Hales Group Limited

Hales Group Limited - Lowestoft

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 5 and 6 September 2018, and was announced.

At our last inspection in 13 and 20 December 2017 and 4, 11, and 15 January 2018, we found breaches of legal requirements in relation to safe care and treatment, staffing and governance of the service. We met with the provider to confirm what they would do and by when to improve the key questions to at least good. They sent us an action plan detailing how systems and processes would be improved to enhance the delivery of care.

At this inspection in September 2018, we found that although new systems and processes had been implemented, sufficient improvement had not been made, and people continued to receive care which was not responsive and did not always meet their assessed needs. We found three repeated breaches of regulations in relation to safe care and treatment, staffing, and governance. We also found two new breaches in relation to safeguarding and notification of events.

Hales Group Limited - Lowestoft is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community [and specialist housing]. It provides a service to older adults, people living with dementia, mental health conditions, and physical and sensory impairments. At the time of this inspection, the service was supporting 69 people. Not everyone using Hales Group Limited – Lowestoft receives the regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

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.

Since our last inspection, the service had made changes to the Lowestoft branch and how they delivered care geographically. The Lowestoft branch now delivers care only to people living in the Waveney area. This means they now support a reduced number of people (69 at the time of this inspection). At our previous inspection on 13 and 20 December 2017 and 4, 11, and 15 January 2018, they were supporting 230 people.

Despite the reduction in the number of people they supported, we found that people were still receiving late visits. Some people had cancelled their care as they couldn't wait any longer for the carer to arrive. Since our last inspection there have also been missed visits. This meant that people did not always receive the care they needed to keep them safe.

Some people required two staff to attend to their needs, but in some cases, we found that only one carer had attended. This placed people and staff at risk of harm and did not meet the person's assessed care

needs. Some relatives told us that they helped the carer to deliver the care their relative needed in the absence of the second carer.

Feedback we received from some people using the service and their relatives indicated that they did not have confidence in the service delivering the care as planned. Others felt that the care was safely delivered. People told us that carers delivering their care were kind and caring, but they did not feel that office staff and management could be relied upon.

New auditing processes had been introduced, though not all quality checks were effective, and some concerns had been missed such as the recording of medicines and length of care visits.

Safeguarding procedures were not understood or followed when one person was found to be at risk of harm. Staff had not reported obvious risks to the person, and others who may visit them in their home. The service had not understood their duty of care.

There was a complaints process in place, however people and relatives told us that they did not always feel assured that they would be listened to and action would be taken to address their concerns.

Staff provided support to people to eat and drink as stated on their care plan. This included assistance with food preparation and providing people with snacks and drinks between calls. However, one persons' care plan needed more detail about diabetes to ensure staff had clearer guidance.

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.

Care staff received supervision and training to support them to perform their role. Recruitment procedures ensured staff were safely employed and did not pose a known risk to people who used the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People continued to experience missed and late visits. People's assessed needs were not always met due to errors in communication and scheduling of visits.

The service had not recognised when a person was at risk, and had not taken action to safeguard them.

Staffing levels were not sufficient to support the care delivered. Staff sickness contributed to poor care delivery.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People did not always receive the full length of time on their allocated visits, in line with their assessed needs and best practice.

The service was working in line with the Mental Capacity Act. There were systems in place to assess people's mental capacity.

People's care records contained information on any nutritional support. Some areas required further clarification to ensure guidance was clear for staff.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's feedback indicated that they did not always benefit from a caring culture.

Carers were reported to be kind and caring.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There was a complaints procedure in place, however, people

were not always confident that these were acted on and that things improved as a result.

Staff developed care plans with people to meet their needs. The service was rolling out a review of care plans as it introduced a new format document. Care plans included the level of support people needed and what they could manage to do independently.

Is the service well-led?

Inadequate

The service was not well-led.

Feedback from people and their relatives indicated that they did not feel confident that the service would deliver the care they needed at the right time.

Not all notifiable incidents had been reported to the Care Quality Commission as required by law.

Auditing processes had not identified all issues in relation to people's care.

People, relatives, and social care professionals told us that the management team at times were slow to respond to concerns raised, and communication required improvement.

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 5 and 6 September 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be available. The inspection team consisted of 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.

