Hales Group Limited

Hales Group Limited - South Tyneside

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Hales Group Limited South Tyneside is a domiciliary care service that provides personal care to people living in their own homes. At the time of inspection 261 people were supported by the service and 229 people were receiving the regulated activity personal care.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
Following the previous inspection in August 2021 the provider sent us an action plan. This included information about the actions they had taken to make improvements within the service.

At our last inspection the provider had failed to robustly manage the risks relating to the health safety and welfare of people, including managing people's medicines safely. At this inspection improvements had been made and the service was no longer in breach of the regulation safe care and treatment as systems were becoming more robust to minimise the risk of harm to people. Improvements had been made to medicines management. Systems were in place to manage medicines safely where support was required.

There were some improvements since the last inspection to ensure people received safe care. People told us they felt safe and the service took appropriate action to help ensure people were protected.

Although people said they felt safe there was a risk of harm as rotas were not well-managed. People were at risk of harm as there was impact to people's safety and well-being where calls were very late. People and relatives gave examples of how this impacted on personal care, nutritional needs and medicines.

Improvements were still required in rota management to ensure people received timely and consistent care from staff they knew. The timings of people's calls and constant change in carers was a major cause of complaint. People were not all informed if a call was going to be late or where there were changes to carers.

All people and relatives were complimentary about the direct care provided by support staff. Relative's comments included, "The girls are magnificent, they really are, and they are very supportive to me as well", "There is a bit of joviality, a good manner. They are really lovely, they do care" and "They are all very friendly and easy to get along with."

Improvements had been made to the quality assurance systems but further improvements were required to ensure people received timely, consistent care and person-centred care with their views being taken into account.

Electronic records provided detailed guidance to assist staff to deliver care and support to meet people's

needs. Risks were assessed and mitigated to keep people safe. Staff recruitment was carried out safely and effectively.

The provider was monitoring the use of PPE for effectiveness and people's safely.

Improvements had been made to staff training. Staff worked well with other agencies to ensure people received appropriate care and support. Staff were supported by the organisation and were aware of their responsibility to share any concerns about the care provided.

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

We have found evidence that the provider still needs to make improvements. Please see the safe, effective and well-led sections of this report.

You can see what action we have asked the provider to take at the end of this full report.

For more details, please see the report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Inadequate (published 15 December 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found improvements had been made and the provider was no longer in breach of some regulations.

However, we found the provider remained in breach of some regulations.

This service has been in Special Measures since 15 December 2021. During this inspection the provider demonstrated that some improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We carried out an announced inspection of this service on 11 August 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, safeguarding service users from abuse and improper treatment, meeting nutritional and hydration needs, staffing and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements. The overall rating for the service has changed from Inadequate to Requires Improvement. This is based on the findings at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will

continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe.	**Requires Improvement**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service well-led? The service was not always well-led.	**Requires Improvement**

Hales Group Limited - South Tyneside

Detailed findings

Background to this inspection

The Inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by one inspector and five Experts-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.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It also provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 27 June 2022 and ended on 25 July 2022. We visited the location's office on 25 July 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We communicated with 64 people who used the service and 46 relatives about their experience of the care provided. Not everyone who used the service communicated verbally or wished to speak on the telephone, therefore they gave us permission to speak with their relative. We spoke with 20 members of staff including the registered manager, one care co-ordinator, two quality assurance offices and 16 care workers.

We reviewed a range of records. This included eight people's care records and multiple medicine records. We looked at six staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures, training data and quality assurance records were reviewed.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Inadequate. At this inspection the rating has changed to Requires Improvement: This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

At our last inspection the provider had failed to ensure rotas were managed effectively so people received care when they needed it. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18

