Hartwig Care Limited

Hartwig Care Ltd - 5 Ella Mews

Inspection report

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 18, 19, 20 September 2017 and was announced.

Hartwig Care Limited is a domiciliary care agency that provides personal care to people in their own homes. The people who used the service had a variety of care needs and included elderly and frail people, as well as those with learning disabilities. At the time of the inspection, the agency provided care to almost 600 people across four London boroughs.

At the time of our visit the agency had two registered managers who were each responsible for different geographical areas of the service delivery. 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 and associated Regulations about how the service is run. Both registered managers were supported by the operations manager, a team of care managers, field supervisors, care planners, care coordinators and monitors and care staff who were all responsible for ensuring care was provided as planned. The agency had also had a dedicated finance, recruitment and training team.

During our inspection, we found positive aspects to the care provided by Hartwig Care Limited. However, we also identified some areas that required improvement. The agency had not always fully assessed and managed all of the risks to care and treatment of people who used the service. We also found issues relating to clear recording of medicines that were prescribed to people and clarity of who was responsible for medicines management for respective individuals.

There were staffing issues identified in relation to time keeping and continuity of care during the weekends and finding emergency staff cover in some geographical areas and the agency was working towards addressing these issues.

Where people lacked capacity to make decisions, staff had not always had full information on what decisions people could have made and how to support them to do so. It was not always clearly documented if family members who consented to care and treatment on behalf of their relatives had been officially authorised to act on their behalf.

The majority of people received appropriate care in relation to their dietary and nutritional needs, however, where needs relating to food were more complex the support had not always been documented clearly.

People's care plans were person centred. They indicated people's strengths and abilities with regard to their level of dependency, along with the actions and support required by the care worker. However, in some cases care plans had limited information on how to provide care to people with specific health care needs or where risks had been identified relating to specific medical conditions.

The quality monitoring systems, such as care file and medicines audits, related to individual care files. There were no overall managerial auditing systems and procedures. Consequently, the agency did not have effective tools to monitor and assess the quality of the care and support provided to identify any patterns for gaps in performance and to take appropriate action to address these gaps.

There were a number of positive aspects about this provider. People spoke positively about the staff who supported them and the service they provided. Staff were well trained and they knew their professional duties and responsibilities. The management team was responsive in addressing identified issues related to keeping people happy with the service they received. External health and care professionals commented positively about the agency and they had not raised any serious concerns with the Commission about the quality of the service provided to people who used it.

The agency helped to protect people from harm and abuse and any safeguarding concerns were promptly dealt with by the management team and appropriate external bodies were notified as required by regulations. Thorough recruitment checks carried out by the agency ensured only appropriate staff were supporting people.

Staff ensured people had access to appropriate external health care support if needed and external health professionals confirmed staff took appropriate action when the person required additional support.

People were usually allocated the same care staff ensuring continuity of care was maintained and people were able to form friendly, long-term professional and caring relationships with care staff. Staff treated people with care and compassion and people spoke positively about staff who supported them. Staff sought people's consent before providing any care intervention and people felt their dignity and privacy was respected at all time.

People were involved in the planning and reviewing of their care and the agency frequently asked people and their family members if they were satisfied with the support provided. Any complaints had been regularly reviewed, analysed and actions had been taken to improve the service provided.

People using the service, their family members and external health and social care professionals had all given us positive feedback about the agency and how it was managed.

Staff understood their professional duties and responsibilities, they felt supported and they thought there was a good communication between staff and all levels of the management team who worked with them and supported them to provide good quality care.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and we made one recommendation related to following the principles of the Mental Capacity Act (MCA) 2005.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. The service did not have clear procedures on all elements of medicines management and it was not always clear who was responsible for the administering of medicines.

The agency had had assessed and managed risk to health and wellbeing of people, however, the amount of detail in risk management plans was not always consistent across people's care files.

The agency helped to protect people from harm and abuse and people said they usually felt safe with staff that supported them.

The agency was working towards addressing emergency staff covers in some geographical areas to ensure all care calls took place as agreed.

The agency had an appropriate recruitment procedure in place, which they followed.

Is the service effective?

Good

The service was effective.