As part of our inspection planning we reviewed all the information we held about the service. This included previous inspection reports and any notifications sent to us by the service including safeguarding incidents or serious injuries. This helped us determine if there were any particular areas to look at during the inspection. We spoke with the local authority team prior to, during, and following the inspection.

To help us assess how people's care needs were being met we reviewed eight people's care records and other information, including risk assessments and medicines records. We reviewed three staff recruitment files, and a selection of records which monitored the safety and quality of the service.

During the inspection we spoke with 11 people who used the service, (four of whom we visited in their home) six relatives, the registered manager and regional operations manager. We also spoke with five members of care staff.

Inadequate

Is the service safe?

Our findings

At our previous inspection in December 2017 and January 2018, we rated this key question as Inadequate. This was because people did not always receive their visits or carers were late arriving to people to support them with their assessed needs. This constituted two breaches of regulation in relation to safe care and treatment and staffing.

At this inspection we found that concerns still remained in relation to people receiving their care on time, despite the reduction in the number of people they were supporting. The rating of 'inadequate' for this key question therefore remains.

Data provided by the registered manager showed that between January and May 2018 there were 54 cancelled visits due to the lateness of carers. This was when people cancelled the visit as they could not wait any longer for the visit to take place or where family had helped out in the absence of the carer. Between June and August 2018 there were 36 cancelled visits. This meant there was still an on-going concern that people's care visits were not taking place at the allocated time. This is particularly concerning where people may rely on care staff to administer medicines at specific times or for those who require assistance with continence or meal preparation.

Following the inspection, the provider told us that 28 of the 90 cancelled visits were due to a period of very bad weather which impacted on staff being able to reach people, and some people cancelled due to this.

People had also experienced missed visits, where no carer arrived. There were six missed visits from the period January to September 2018. This was due to errors made by the care co-ordinator and carers not reading the rota correctly. Out of the six missed calls one person had four missed visits over two days and relied on the carers to administer their medication.

Between January and August 2018, there were 242 late visits (over 45 minutes late). Eight out of the 11 people we spoke with reported that they received an unreliable service. One person said, "The carers are nice but the times are dreadful. We need help to dress and to get breakfast in the morning. My [family member] only came out of hospital on Friday yet on Sunday our 9.45am call didn't happen until 1.30pm and today not until 10.45am. We just had to manage. Weekends are awful for lateness, but they do always turn up eventually and ring to let us know." A relative said, "We are looking to change company now as we need some normality and regularity. It is important and we don't have it. I don't know who the manager is and sometimes if you try to call there is no one answering the phone. They seem short staffed and lots of staff are leaving."

Following the inspection, the provider told us that 86 of the 242 late visits were due to a period of very bad weather which impacted on staff being able to reach people on time.

One person was receiving four visits daily and was assessed as requiring two staff to attend to their care needs, as they were moved using a hoist which needed two staff to be operated safely. When we checked

their daily records log book, we found that in the month of May and June 2018, only one carer had signed the log book to evidence they had attended on 11 occasions, and that on four occasions the carer had documented that they had hoisted the person. This put the person and staff member at risk of harm. The care plan stated that a hoist should be used at each care visit.

The registered manager said they were confident that the visits were covered with two carers; they told us they checked through the daily log book for the other 'double up' visits either side of this and both carers signed and attended these other calls. However, in the absence of information in the daily log book we could still not be sure that two workers had visited the person. One person commented, "Occasionally there is only one carer sent which means that my [relative] has to help. This happens perhaps once a month. My care is safe in general but less so if there is only one carer."

We also saw that that on two occasions the carer had documented that they had explained to the person that they couldn't provide personal care for them or use the hoist as the second carer hadn't arrived. This meant the assessed person's needs were not being met.

Another person was receiving care and required two staff to assist at each visit. We saw an investigation completed by the registered manager which identified that three visits in April 2018 were carried out by just one carer, who relied on the family to assist with their care. The person was receiving end of life care, and it was clear from the investigation report that the situation had caused the relatives distress.

Investigations by the registered manager showed that there had been 16 visits in total where only one carer had attended from the period January to August 2018, for five people using the service who were assessed as requiring two staff at each visit.

As part of our inspection we liaised with the local authority who we share information with. We were made aware that a relative had recently cancelled the care provided by the service. They told us that they simply could not rely on the service any longer due to several occasions when no carer turned up and there was no communication from the office.