● People were still at risk due to rota management. Although some improvements had been made to ensure people were cared for safely, further improvements were required.
● People were still at risk of harm and poor well-being due to staffing arrangements. A relative commented,"[Name] has three calls a day but the most important call is the morning, which should be 8 to 8.30 but it can get to 11am before staff come, they need their medicine early to stop having strokes, I did ring about it and they said they would look into it but I don't know what happened."
● Improvements were required to rota management to ensure people received consistent care from people they knew and at regular times. The majority of people had concerns about this aspect of their care. A relative told us, "We had meetings with staff and agreed a plan on the timing, certain staff are excellent, and others were a bit hit and miss. The plan worked for a while and then stopped working" and "We were getting the same carers in the morning because some of the carers are excellent, it comes off the rails in the evening and at the weekend it's a free for all. It's hard for [Name] because they haves Alzheimer's and it would be better if they knew who was coming and when."
● People and relatives said staff were changed regularly, were often early or later than expected and did not always stay for the full length of the call. One person told us, "Staff do turn up at some queer times, they can come at lunchtime for my morning visit and my shower, the evening visit can be very late and it's all different girls that come" and "It is always better to know them [staff] it makes all the difference. It makes [Name]'s life easier. I say please do not send out any strangers out, as it takes too long to explain."
● People were not routinely informed when their call was going to be late. A relative commented, "I wouldn't mind so much if they would let me know, if someone can't come, I could come and give [Name] food and their medicine, but they don't let me know. When I telephone, I'm told someone is off sick, that doesn't matter, why don't they ring me and say." A person said, "They never phone up. I was sobbing at the weekend and had to call my friend for help. All I want are regular carers at proper times."
Rotas were not managed effectively so people received care when they needed it. This placed people at risk of harm.

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

● Safe and effective recruitment practices were followed to help ensure only suitable staff were employed.

Learning lessons when things go wrong

At our last inspection the provider had failed to ensure effective systems were all in place to ensure the safety and care people received. This placed people at risk of harm. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● Learning lessons when things go wrong was improving.
● Systems were becoming more robust to ensure any risks to people's health, safety and well-being were mitigated. However, people's feedback showed that improvements were still urgently required to rota management.
● People's feedback showed that improvements were still required to medicines management to ensure all people received their calls at the scheduled times. Including people who were administered 'time specific' or 'time sensitive' medicines.

Effective systems were either not in place or robust enough to demonstrate people received care that met their needs in a timely and consistent way. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider had failed to ensure medicines were managed safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12

● Medicines were becoming better managed.
● Systems had become more robust to ensure medicines were being managed and recorded effectively.
● Additional documentation had been put in place to support medicines administration.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure appropriate and timely action was taken to safeguard people at risk of abuse to ensure they remained safe. This placed people at risk of harm. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had been made at this inspection and the provider was no longer in breach of regulation 13

● People were cared for safely. Several improvements had been made to ensure people were protected. People and relatives told us people were safe and trusted staff. One person told us, "Yes, I trust the staff, they know their job. I feel safe when they hoist me" and "I feel safe, the girls are more like friends to me."
● There had been a substantial reduction in the number of safeguardings raised due to missed calls to people, although improvements were still required to reduce the impact to people when calls were late. One person told us, "I do feel safe enough especially with my regular lady, but it is a bit of a mess really, when I don't know when they're coming."
● Staff were aware of the steps to follow to raise any safeguarding concerns. Staff had received training relating to safeguarding adults.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly manage the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had been made at this inspection and the provider was no longer in breach of regulation 12

● Systems to manage risks to people's health, safety and well-being were becoming better managed.
● There had been a substantial reduction in the number of safeguardings. One person told us, "In the beginning after the inspection, it started to improve, I was getting a rota on a regular basis, now they are spasmodic. It had improved but it has gone back."
● There was still impact to people's health and mental well-being when calls were late. We were told by the registered manager a new system was being introduced to manage the timings and consistency of people's calls. People would receive care in geographical areas from a regular care team.
● Staff understood where people required support to reduce the risk of avoidable harm. Risk assessments were regularly reviewed to reflect people's changing needs.

