Hartley Home Care

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Inspection report

Penclease House, 13 Clease Road, Camelford, PL23 9QX
Tel: 01840 213294
Website: no website

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

Overall summary

We inspected Hartley Home Care on 3 February 2015. Hartley Home Care provides care and support for people in their own homes. The service provides support and care to mainly older people who require assistance with washing, bathing, dressing, assistance to use the toilet, meal preparation and the prompting of medicines. Some people who received support from the service were living alone with dementia and were dependent on the service for all their daily care needs. The service provided support for 100 people, in their own homes, at the time of the inspection.

The service had reduced the number of people for whom it provided support, from over 300 people in February 2014 to 100 people in 2015. There have been concerns about this service which has not met the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 since March 2010.

There was a registered manager in post at the service. 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.

At our previous inspection on 2 September 2014 we found breaches of the regulations.

Summary of findings

This inspection was a comprehensive inspection at which we also checked on the action the provider had taken to meet the requirements of the regulations.

People told us they felt safe with their staff, however, we found not all aspects of the service provided were safe. Where risks had been identified following assessment of a person's needs, staff were not always provided with specific guidance in the care files to mitigate these risks. One person who had recently begun receiving support from the service did not have a care plan in their home for nine days, to inform care staff of the needs of the person. However, the care plan was held on the computer at the office of the service. It contained specific guidance for staff on how to meet the person's specific needs. Staff told us "We had no instructions at all" and "the (person's) daughter told us what to do." This meant the person was being cared for by staff who were not directed and informed as to the person's specific needs or the risks associated with providing their care.

On 9 January 2015 health and social care professionals raised concerns, to the Care Quality Commission (CQC) and the local authority safeguarding unit, about a person who was receiving support from the service. This person was regularly refusing personal care, a change of clothes or bed linen and was experiencing poor outcomes. The increased risks to this person arising from their continued refusal to accept care had not been reviewed since 8 October 2014. This meant the person continued to experience poor outcomes.

At our last inspection we found people were experiencing missed, late visits and shortened visits. At this inspection we found some improvement. However, people were still reporting some missed, shortened and late visits. This meant people were not having their needs met safely. People told us staff were not always staying with them for the agreed period of time as stated in their care plan. People told us; "We are paying for a service that we are not getting" and "We have been trying to get our money back for things we have not had, it's not easy." People experienced visits that were not at the time of their choosing. Families told us;"(the person) has to call us (family) to take them to the loo as they get desperate when the carers are late and (the person) cannot go on their own." People told us "I have to miss going to church on Sundays even though they know it is important to me, they rarely get here on time to help with my personal care" and "There are times like today when I need to go to the doctors and no one came. I cannot shower without help."

Some people were satisfied with the service they received; other people did not always have their concerns and complaints acted upon to their satisfaction. People told us; "I do complain sometimes especially about the missed calls and lateness. My son will ring and blast them off but nothing ever improves," "I have complained about the lateness, we have had no response from managers about our complaints," "We have complained about the missed calls. They have been very off hand and I have never had an apology."

At our last inspection we found the service was not monitored effectively by the provider. At this inspection we found there had been improvements in the way the service gathered and recorded information. However, people told us they were still not having their concerns responded to effectively. They told us "No I don't feel management staff are effective at all. They need training on how to manage and retain staff," "I have nagged the office when carers are not good and slapdash but they are slow to get rid of those ones." One person contacted the CQC to tell us of their frustration with not being able to contact the management; "I have been trying to speak to the management for ages, they won't speak to me."

Providers have a responsibility to comply with the Health and Social Care Act 2008 regulations and submit statutory notifications to the CQC when any event which may impact on their service provision occurs. The provider had failed to notify the CQC of the safeguarding alert made by healthcare professionals on the 9 January 2015 of which they were aware.

Information held by the provider at the office relating to people's needs, staff training, and staff supervision and appraisal was not accurate. Care files held at the office did not contain key information, which was held at people's homes, this meant operational staff at the office did not have all the information they required relating to individuals' care needs and risks. Records relating to staff training, supervision and appraisal did not contain the names of all the staff working at the service. This did not help ensure the provider was effective and responsive in managing the needs of both the people who used the service and the staff who worked there.

Summary of findings

People were very complimentary about their care staff. People were cared for by kind and considerate staff. Most felt they had their privacy and dignity respected. People were asked for their consent before care was provided, and were given the opportunity to sign their care plans, where available, in agreement with the contents.