All of the above constitutes a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager sent us a trend analysis which showed a high percentage of late calls were caused by sickness of carers. They told us that during the months of July and August 2018, there were also staff on leave which led to further staff shortages.

We looked at the staffing arrangements in the service and how this impacted on people's care delivery. One staff member told us, "Staff leave because they are constantly bombarded by the office asking for calls to be covered. There are not enough staff to cover what visits they have which is why the office staff have to come out and cover." Another said, "This weekend all visits were covered. This is very rare. Weekends are the worst."

The registered manager told us that they had recruited 12 new staff since January 2018, but six staff had since left and they were still trying to recruit more. One staff member told us, "Staff call in sick all the time and think its okay. Then people's visits are late as we [carers on duty] have to cover them. They [management] need to take a harder approach to this."

The services' contingency plan stated that office staff and care co-ordinators covered visits if staff went off

sick at short notice. On the weekend of 1 and 2 September 2018, three staff called in sick and two were already on leave. Office staff and staff already on shift covered the visits, however, eight people cancelled their visits due to the lateness of carers. This demonstrated that the providers contingency plan was ineffective.

We concluded that the current staffing arrangements had not served to address the previous concerns around staffing levels and the effect on the delivery of care.

This constitutes a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received training in safeguarding adults. Staff we spoke with understood what constituted abuse and who to report concerns to. However, we were made aware by the local authority of a situation which should have been reported to the local authority safeguarding team but hadn't been. The person was regularly receiving care visits, and was reviewed by a care co-ordinator who had visited the person's home. However, no staff members had raised concerns about the person's living conditions, which placed the person and others visiting the property, at risk of harm.

We were also made aware that a member of care staff was carrying out other tasks not within the person's assessed care needs, and which was not known by the management team. This placed the person at risk of being exploited.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the arrangements in place for managing people's medicines. We looked at medicine administration records (MAR) to see if staff had signed to say that medicines had been taken. However, we found some gaps in the recording on these. The registered manager was reviewing MAR charts each month to identify issues however, not all issues had been identified.

For example, one person was taking a strong pain killer, and we saw the interval between doses was less than four hours on 18 occasions in July 2018. This could potentially affect the person in terms of over dosing or causing them to fall if they were taking too much. We brought this to the attention of the registered manager who promptly sought advice from the GP. They confirmed that as it was only one tablet it would not cause harm. However, the management team had not identified this as a concern independently when reviewing the person's records.

We also advised that it would be beneficial to ensure MAR charts were clear about instructions for certain medicine types, such as those which need to be given in an upright position and before food. This would ensure staff were following the prescriber's instructions and there would be less risk of giving medicines incorrectly.

Temperature sensitive medicines were stored correctly in people's homes, and dates medicines were opened were noted to ensure they did not expire.

Staff received training in medicines management. They also had had their competency assessed to ensure they gave them to people safely. However, due to the issues we found with some documentation, the provider could not be assured that all staff were sufficiently competent and able to identify and raise concerns in relation to people's medicines.

People's care records included risk assessments and guidance for staff on the actions that they should take to minimise risk. These had been reviewed to ensure any needs which had changed were updated. These included risks such as those which may occur in a person's home environment, skin integrity, falls, nutrition, and moving and handling. These ensured that staff and people were aware of risks that could affect them

The service had a recruitment system in place. Appropriate checks were carried out before staff began working at the service to ensure they were suitable to work with vulnerable adults.

Staff received training in infection control, and were provided with personal protective equipment, such as gloves and aprons, which prevented the risk of cross contamination. We saw stocks were held in the main office which staff could collect when required. Care plans also made reference to infection control within people's homes.

The provider had taken some steps to demonstrate that they were taking a lessons learned approach to delivering people's care. For example, they had introduced fixed shift patterns and rotas for staff, and a RAG rating system (a 'traffic light' system, where each item is marked as red, amber or green) which identifies those people most at risk. They had also spoken to the carers and reminded them that they must not attend 'double up' calls without the other worker being present and that they must ensure that they both sign for their attendance. However, the identified breaches of regulation demonstrates that people were still not receiving a reliable service. The provider had failed to take the necessary measures to ensure people received safe care that met their needs.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in December 2017 and January 2018, we rated this key question as requires improvement. This was due to the late and missed care visits, where people did not receive care in line with their assessed needs and choices. At this inspection in September 2018, we found that this was still the case for some people and this key question continues to be rated as 'requires improvement'.