Preventing and controlling infection
● Systems were in place to reduce the spread of infection.
● Staff received training in infection control to make them aware of best practice.
● Gloves and aprons were available to staff to reduce the risks of infections spreading. A relative commented, "The girls always wear their gloves, masks and aprons."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

At our last inspection the provider had failed to ensure rotas were managed effectively so people received food and drink at regular intervals. This placed people at risk of dehydration and malnutrition. This was a breach of Regulation 14 (Meeting Nutritional and hydration needs) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Sufficient improvements had not been made at this inspection and the provider was still in breach of regulation 14

- People were not always supported to have enough to eat and drink at regular intervals.
- People and relatives gave feedback about the impact on people's nutrition due to call times not being attended as planned. They were often early or late and this impacted on people's mealtimes and medicines management.
- There was a serious impact on some people's medical conditions, such as for the management of diabetes. A person told us, "It's the unreliability that is an issue for me no food means no medication and for a diabetic person that's so serious."

Rota management was not effective so people received food and drink at regular intervals. This placed people at risk of dehydration and malnutrition. This is a continued breach of Regulation 14 (Meeting Nutritional and hydration needs) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff received good support and all of the training they needed. This placed people at risk. This is a breach of Regulation 18 (Staffing) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Sufficient improvement had been made at this inspection and the provider was no longer in breach of this aspect of regulation 18

- Effective systems were now in place to ensure staff were trained and competent to carry out their role to ensure people's care and safety.

● New staff completed an induction, including the Care Certificate and worked with experienced staff members to learn about their role.
● Staff received training including, for specific or specialist needs such as catheter care and stoma care. Their competence was checked before they delivered care to the person. One relative commented, "Staff are skilled and trained with our needs. When we had a catheter problem, they gave good advice" and "The staff that I see are definitely trained. They know how to use the equipment, like the hoist. The girls know what they are doing."
● Staff received regular supervision to discuss their performance and personal development. Staff members all said they were, "Well-supported" and the management team were "approachable."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed prior to using the service and reviewed on an ongoing basis.
● Care records were available electronically for staff. Care records were up-to-date and person-centred, providing detailed guidance to staff about a person's support needs. A person said, "They [staff] do everything, I want them to do."

Supporting people to live healthier lives, access healthcare services and support;
Staff working with other agencies to provide consistent, effective, timely care
● People's healthcare needs were met. Staff followed guidance provided to ensure people's needs were met appropriately.
● Where people needed assistance, staff alerted a health care professional or family member if they had concerns. One relative commented, "The girls are really good, they let me know if things need done or they are worried about [Name] and I get back to them direct with what the GP has said or the Specialist nurses are doing."
● Staff worked closely with a range of other agencies to provide co-ordinated packages of care. One relative said, "The girls are doing brilliant looking after [Name]. The girls tell me what is going on and if I need to sort anything out."

Ensuring consent to care and treatment in line with law and guidance
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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
● No one was subject to any restrictions under the MCA.
● Staff received training about the MCA as part of their induction.
● Information was available about people's capacity to consent. Where people no longer had capacity to consent records showed who was responsible for decision making with regard to care, welfare and finances,

when formal arrangements had been made with the Court of Protection.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Inadequate. At this inspection the rating has changed to Requires Improvement: This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At our last inspection the provider did not have effective systems in place to monitor and improve the quality and safety of the service. The management team and the provider failed to ensure the regulations were being met. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance.

Sufficient improvement had not been made at this inspection and the provider was still in breach of regulation 17

● Systems had been improved to ensure people received safe care but rota management did not promote person-centred care.
● Some improvements had been made since the inspections of August 2021, but significant improvements were still required to rota management to ensure people received timely and consistent care. A relative commented, "When my main carers have a day off, that's when things go wrong. The regular carers are on time, but not when I get different carers" and "It's going well now but we don't know how long it will last."
● There was documentary evidence of audits and action plans to monitor service provision including the late calls to people. However, improvements had not been sustained or significantly reduced and the same problems with rota management continued to recur in several identified areas placing people at risk of care that didn't meet their needs. A relative told us, "Since the last inspection, there has been no real improvement. To be quite honest, it was improved for about a fortnight and things went back to normal. The timing for [Name] is important. It upsets them when they don't come at set times" and "I need [Name] sorted so I can get the kids off to school but it doesn't always happen, sometimes they have been so late I have just rung up and cancelled them as there is no point them coming."
● The registered manager understood the duty of candour responsibility, a set of expectations about being open and transparent when things go wrong.
● The management team understood their role and responsibilities to ensure incidents that required notifying were reported to the appropriate authorities in a timely way.