The agency was working within the principles of the Mental Capacity Act 2015 (MCA). Improvements were recommended in relation to recording matters related to the Act.

Staff supported people to maintain healthy and nutritious diet, however where needs were more complex the support had not always been well documented.

Staff received regular training and supervision and they were sufficiently skilled to meet needs of people who used the service effectively.

We saw from records that people had access to relevant health professionals if required.

Is the service caring?

Good

The service was caring. People said the care workers treated them with compassion and respect.

The agency matched staff and people who used the service with respect to their individual preferences and people said they were usually supported by the same care staff

People said they felt listened to and were encouraged to make decisions about their own care.

Care workers respected people's privacy and dignity when delivering personal care.

Is the service responsive?

Good

The service was responsive.

Care plans were person-centred and reflective of people's assessed care needs and individual preferences, however they would benefit from more details on how to provide specific care for people with particular health care needs, or where risks were identified from specific medical conditions.

Staff knew about people's care needs well and the agency had informed respective staff about any changes to people needs.

People who used the service and their relatives felt involved in the care planning and reviewing of their care.

The agency had a complaints procedure and dealt with complaints in a professional and timely manner.

Is the service well-led?

Requires Improvement

The service was not always well led. The agency's quality monitoring systems in place were not always effective in highlighting and addressing issues

Staff and people using the service felt the agency was well led and they felt confident the management team would support them and address any issues and concerns raised if required.

There was clear line of responsibility and accountability within the service and staff and the management knew their responsibilities well.

The agency received very positive feedback from external health and care professionals.

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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 checked 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, 19 and 20 September 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to make sure someone was available.

This inspection was carried out by three adult social care inspectors, one pharmacy specialist advisor and six Experts by Experience. An Expert by Experience (ExE) is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we gathered information from 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.

During our visit, we spoke with the members of the management team including the operations manager, two registered managers, the head of care managers, the recruitment manager, one care manager, one field supervisor, the provider's complex care director, and one care planner. We also spoke with 15 care workers.

Prior to our visit our ExE's carried out phone interviews with 46 people who used the service, and 12 relatives who gave us their feedback on the service provided by the agency.

We looked at records these included 50 people's care records, recruitment, training and supervision records for 20 staff members, and other documents relating to the management of the service.

Following the inspection, we contacted further nine external health and social care professionals who gave us feedback on their partnership relationship with the agency.

Requires Improvement

Is the service safe?

Our findings

People told us they were happy with how staff supported them with their medicines. However, during our inspection we noted a number of issues and concerns relating to medicines management. The agency used three types of documents to record information on people's medicines. These included the person's care plan, Medicines Administration Forms (MAFs), which were stored in the agency's office and used to list the most current medicines prescribed to each person and Medicines Administration Records (MARs), which were kept in people's homes. The MARs were used to inform staff what medicines the person should be receiving and to record medicines administration. We looked at these documents for 10 individuals and we saw that there were discrepancies in information recorded in all 10 cases. For example, one person's MAR chart indicated that the person had been prescribed antibiotics between 13 and 19 July 2017, but the centrally held MAF form had not been updated since May 2017.

In another example, a person's MAF form had been updated on 31 July 2017, a day after the new medicine had been started. However, the information was transferred incorrectly. The person's daily records indicated that the medicine was administered twice a day. However, the MAF stated it should be administered three times a day. It was not clear which information was accurate and we could not evidence if the medicine was administered as prescribed. Another person had their anti-convulsive medicine recorded twice on their MAF. This could lead to medicine administration errors, as there was a risk that if staff transferring information to the respective MARs had not recognised the mistake they could incorrectly instruct care staff to administer the medicine twice.

In another example a person had a care plan completed in June 2017. There were several MAR charts and daily audit forms for this person in place which documented no concerns or actions to be taken. The medicines audit dated 17 to 20 August 2017 documented "no action" to be taken. However, the person had been prescribed a painkiller and this had not been updated on the centrally held MAF record.

We were told by one of the registered managers that the agency did not have formal procedures and policies on transferring information about people's medicines across respective documents. This meant that senior staff, responsible for transferring this information, had not had appropriate guidelines on how to do this, thereby resulting in errors found during our inspection.