People's care needs had been assessed and included a number of different areas that included their physical and mental well-being. People's preferences and choices were noted, which included their preferred name, method of communication, some likes and dislikes and what was important to them. We had mixed views from people as to whether other preferences such as the times of their call visits were being met. Although these needs and some preferences had been assessed, the care had not always been delivered to meet all people's needs and choices. Rotas held in people's care plans stating times and length of call visits, did not always match what the office held on their system, or what was recorded in the daily log books.

One person told us, "They [carers] don't always wash me down properly. I have also noticed they don't spend the full half hour with me, usually only 20 minutes. The carer says they haven't got time, but I don't like to complain. My [relative] said they are going to though". Another said, "The girls [carers] get messed about. They have to rush in and out." A third told us, "The care is alright and we have the same familiar staff. We have a rota sometimes but not always. I have only been let down by staff not coming twice in the last three months. If it happens I do struggle a lot as I have to have food prepared to take with medication. It is important that I have care delivered on time. The care overall is safe but there are no back up staff." A relative told us, "The care is safe and they always turn up. There is occasional lateness. I have a weekly rota and we have regular carers."

We looked at the daily logs for nine people and found that they were provided with a 20 minute visit, when they were assessed as requiring 30 minutes. We brought this to the attention of registered manager and operations manager who told us that some people liked the carers to leave once the tasks had been completed. However, it would be unlikely that this many people would request a shorter visit, and in three cases people commented that the carer did not stay the full time. This indicates that staff may feel under pressure to complete tasks as quickly as possible to get to the next visit. One staff member said, "Five minutes travel time is all we get. It's not always enough time to get to the next person."

The National Institute for Health and Care Excellence (NICE) advise that services should ensure that home care visits are long enough for home care workers to complete their work without compromising the quality of their work or the dignity of the person, including scheduling sufficient travel time between visits. They also advise that services should take into account that people with cognitive impairments, communication difficulties or sensory loss may need workers to spend more time with them to give them the support they need.

The provider told us that rota's were produced using map technology to provide adequate travel time

between visits in line with the workers mode of transport. However, feedback we received from some people indicated that they sometimes felt rushed by staff.

Staff received training and support on areas to carry out their role and improvements were being implemented to ensure all staff felt competent in their role. This included observational checks and themed supervisions which focussed on subjects such as safeguarding and medicines. One staff member told us, "I get more regular supervisions now, it's getting better." The registered manager told us that care staff now received two 'field based competency' assessments (which involved observing the staff member), two office based supervisions, and one annual appraisal.

There was a staff induction procedure in place, which provided staff with an overview of working for the service and their role and responsibilities. One staff member told us, "My induction was very good. [In house trainer] covered all my training needs. I have worked in care before but I still had one week of shadowing other staff." Staff received training on areas including safeguarding adults, medicines, moving and handling, pressure area care, and health and safety. One member of staff told us, "I have now been put on my training to do my National Vocational Qualification. I've done moving and handling training too. This was with hoists and I went in it so I know what it feels like for our customers." One relative told us, "The care is thorough and complete. [Relative] has all of their needs taken care of by staff who appear to have the skills and the training."

People's care records contained information on any nutritional support needs people may have and their food preferences. People told us staff helped them to prepare meals and choose what they wanted. One person told us, "They help with my meals. I plan the meal and they prepare it. It works well. They are all very nice girls to work with and very skilled."

Records also included details on any dietary needs, such as diabetes. One person's care records stated they were diabetic, and required their blood sugars to be monitored. However, it did not say who would do this, the target that blood sugar levels should be, what action they should take if they became too high or low, or the associated symptoms of this. Further information is needed to ensure staff have clear guidance on what assistance they should be providing.

The provider worked in line with the Mental Capacity Act 2005 (MCA) in order to ensure people had consented to their care. The Act 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.

In most cases people had recorded their consent to care by signing their care plans. When people had capacity to make decisions but were physically unable to sign the provider had systems to record verbal consent to care. If there were doubts about a person's capacity to consent to their care the provider carried out assessments in line with the MCA. This included whether the person was able to retain information and use it to weigh up a decision.

People's healthcare needs were met and the service assisted people to access healthcare professionals when necessary. Care plans contained a summary of information which could be shared with other services involved in people's care, or in the case that a person was admitted to hospital. This would help staff less familiar with the person to understand their preferences in how they liked their care to be delivered.