The provider did not have effective systems in place to monitor and improve the quality and safety of the service. The management team and the provider failed to ensure the regulations were being met. The above

is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider had failed to promote a culture where the views of people and staff were actively encouraged and acted on. This placed people at risk of harm. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● The culture of the organisation did not promote a person-centred approach to delivering care or an openness which empowered staff and people.
● Person-centred care was not always provided, with people the main focus of decision making about their daily lives. A relative told us, "Calls aren't on time. The times have to suit them and not us."
● Improvements were required to some aspects of care provision to ensure people were central to the processes of the delivery of care.
● Although an electronic call monitoring system was in place to monitor people's calls, systems were not in place to ensure people received timely and consistent care that respected their needs and wishes.
● People were not kept informed when staff were late, and people did not always know who would turn up to provide care. A relative commented, "I have had to cancel Dr appointments because staff don't come when they are supposed to. If they'd just let me know" and "In total we had 18 different carers from Monday to the Sunday. I was getting anxious and phoned the office."

The provider had failed to promote a culture where the views of people and staff were actively encouraged and acted on. This placed people at risk of harm. The above is a continued breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection the provider had failed to learn lessons from previous feedback and improve people's care. This placed people at risk of harm. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● Engagement with people and staff was not fully effective.
● There was evidence of communication with people and staff. A person told us, "Someone from the office rang asking how things are." However, feedback received showed communication was not always effective with office staff. People and relatives' comments included, "If you can get through it's not too bad, but when they say someone will call you back it never happens", "Messages are not passed on" and "Communication with the office is very rare. I found out, I get more out of the carers than the office."
● People were involved in decisions about their care. They were consulted on an individual basis. However, improvements were needed to show that people were consulted and listened to with regard to their care

and support requirements.

The provider did not have effective systems in place to improve the quality of the service, using feedback to provide person-centred care to people. The management team and the provider failed to ensure the regulations were being met. The above is was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance.

Continuous learning and improving care

At our last inspection the provider had failed to ensure learning and take decisive action to improve the care people received. This placed people at risk of harm. This is a breach of Regulation 17 Health and Social Care Act 2008 (Good governance) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● People and relatives told us there had been some improvements to care provision, but it had not been sustained. Although people told us they felt safe supported by staff they had concerns about rota management and the impact on their lives with the unreliability and inconsistency of calls. A person commented, "I phone the office because they are squeezing new clients in front of me and that makes everything late. My 9am call has now been pushed back to 11.45." A relative told us, "I am not informed about the changes from the office. I was taken aback when the carer told me there was a changeover. We have built a rapport, it was a shock to [Name]. If they get their routine upset, it can affect them mentally and physically."
● The provider and management had worked to make improvements, but rota management was a key factor in people's dissatisfaction. A relative told us, "There are far too many strangers coming to the door. I was told at the beginning (3 months ago) eventually, we will get regular carers coming in, it is still new people coming now. It's the routines you know, that are important and that isn't happening."
● The provider's analysis of complaints and safeguarding referrals identified rota planning and rota management as a major contributing factor. The provider acted to address some concerns. However, improvement was still needed and to ensure they were sustained. A relative commented, "Complaining and getting a response is a lottery but the issues are not resolved."

The provider did not have effective systems in place to improve the quality of the service, including providing person-centred care to people. The management team and the provider failed to ensure the regulations were being met. The above is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance.

Working in partnership with others
● Staff communicated with a range of professionals to ensure that people's needs were considered and understood so that they could access the support they needed.
● The registered manager was appointed to the service since the last inspection and was working to make improvements to ensure people received safe and person-centred care.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to ensure effective systems were in place so people, who required support with their nutrition received regular food and drink. Regulation 14

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to monitor and improve the quality and safety of the service. The management team and the provider failed to ensure the regulations were being met. Regulation 17

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure rotas were managed effectively so people received care when they needed it. This placed people at risk of harm. Regulation 18