The service had adequate staff to meet the needs of the people who were receiving a service. Recruitment processes were robust and staff were checked to help ensure they were safe to work alone with people in their homes. New staff were provided with induction training and shadowed experienced staff before working alone. Staff told us they felt well supported by the management.

Care plans were person centred. Some people told us the staff were knowledgeable and able to meet their needs effectively. Staff received appropriate training to support them with their work. Training updates were regularly available.

Daily records were returned to the office regularly for audit. This meant the provider was able to monitor the service provided to specific individuals.

The service had commissioned the assistance of two consultants to support the service to meet the requirements of the regulations. Improvements were seen as a result of this support. The processes used by the provider to gather and record information had improved. The service used a new electronic call monitoring system which had improved their ability to monitor the service provided. However, this had not always had a positive impact on people's experiences of care and support provided by the service. There was a disconnect between information gathered and recorded at the office and the effective use of that information in the practical provision of appropriate and timely care and support for people who used the service.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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

People told us they felt safe with their carers, however, we found the service was not safe. Risks to people were not always addressed and staff were not given sufficient information to help ensure risks were reduced.

Some people experienced missed or late visits.

There were enough staff to meet people's needs.

The service had effective recruitment procedures to ensure staff were safe to work alone with people in their homes.

Is the service effective?

Requires Improvement

The service was not effective. People experienced visits at times not of their choosing often resulting in care not being delivered, or delivered by a family member.

Carers' visits were not always of the agreed amount of time and people did not always have their preferred choice of gender of carer respected.

People's consent was sought before care was provided. However, the provider was not aware of the details of the Mental Capacity Act 2005 and the protection of liability for care staff.

Most staff received regular supervision.

Is the service caring?

Good

The service was caring. People spoke highly of their care staff.

Care staff communicated well with people they visited.

People felt involved in decision making about their care.

Is the service responsive?

Requires Improvement

The service was not responsive. People had raised concerns and complaints about the service they received, which had not been resolved to their satisfaction. Issues re-occurred. The provider did not follow their own complaints policy.

A new care plan model had been adopted which was person centred and individualised.

A new electronic call monitoring system had helped to improve the services ability to monitor the service it provided

Is the service well-led?

Requires Improvement

The service was not well-led. Information held by the management was not accurate and comprehensive.

Summary of findings

Quality assurance processes although regularly carried out, were not always effective in improving the service provided.

Staff reported an improvement in the way the rotas were created. Staff felt well supported by the office staff.

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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 was planned to check whether the provider was 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.

We visited Hartley Home Care offices on 3 February 2015 and the inspection was unannounced. The inspection was carried out by three inspectors, and two 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. Their area of expertise was in older people's care.

Before the inspection we reviewed the information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law. We sent questionnaires to 60 people, who received a service and spoke with 48 people, including family members, on the telephone prior to this inspection. We spoke with nine healthcare professionals who worked with people who were receiving a service from Hartley Home Care. Information of concern was received and gathered from professionals. This related to 14 people. Information regarding the care and support of 10 of these people was followed up at the inspection.

During this inspection we spoke with the provider, the registered manager, two consultants working with the service, and two operational staff in the office. We looked at 11 records which related to people's individual care. We also looked at 10 staff files, and records relating to the running of the service.

Following the office inspection visit we spoke with two people and two families of people who received a service, seven members of staff and two healthcare professionals.

Is the service safe?

Our findings

People told us they felt safe with the staff who attended to their needs. However, we found that not all aspects of the service provided were safe.

At our previous inspection on 2 September 2014 we had concerns regarding risk assessments not having being undertaken to inform and direct staff how to reduce specific risks to individuals. We were concerned about people experiencing late and missed visits. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider stated in the Provider Information Return (PIR) "Extensive assessment, risk assessment and care planning process ensure all risks are known, shared …." Risks had been identified in people's care plans. However, the specific risk assessments where staff could find information and direction as to how to mitigate the identified risk were not present. For example, people had been assessed as at risk from falls however, there was no specific guidance for staff on how to address these risks in the care file held at the office. The provider stated that specific risk assessments were in the file at the person's home. Copies of relevant assessments were sent to CQC three days after the office inspection visit by email. One person's file which stated "Fallen many times," held no specific guidance for staff on how to reduce this risk. We contacted the family about this person. They checked the file at the house the day after the inspection and confirmed there was no specific risk assessment guidance for staff in the care file held at the home. This meant staff were unaware how to reduce the risk of falls for this person and could not reduce the risk of re-occurrence.