The service had liaised with other services for further training opportunities, and were waiting for the local clinical commissioning group to arrange further training in end of life care, specifically around providing emotional support to people and families.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in December 2017 and January 2018, we rated this key question as 'requires improvement'. This was because people had not always received the care and support they needed due to late and missed visits. At this inspection in September 2018, we found that although people spoke highly of the individual carers, they did not always receive person centred care, and this key question remains as 'requires improvement'.

The service was still not consistently caring. One person said, "The carer tells me she is rushed, she darts in and out. I tell her I don't mind but what can you do, it's not their fault." A carer said, "We have one [service user] who said their rota was given to them but some entries stated 'uncovered' [no carer name listed for the visit]. They were so worried they wouldn't get a carer the next morning that they slept in their clothes." Another carer told us, "I go in to people, they are sat on the edge of the bed with their head hanging down, asking me why no one turned up for the previous visit. It's so frustrating for us [carers], but I can't tell them they don't have the staff."

People told us that despite the organisational issues, the care staff that visited them in their homes were kind and caring. One person told us, "The staff are courteous and we always have a good laugh which is exactly what I need; a good giggle. I get on with them all. They are brilliant." A relative told us, "We get on well with all the girls. They are all nice girls and most are likeable and kind. You can't get on with everyone but none of them are bad. There is never any rudeness. We all have a laugh and a joke with each other. We did have a male carer who came once and we were ok with it, although we weren't asked first. He was nice too."

People told us that staff respected their privacy, dignity and independence. One person said, "Most of the staff are nice and polite and they seem well suited to the job. They always show me respect." Care records also made reference to the importance of respecting people's dignity. One care record stated, "Respect my privacy, cover me with a towel, and close doors and curtains." Records reflected areas of care that people could attend to independently.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in December 2017 and January 2018, we rated this key question as 'requires improvement'. This was because the feedback we received from relatives indicated that the service was unreliable and verbal complaints were not always responded to. At this inspection in September 2018, feedback we received from some relatives and people indicated that further improvement was needed. We have therefore rated this key question as 'requires improvement'.

The provider had a complaints process in place. At this inspection we found that although the number of complaints had reduced, complaints continued to be received. The registered manager told us that between January and July 2018 six complaints had been received. Four of the six complaints were in relation to missed visits.

One relative told us, "I complained and nothing was done about the one carer turning up [should have been two] but as I have now refused to pay for the care that effectively I am delivering myself it seems to have improved. I call them and I don't know if messages are passed on to the manager. I don't have confidence in the office at all. It just seems to go round the mulberry bush. I have to spend my time chasing them by phone and sorting out invoices. The problem doesn't lie with the care staff, it lies with the management and finance." One person using the service told us, "My [relative] and I have called them to complain about extreme lateness for mine and my [relatives] care calls and they listen but the improvement is short lived before it goes back to normal."

Another relative told us they had made a complaint verbally but no one had responded. The registered manager told us that they were not aware of the verbal complaint having been made. However, given the feedback we received we were not assured that the processes and procedures in place were effective or that people had confidence in their concerns being addressed.

The registered manager told us that people received rotas which listed which carer was visiting and at what time. However, feedback we received from some people and their relatives indicated that rotas were either not received or contained a lack of information. One relative told us, "Our issue is the rota, we don't know who is coming or even if they are going to turn up". A person using the service said, "We haven't had a rota for a while now." We also saw a rota which had been sent to one person in September 2018. There were five days which had no carer listed and just stated 'uncovered' on the rota. The person did therefore not know who would be visiting them, and which they told us caused them concern.

The provider used telephone monitoring to obtain people's views of the service, which typically took place every six months. This included checking how people were finding the service, whether they were happy with the length of calls, and whether care workers did the things they were asked to do. Comments from May and June 2018 included, "Times aren't regular", "They [carers] don't stay the full length of time", and, "Lack of care and response from office." This did not reflect that people felt the service was responsive to their needs. However, some people reported that they were satisfied with the service. One person said, "Whilst in hospital I had the option to change providers but wanted to come back to Hales". Another said, "Without the

care I couldn't manage. Office staff help where they can."