From people's records, it was not always clear if a person self-medicated or if administration was shared between the agency's staff and a person's family. Therefore, there was a risk that a person would not receive their medicines as prescribed. For example, a person's MAF form completed on 17 August 2017 stated staff were to assist the person with medicines. The person's care plan, dated the same day, stated staff were to administer medicines. The same care plan stated in a different section that the person was "self-medicating". In another example, a person's recent care plan said they were self- medicating and their family was responsible for collecting medicines from a pharmacy. The same person's most recent MAF form said that it was staff who were responsible for the collection and administration of medicines to this person. Another person's care plan stated staff were to prompt the person to take medicines from the blister pack. The person's MARs indicated they administered the medicine. This included administration of warfarin. We

did not see a record of correct prescribed dosage for this medicine, therefore, we could not cross-check with the MAR if the right dose of the medicine had been administered by care staff.

The above is evidence of a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service, their relatives and external health and social care professionals told us the agency provided very good support to all people using the service, even those with the most complex needs. We saw that the level of detail in risk assessment documents had varied and was not always consistent across the files depending on the complexity of people's needs and identified risks. We saw a number of risk assessments that were comprehensive and had a good amount of detail on how to minimise the identified risks. However, we also saw other care files where risk assessments would benefit from more information for staff on how to manage or monitor the identified risks. For example, some care files consisted of a comprehensive risk assessment related to supporting people during outdoor activities and visits in the community, risk of pressure ulcers and risks of pain including respective body maps and risks related to using specialist equipment. Other care files identifying the same risks for people however, they had less detail on how to support people and respective body maps had not always been maintained.

We spoke with the agency's management team about the inconsistencies in the quality of the risk management plans we had identified. They assured us this matter would be addresses to guarantee the same good quality of risk management for all of the people who used the service.

Each person had an environmental risk assessment in place and hazards had been well documented. The risk assessments were comprehensive with detailed information on access arrangements in relation to all areas of the people's property.

The majority of people using the service told us that they felt safe with staff who supported them. Their comments included, "Yes I do feel safe. I had a stroke a number of years ago and I have to walk with a stick and [staff name] holds my arm as we go to the bathroom – it gives me confidence", "I do feel safe with them even when the other ones come, they are alright, well I stand no nonsense anyway". One person using the service and one relative told us about a situation when they had not felt fully safe with the staff supporting them. However, they both told us that the agency had listened to their concerns and addressed them immediately and to their satisfaction.

The agency had policies and procedures in place helping to protect people from harm and abuse. We looked at the agency's central safeguarding register and we saw that all safeguarding concerns were dealt with promptly and appropriately. The relevant external organisations, such as, respective safeguarding bodies and CQC, were informed about any concerns as required by the Regulations. During our inspection we had identified a potential safeguarding concern where a person was provided with a regulated activity. We had identified that no formal care package was in place for them. Following our detailed discussion with the management team about this we were confident that the person was not harmed. We were also provided with evidence that the matter was dealt with immediately and a formalised and safe care package was set up for the person.

The majority of care staff we spoke with told us they had had completed safeguarding training and they understood their role in protecting people from possible abuse and avoidable harm. Two staff members had limited understanding of how safeguarding was related to the provision of care and support provided to people.

People said staff who supported them were usually on time and they attended all calls as agreed. However, they told us about issues around time keeping during weekends and when their regular care staff were absent. Two people reported that they had recently experienced a missed care visit. All of the people we spoke with said the agency had always informed them if staff were running late. Evidence showed that the agency had appropriate processes in place to ensure suitable staff levels were deployed to carry out care visits as scheduled. The agency's office was open from 7:00 – 22:00, from Monday to Friday the whole year around and had an on call system starting at 22.22. This was to ensure that the office staff were available for any enquiries and emergencies at all times. The agency had also carried out a range of checks to ensure all calls were covered. Evidence showed that these checks included information on care staff who reported a sudden absence from work, unallocated visits and cancelled visits due to people not being able to receive them. The operations manager was aware of challenges in some geographical areas where it was more difficult to find emergency staff cover, which could have affected the care provided. They told us they were working towards increasing staffing by recruiting more care staff in order to ensure all care visits took place as agreed.

