information was available for people if they needed to be supported with this type of service. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Good

# Is the service responsive?

## Our findings

People who used the service and their relatives confirmed to us that they knew how to make/raise a compliment or complaint should they need to do so. Staff were also aware of the procedures to follow if anyone raised a concern with them. Although, people and their relatives told us that they had a mixed opinion about how concerns raised by telephone/verbally were handled by office staff. A relative told us, "I have only had an occasion when I have had to raise an issue. It was very well dealt with. I would absolutely recommend [the service]." However, another relative said, "It seems to be communication that is the biggest issue. It's like one half doesn't know what the other half is doing." The registered manager confirmed they had identified this as an area for improvement. Actions taken by the registered manager to improve how complaints were handled included further staff training, additional processes and more robust monitoring and accountability.

The types of complaints raised by people and their relatives in the last four months included care call times and missed/late care calls. Actions to some of these complaints included, but were not limited to, additional training for a staff member involved, a meeting set up with the person and their family and the reassessment/review of a person's care needs. These actions were in response to the complaint and to reduce the risk of recurrence. A relative said, "I have to say I think the new [registered] manager is really trying to sort things out. [Registered manager] came out to see me and we discussed the issues. The [registered] manager asked me to bear with them. I don't think [registered manager] could've been any fairer with me."

People's health and welfare continued to be met by staff who remained responsive to their needs. People's support and care needs were assessed, planned and evaluated to agree their individual plan of care and support. These records prompted staff on what a person was able to do for themselves and where a person needed some assistance. Staff demonstrated to us a good understanding of each individual persons care, support needs and backgrounds. Care plans contained information about people's lives [life history] before they used the service, so that staff could understand the people they assisted with their personalised care needs.

Good

# Is the service well-led?

## Our findings

There was a registered manager in post during this inspection. They were assisted in the day-to-day running of the service by a team of care co-ordinators and office staff. People and their relatives had mixed opinions on whether they would recommend the service. One person said, "Overall I am very happy and would recommend Hales Group to others." Another person told us, "I can't think of anything they could do better. I would certainly recommend [them]." However a relative said that they would not recommend Hales Group Limited.

During this inspection we saw that the registered manager, who was new to the service, had identified and was working on areas of improvement required. These improvements had been noted by the majority of people spoken with. People and relatives of people using the service told us that they could telephone the office and speak to staff if they had any questions or comments. A relative said, "One morning the carer didn't turn up and I rang the office and got the [registered] manager. She came out and carried out the care herself and gave me her number. She was very supportive. Another relative told us, "I am aware there is a new manager. [Registered manager] came to see me and I feel more positive than I have in the past that things will improve." Although one relative said, "I am not sure the new [registered] manager has made a difference yet."

Staff spoke of a positive culture that existed within the service and that they were free to raise concerns, make suggestions and drive improvement. They told us that the registered manager was supportive to them and were approachable. This meant that staff could speak to them if they wished to do so. One staff member said, "[Registered manager] is approachable, open and you can contact her at any time." Another staff member told us, "The [registered] manager always deals with issues." Then they went on to tell us how the registered manager had supported them. This showed us that staff were made to feel supported.

The registered manager told us how they had introduced a 'carer of the month' award scheme. This scheme was to boost staff morale and award staff for good practice. This award resulted in a formal certificate and praise for the individual staff member involved. This demonstrated to us that the registered manager was putting processes in place to make sure staff felt valued.

People and their relatives were given the opportunity to feedback on the quality of the service provided. This was gathered either by a telephone call or a survey to complete. One relative said, "We get regular questionnaires, about every two to three months I think." Although another relative told us, "They [staff] rang…asking questions but it was a series or yes/no answers and took very little time. So I am not sure what benefit it was to them." Information from the feedback was used to improve the quality of service where possible. The feedback showed positive comments about the quality of the service provided. One person had said, "Very happy with the carer and care I'm receiving." However areas for improvement, such as, "[Care call] timings are bad," were also noted and were being worked upon.

The registered manager notified the CQC, in a timely manner, of incidents that occurred within the service that they were legally obliged to inform us about such as incidents of harm.

We found that the provider was not using the correct template to display their previous inspection report rating conspicuously within the service for visitors to view. This was corrected and evidence submitted to the CQC, during this inspection.

Staff demonstrated to us their knowledge and understanding of the whistle-blowing procedure. They knew the lines of management to follow if they had any concerns to raise and were confident to do so. This demonstrated to us that staff understood their roles and responsibilities to the people who lived at the service.

The registered manager showed us records of their on-going quality monitoring process. Audits were carried out and these included audits for people's prescribed medicines; missed or late care calls analysis; and people's daily notes. Any improvements required were recorded in an action plan. Improvements included, "staff informing you of a change to your visit [care call] times.