We found that some people were not receiving their visits punctually and care staff were not always staying the required amount of time. People we spoke with told us that sometimes timings impacted on the quality of their care. One person said, "I have concerns about the office. We are never informed if staff are going to be late although the lateness has reduced over the last month or so. Still though they didn't arrive on Sunday until 10.20am for an 8.30am call. It causes a lot of inconvenience as it means I have to stay in bed until they come."

The service was still not consistently meeting people's assessed needs, and feedback we received from people indicated that they felt they were not always listened to or their views acted on. One person said, "I've mentioned the lateness [of my visits] before, it improves for a while then it gets worse again." Another said, "I did complain to them initially about lateness and staff shortage as there seems to have been no back up plan. I had concerns as no one would turn up and we had to manage ourselves. They have never taken it on board or even apologised to us."

The service had introduced new care plan templates which contained more information and guidance for carers. Not all of the plans we looked at included the new template, and one care plan we reviewed required updating and held far less detailed information. The registered manager told us they were replacing all the care plans and this was work in progress.

The new care plans we looked at contained detailed information about the support people needed on each visit. This included routines for each visit, and information such as the order in which people wanted to receive care, how people preferred to receive their care and what people could do for themselves. There was key information on people's routines, such as when people liked to have a cup of tea in bed before breakfast, information about whether people preferred baths or showers and how people preferred to be addressed. At the front of the care plans there was information on, "Key things you need to know about me." This gave an overview of the things most important to people and their care needs.

People told us they were involved in creating their care plans. One person said, "My care plan was reviewed recently and it includes and takes account of my views. Another told us, "We were involved in drawing up a care plan and we have had a review in the last few months. However, one person told us, "I was involved in agreeing my care plan but it has not been reviewed in the year and a half that I have been with them." The registered manager told us that they were in the process of reviewing people's care plans and we saw these were being completed by staff when we visited people in their own homes.

Care workers maintained logs of the care they had provided, however, in some cases we saw the recording of detail was very poor, and some were illegible. The registered manager told us they were addressing this with training and monthly auditing of daily logs, and where trends were identified or particular staff, this was being addressed.

Staff had completed end of life training. Staff completed this during their induction and as part of the Care Certificate. Hales also provided a development week for end of life care in 2017, where care workers attended set days for a training session on this subject and as a branch. At the time of this inspection no one was receiving end of life care, however, we saw there was an 'end of life care management plan' template which could be used to record people's wishes on how they wished their care to be delivered were they nearing the end of their life. The registered manager told us they were trying to source further training for staff to support them in managing the emotional side of caring for people and their families.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in December 2017 and January 2018, we rated this key question as 'requires improvement'. This was because the systems in place to make sure people received their care were not robust, and communication between the office, people using the service and carers had failed.

At this inspection in September 2018, we found that although some new systems and processes had been implemented to improve care delivery, not enough progress had been made and the current systems did not always effectively monitor or drive improvement in relation to the quality of care people received, especially given the now significantly reduced number of people using the service. Feedback we received from some people during the inspection did not indicate that they had confidence in the service. We have therefore rated this key question as 'inadequate'.

Since our last inspection in December 2017 and January 2018, the service had split the Norfolk and Suffolk contracts which meant that the Lowestoft branch now only covers the Waveney area. This has resulted in a reduced number of people using the service. Despite this reduction, people had continued to experience late calls, and in some cases, missed visits. The provider told us following the previous inspection that redefining where people's care was organised from would be part of the resolution.

The local authority had raised concerns with us about the delivery of people's care and that concerns were being raised with them about the quality of care people were receiving. Concerns continued to be raised by people using the service and professionals involved in their care. Two people had chosen to leave Hales Group Limited - Lowestoft in search of a more reliable care provider.

CQC attended a safeguarding meeting in August 2018 with the local authority and Hales management team in relation to one person who had not been identified as being at risk by care staff or senior staff when they had visited them in their home. In August 2018, in consultation with the local authority, the service agreed to a voluntary suspension, to enable outstanding concerns to be resolved. Voluntary suspension meant that the service were unable to take on any new care packages until they could assure the local authority that concerns were being addressed.

At our last inspection we found that the service was not effectively providing people with rotas to inform them of who was visiting to provide their care which caused some people distress. The registered manager told us that a new system was now in place to improve information for people using the service. However, feedback we received indicated this was still an on-going issue, and we had also seen a rota which was sent out to one person recently with five days which were listed as 'uncovered' (meaning a carer had not yet been allocated). This meant people could not be assured who to expect.