The agency had a dedicated recruitment team who ensured safe recruitment procedure and necessary pre-employment checks had been completed before new employees started work. A value based interviewing process, focused on understanding an applicant's values, carried out by the recruitment team, helped with ensuring that only the most appropriate candidates were recruited to work with people who used the service.

Good

Is the service effective?

Our findings

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's mental capacity and ability to make decisions was discussed during their initial assessments and additional information was gathered from the referral form sent by the relevant local authority. If a person had not been previously assessed and there was a concern that they might have lacked capacity, appropriate referrals for assessment had been made. The information on people's mental capacity was recorded in their care files. We were told that if a person lacked capacity to make decisions the agency would complete a decision making form guiding staff on what specific decision a person could make and how staff should support them in this process However, we saw that not all people who lacked capacity had the decision making form completed. This suggested that care staff might not have full information on how to support these individuals in decision making effectively.

Evidence showed that where people lacked capacity to consent to their care and treatment the consent forms and care plans were signed on behalf of people by their family members. However, we noted that there were not always clear records stating if those family members who were making decisions on their behalf had a Lasting Power of Attorney in health and care matters (LPA) giving them the legal right to do so. Therefore there was a risk that the care and support would be provided with the permission of a person not authorised to do so.

We recommend that the agency seek further advice and guidance from a reputable source in relation to the Mental Capacity Act 2005.

There was evidence that the agency sought consent to care and support from people who had capacity to do so. We saw examples of signed consent documents showing people had agreed to the support provided by the agency. Additionally, people's care plans had guidance for staff reminding them to always seek people's consent before providing any care intervention.

The majority of staff we spoke with told us they had received the MCA training and they were able to explain the principles of the act and how it informed their work with people they supported. Their comments included, "Every person is able to make decisions for themselves. If they are not able and somebody makes decisions on their behalf they need to have a court permission to do so" and "Even people with no capacity can make decisions about what they want to eat or wear and we support them to make better choices."

People told us staff supported them in maintaining good health and had access to appropriate external health care support if needed. Their comments included, "I was very ill once and they decided that I needed an ambulance" and "Hospital appointments, they help me with that they sort transport out." External health

professionals told us that staff took appropriate action when they thought the person needed additional support and they were keen to share any information to inform people's care. One professional told us, "I have been very impressed with the care supervisor. Always updating me/checking on the person when I have explained concerns, very responsive, very personable but professional." A second professional said, "There seems a very good system of carers reporting back to the office regarding changes in clients function and well-being and the office staff have disseminated this information to the multi-professional team involved." Positive comments from people and professionals indicated that good care was provided. However, we observed that in some care plans where needs were more complex the support had not been always well documented. For example, when people were at risk of weight loss or had a poor appetite, there was no clear plan to monitor progress. Most commonly the actions required by care staff were noted as 'Care worker to monitor and report any concerns to Care Manager' or 'Encourage to eat regular meals' without any further detail on how to monitor. We did not see regular weight monitoring or MUST scores, a screening tool to identify adults, who are at risk of malnutrition. Although the members of the management team told us this had been done if possible, no records were seen. Subsequently we could not assess if people's care was monitored effectively and if the agency had responded to changes in their health appropriately. We spoke about the above issues with the management team at the agency and they assured us that this matter would be looked into and addressed immediately

People told us they were supported by staff to maintain a healthy and balanced diet. Some people required staff support at mealtimes, such as warming up already prepared food of their choice or assistance with cooking or meal preparation. Their comments included, "I've got to be careful what I eat and my carers are very good at removing things that I can't have because of my stoma, nothing with a skin and just little meals" and "I like to do my own food. Usually I go out but some carers are very good at cooking. They offered to cook for me. They will cook when I asked them."

With the exception of records relating to weight loss, we saw good examples of records related to people's dietary needs and preferences. For example, one person's care plan said the person liked "finger food and protein shakes in the day and a meal for dinner". Another person's care file stated they "did not like Brussel sprouts".

People and their relatives told us that care staff were sufficiently skilled to meet their needs. Comments received included, "They know their job. I feel glad and lucky to have the help", "The carer knows everything", and Hartwig are absolutely invaluable, I couldn't have [relative] at home otherwise." A family member told us "They are well trained. The agency worked hard to train the carers for us. The agency gives them long induction."

All new employees received four-day induction training to ensure they were familiar with the services policies and procedures and how to support people effectively. New staff were also asked to complete the Care Certificate, a set of standards that social care and health staff followed when carrying out their professional duties. New staff also undertook two or more days of shadowing of their more experienced colleagues and completed a training workbook consolidating their knowledge. We noted that new staff competencies were checked by observations and discussions in one to one meetings and spot checks by the respective field supervisors. The agency had also employed two care worker liaison officers and a mentor whose role was to offer additional support to new staff in the first four weeks of their employment. They were able to identify any gaps in staff knowledge and offer additional training if needed. We saw evidence of completed induction workbook, shadowing forms and four weekly review meetings. This confirmed that staff competencies were checked before they started working with people unsupervised.

Other staff received annual refresher training, which included safeguarding, moving and handling, safe

handling of medicines, the MCA 2005 and dementia awareness. Some staff told us they were also in the process of completing their diplomas in Health and Social Care. All of the staff we spoke with told us, and the records confirmed, that they completed annual refresher training and they had access to additional specialist training if required. The agency had a system in place to ensure all of the staff had completed their mandatory training. They were also in the process of purchasing a new online training platform to allow quick track of staff learning and access to a variety of professional courses and training.

Staff we spoke with told us they felt supported by their managers. Their comments included, "They are very good if I want clarification I can ask informally for a meeting with my manager" and "[They support me] so much, always there asking me if I'm ok." Evidence showed that staff received regular supervision from their managers. The agency was also in the process of introducing annual staff appraisals. Staff told us that they took part in appraisal of their work and we saw examples confirming that such meetings were taking place.

Good

Is the service caring?

Our findings

People told us that Hartwig Care staff treated them with care and compassion and they spoke about staff in a complimentary way. Some of their comments included, "All the carers I've had have been very good in the main", "I can't fault them. I've only got to say anything and they do it for me. I feel very comfortable with them" and "Very kind and caring and very considerate."

Relatives told us, "I can only say how really happy I am with the care team we now have. The carers we have are just brilliant, so good with [relative]" and "They are wonderful, especially the live-in carers. Show enormous affection for my [relative]." We were told about four care staff whose caring approach had been recognised by people that supported them. We saw evidence that four care staff members had been nominated by people using the service for a Care Worker of the year award 2017 awarded by one of the local authorities that commissioned services from this provider.

People were usually supported by the same care staff. This ensured there was continuity of care and people were able to form friendly and long-term relationships with staff who visited them. People told us, "I have regular carers most times; two different ones per day. The regular ones are part of the family and we have every day, normal conversation", "It's always nicer to have regular carers, they're used to me and I'm used to them" and "They have become like my friends. We laugh and joke together - it's fun." A relative told us, "My [relative] is very challenging to care for and they have to keep the same team of carers to be able to manage [relative] safely." While matching people the agency had taken into consideration certain attributes including people care needs, geographical areas of residence and personal preferences of both people and care staff.

Matching information, such as preference of a female/male worker or any religious matters, was stored on the agency's central database. It was used by the scheduling team to ensure that the most appropriate staff were allocated to support people. People confirmed that they were happy with how the agency allocated staff to them. They said, "I have emphasized who I wanted to come as in the type of person and they've matched them for me", "I prefer female carers and I always get them" and "Yes I did state a preference for female staff."

People said they felt listened to and encouraged to make decisions about their own care. They said, "If I ring the office I feel listened to I can talk to them if I have an emergency", "Yes I do have choices about my needs for the day" and "Yeah, [staff are] definitely very good listeners." A relative told us, "They [staff] are very good at persuading and encouraging [my relative]". A staff member told us, "If they [people] can do things, I want them to do. I want them to feel they can do it and be empowered". This meant that staff took actions to ensure people felt they mattered and that they were respected at all times.