The senior management had implemented new audits in an attempt to try and improve systems, however, auditing processes had not always been effective. For example, where documentation had been audited, issues such as medicines being given at intervals of less than four hours had not been picked up. We also found nine cases where visits had been carried out as less than the assessed 30 minute visits. Although

known by the provider, this was not flagged up as a concern. This reduced amount of time could impact on the quality of care being delivered.

This is the second inspection where the issue of late and missed visits has been raised which means we have not seen evidence of adequate leadership and governance which ensures that risks are mitigated as far as possible.

The provider therefore remains in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were required to how CQC were notified about certain events that affect their service or the people who use it. The registered manager had not always notified us without delay of events which had happened in the service, such as a safeguarding incident. We only became aware of this incident via the local authority.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager was supported by a regional operations manager and one care co-ordinator who was being trained to be the deputy manager. There was also one field based supervisor whose main role was to update care plans and complete reviews, a recruitment administrator who managed applicant screening and administration, a payroll and compliance officer and two out of hours care coordinators.

In total it was reported to us that there were 32 care staff, but that four were currently off sick. Staff sickness continued to be a concern and directly impacted on care delivery. One staff member said, "If you call in sick they ask you to find cover for the visits. How can you do this when you are ill?". The management team had implemented a system which will monitor more closely staff sickness levels. The impact of this is yet to be determined, but will enable the service to identify those staff most often on sick leave and take appropriate action.

The registered manager and senior managers of the organisation made reference to a call monitoring system called 'people planner' they were planning to implement, which they considered would be a positive step in addressing many of the issues around missed, cancelled and late visits. Staff would carry a handheld electronic device which they could use once in a person's home to alert the main office that they had arrived on their visits. The registered manager told us that the new system would eradicate many of the issues and the process of implementation would commence in December 2018, although it may not be fully operational until March 2019 once all the configuration and safety checks were completed.

People we spoke with and relatives still had concerns about their care. One person told us, "The care is safe but there are a lot of staff changes which can be unsettling. They don't always send someone which is annoying, it happens up to six times a month and if they don't come then we just have to leave things until they do come. It is mainly household things such as opening the curtains but I have tried to do it myself and I am just not safe." Another said, "The office are not very organised. I know who the manager is, and sometimes the office staff cover care calls. I haven't had to call the office too often but when I have they didn't have the best response as they don't seem to know where their staff are. The care staff get no back up from the office." A third told us, "The invoices are always wrong and I have to keep withholding payment and chasing them up for the correct bill. They don't call me back and it is very frustrating."

A relative told us, "I haven't been asked for any feedback by anyone. We would like to know that two carers will always be available as well as be informed of any late calls. These things would be big improvements. It

would also be good to know that messages are passed on in the office when I call." A second relative told us, "The office isn't as organised as it could be. We were very close to changing company but we feel that there have been improvements lately. The office definitely needs some direction. I have had no contact with [registered manager] but I have dealt with [care co-ordinator] regularly and they have been more helpful of late. Weekends seem to be a major issue and the carers are not given the support that they need."

Staff we spoke with told us they felt frustrated in their roles. One carer said, "I love my job, but I don't feel valued. We [carers] are really needed out in the community, but I feel sorry for the service users. I still haven't received my rota for my visits tomorrow, I don't know what I'm doing."

Spot checks were now being carried out on care workers. These were used to assess that care workers arrived on time, communicated well with people and their families and completed and recorded tasks as planned. Auditing of daily log books that carers completed was proving to be beneficial as it highlighted where further training was needed.

Satisfaction surveys had been sent to people who used the service and their relatives to seek their feedback about the service they received. There were also telephone surveys six monthly, the results of some reflected our findings, and people felt it was a service they could not always rely on. Other people using the service told us things had improved. One person commented, "Didn't used to have regular carers but is resolved now", another said, "Very pleased at the moment, had problems when first started (2015) but all ok now."

The service liaised with health and social care professionals and commissioners. However, feedback from the local authority indicated that response times to requests for information was often delayed or not always sufficiently detailed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not always notified us without delay of events which had happened in the service.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding procedures were not understood or followed when one person was found to be at risk of harm. The service had not understood their duty of care. 13 (1) (2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing arrangements were still not sufficient to ensure people's assessed needs were met.