People's care plans highlighted their personal preferences with relation to their personal care and directed staff on how to ensure that people's dignity and privacy was respected when supporting them. For example, one person's care plan stated that they liked their personal care to be done in the morning. All of the staff we

spoke with told us, it was important to them to ensure people were involved in their personal care and that they felt comfortable with staff who supported them. They told us, "I always ask if they want a shower, if he/she doesn't mind, asking all the time" and "I do help the person to wash but only the parts they cannot manage. I close the curtains and make sure the door is shut." People confirmed that staff treated them with dignity and respect when providing personal care and they felt comfortable during the process. Their comments included, "[Care worker] is very patient and very supportive and she's really helped me to get my confidence in the shower", "They help me to wash the hard to access areas and they're very respectful indeed and always chatty" and "I have a walk in shower they keep me covered I'm comfortable with them."

Good

Is the service responsive?

Our findings

People's care needs and preferences were recorded in their personal care plans and people told us they were involved in planning of their care. Their comments included, "Myself and my [relative] worked out my care plan", "Yes, I got the care plan. I signed it and they explained everything to me" and "I have a care plan, I helped to write it and I participate every time they come to re-do it, they do the reassessment and the risk plan and everything and write it all down."

Care plans were person centred, easy to follow with a range of directives for staff to cover different aspects of care. They indicated people's strengths and abilities with regard to their level of dependency, along with the actions and support required by the care worker. Feedback from people, their relatives and external health professionals indicated that staff were skilled and provided appropriate care even for people with more complex needs. However, we noted that in some cases care plans would benefit from more details on how to provide specific care, for example, where there were particular health needs, or where risks were identified from medical conditions. In one case, for a person with epilepsy, although it was noted that this was controlled by medicines there was no direction or advice on how to manage or respond to a seizure if necessary. In another example, a person had a tracheostomy and although there was a note that a community nurse had provided training on how to manage this, the record dated from 2015 and only related to one staff member. Similarly there were not always guidelines available in other people's care plans, or reference on how to access advice, on the management/cleaning of catheters, stoma bags, nebulisers, suction caps or other specialist equipment where required. We spoke about this identified gaps in recording with the agency's management team on the day of our inspection. They assured us that staff had appropriate guidelines provided and the records would be updated to reflect this. Because of the positive feedback from people who use the service and external health professionals about staff providing good and safe care to people, including those with more complex needs, we were assured that the provider could address these matters effectively .

People's care plans had information on people's preferences, routines, social activity and any cultural or religious needs. The majority of people we spoke with told us that they were self-sufficient and did not need much of staff support to follow their interests. However, when it was required staff were happy to help. Some people's comments included, "Once, the Day Centre cancelled transport for my relative which meant that [relative] would be on his own all day and without any care. Hartwig, within one hour, organised a care visit, they really pulled out all the stops. They were amazing, couldn't fault them" and "If I want to go to the shops I'll pre-warn them so they can get the time aside". One person told us that the agency had sent a care staff at the incorrected time on Sunday and the visit interfered with their usual visit to Church making it difficult for the person to attend the Mass.

Staff knew about people's care needs as they regularly supported the same persons, they read their care plans and they were in continuous communication with the agency who informed them in case people's needs had changed. They told us, "I read every time I visit a client. It's even more important if you are going to a client for the 1st time" and "I always read and if I don't understand something I ring the office." The agency had a detailed scheduling system in place to ensure care staff were always up to date with anything

related to supporting people. We saw samples of rotas sent to respective staff members with a variety of instructions and details that they needed to have before care visits. This indicated that staff had always had up to date information on people and were able to provide care that was in line with people's most current needs.

The agency involved people in reviewing of their care and frequently asked them if they were happy with the support provided. People told us, "Hartwig have visited already to check how things are going", "I have an assessment every six months. They do a questionnaire when they come to talk through it. If I've had concerns they sorted it out it was good" and "I had a review a few months ago they are once or twice a year. I've done a couple of questionnaires. I have the number of head office if I need to call them." We saw records or regular quality monitoring contacts with people in their care files. The operations manager had also informed us that the agency had recently conducted a yearly satisfaction survey and they were in the process of analysing its outcomes and formulating an action plan to implement improvements that had been identified as a result.

The agency's complaints procedure in the person's home folder gave information on how people could complain about the service. People told us that they were aware how to raise any concerns with the agency and they told us any complaints had been dealt with immediately and to their satisfaction. We looked at the agency's central complaints register. We saw that the management team had dealt with all received complaints promptly. All complaints had been regularly reviewed, analysed and actions had been taken to improve the service provided.

Requires Improvement

Is the service well-led?

Our findings

The agency had care plan audits in place. However, they were designed to check if care plan reviews and quality spot checks had taken place and their frequency. They did not check the context of these documents and whether identified issues and changes had been actioned upon. These audits were carried our regularly and therefore all care plans and spot checks had taken place regularly and as required. The agency had also recently introduced a new qualitative care file audits to monitor the context of care records. However, we saw that only small number of the files were audited, and the audits were not effective in identifying issues highlighted by us during the inspection. For example, medicine audits for one person for the month of July and August 2017 had not identified that MAR charts for this person did not have recorded medicines details, known allergies and other information requested by the form. Another person's MARs audit stated "no action" to be taken, even though the person had been prescribed new medicine and this should have been recorded on their centrally kept medicines record.

In another example, an audit related to daily care records stated that there were no concerns identified about care provided to that person and no action was needed. However, we saw that these daily records consisted of details of care provided to two different persons and as such should be recorded separately.

We saw that people's files had relevant information about people. However, we observed some inconsistencies regarding what was filed in various file sections. Therefore, it was not always possible to locate relevant information easily. For example, decision making capacity assessments were filed at the back of the file in one case and in the medication section in another. Existing care file audits had not identified this issue.

The audits we saw related to individual care files and there were no overall managerial auditing systems and procedures. This meant the agency's senior management did not have effective tools to monitor and assess the quality of the care and support provided, to identify any patterns for gaps in performance and to take appropriate action to address these gaps.

The positive feedback we received from people, their families and external professionals suggested that the agency had provided good and suitable care to people, however our findings showed that this has not always been appropriately documented and the agency's auditing system had not recognised it.

We spoke about this matter with the management team during our inspection. They told us they had been aware of issues around effective auditing and monitoring and they were in the process of introducing another level of managerial checks to ensure that required audits had taken place and that they were effective in recognising and addressing issues.

Hartwig Care had two registered manager who were supported by the operation manager and the team of the administration staff, middle management team and front line care workers. Everyone we spoke with gave us positive feedback about the management and how the service was managed. The management team had a long time experience in the health and social care field. They had also had previous experience

of direct provision of care for people who used the service. We observed they had a good understanding of issues and challenges that care staff could experience during care visits.

The majority of people using the service and their relatives told us they knew the management and they felt confident that if they raised any concerns these would be dealt with promptly. They said, "In my opinion, they are an excellent agency and I would recommend them to anybody", "It's a lovely service. Quite often, they check how things are going and to see if I need anything changing", "The manager is always very good, always available and very understanding of our wishes" and "They're quite good as a company. They're a fairly responsible company and their work ethic and ethos is good". Relatives told us, "We always work as a team, they are fabulous."

Staff felt the agency was well led and they were happy to work there. They told us that there was good communication between staff and all levels of the management team who worked with them and supported them to provide quality care. Some of their comments included, "I'm very happy. They are good managers and if I have any difficulty my manager helps me" and "I keep coming back to work for this agency because they are well organised, the hours are ok and they are flexible. Staff felt that roles within organization were clearly defined and everyone knew what their responsibilities were. Consequently, if staff had any difficulties they knew how to approach to receive support. A staff member told us, "Everyone knows what their tasks are and they follow it, the roles are clear and people don't get into each other's way. This makes it easier for us care staff."

Staff we talked with demonstrated good understanding of their roles and professional duties. We found the service had clear lines of responsibility and accountability with a structured management team in place.

External health and care professionals spoke positively about the staff and the management team at Hartwig Care. We were told that the agency had sufficient skills to work with people, and they were always happy to communicate with respective professionals regarding care and support for people who used the service. Their comments included: "[staff name] is excellent at communicating with customers and their families and responds promptly to emails and phone calls. I do not hear complaints from customers about Hartwig staff"; "I have no concerns about the leadership or management. Hartwig Care Ltd has been cited as a good example in our bi-monthly homecare provider forum in the performance of their electronic monitoring systems" and "We are very impressed with Hartwig, They are excellent."

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 registered person did not ensure care was provided in a safe way for service users because: They did not ensure the proper and safe management of medicines. Regulation 12 (2) (g)