On 9 January 2015 health and social care professionals raised concerns, to the CQC and the local authority safeguarding unit, about a person who had dementia, lived alone and had experienced poor outcomes as a result of regularly refusing to allow the service's staff to provide personal care, a change of clothes and bed linen over a period of time. This person's home was found to have a large amount of mouldy, rotting and out of date food present and the person concerned was wearing very soiled clothing. Staff had raised concerns to the provider about this person's deteriorating condition over the past three months. Staff had attended best interest meetings, with community mental health teams, to discuss the person's changing needs. The morning visit was assessed as needing to be at, or after, a specific time to help maximise the person's acceptance of the care staff support. Care staff arrived up to one hour earlier than had been agreed in the care plan. This did not help ensure the person would accept support.

A telephone call was received by the community mental health team on the 5 January 2015 from the provider asking if a care home had been found for this person. The provider told the care worker; "Concerns are ongoing." In the office copy of the person's care file, the care plan was dated on 8 October 2014. We checked the date of the current care plan held in the home, with visiting healthcare professionals, this was also dated 8 October 2014. The plan of care had not been reviewed to mitigate the risks to this person regarding their deteriorating condition arising from their continued refusal to accept care. Staff had not been supported with advice and guidance on how to improve the outcomes for the person. Staff did not meet the person's needs, as offers of support to wash, change their clothes and remove rotting food from the home were refused by the person. This meant the person continued to experience poor outcomes.

Insufficient action had been taken by the provider following the safeguarding alert. On the 9 January 2015 staff were advised to ensure they recorded all care provided in the care log. On the 19 January 2015 tabards were provided for the staff to see if 'uniform' worn by staff may improve the person's acceptance of care. Staff were not aware of any other change to this person's plan of care. The provider sent a report to the safeguarding unit stating "the care assistants have for some time been checking the fridge for out of date food." Following the inspection we were contacted by a social care professional who told us they had visited on 5 February 2015 and continued to find mouldy bread, black bananas and out of date buns and scones in the home. This person continued to experience poor outcomes because the service was not carrying out the action that it said it would during visits to the person's home.

We asked people if they always received visits at the time that had been agreed in their care plan and if they had experienced missed care visits. Most people said they received their scheduled visits. Ten people told us they had experienced recent late or missed visits. Comments included; "I only have them three times a week for help in

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the shower but I keep getting missed," "They have missed me sometimes and I never know who will come or when" and "They didn't come today and I had to go to the doctors. They couldn't care less, it is worse on Saturdays I can say nine out of ten they don't get here on a Saturdays. When I phone they say they forgot and they don't have anyone else to send." Another family told us; "(the person) gets distressed when they don't come and (the person) hasn't had a shower. It means the family are left to do it before taking him out." Another person told us; "We have experienced missed calls always on a Saturday and it has happened six times lately. We ring the office but they don't send anyone so I, with the help of our daughter, have to do it."

We checked people's care logs and the computerised records at the office for these reported missed visits. The missed visits reported by families or users of the service were not recorded. Operational staff told us the person, or their family, would ring up to alert the service about the visit not having been made, the service then offered to send a carer which the family often refused because they had provided the necessary time critical care, so the visit was then unnecessary. Staff then cancelled the visit on the system and therefore there was no record of such missed and then cancelled visit.

At previous inspections the service had been unable to quickly identify and respond to missed or late visits as identification was dependent upon daily care records being returned to the office and reviewed. The service had improved their ability to monitor late or missed visits, were mostly aware when they had occurred and were usually able to offer a care visit later. This offer to visit later was often declined by people because their care needs were time sensitive i.e. care required at a particular time of day or with particular tasks and family or friends had stepped in to provide the missed care. Families confirmed they refused the offer to send carers late for the visit, as they had already provided the care needed at the time and the visit was therefore no longer required by the person. However, for those people without family or neighbour support the provider's ability to identify more quickly late or missed visits meant they were safer as they were not going prolonged periods without support.

Despite the improvement of the service to monitor late or missed visits, some people were continuing to experience poor outcomes. People continued to experience missed and late visits as had been found at previous inspections. Such reported missed visits were not always evident on the system held at the office. There had been one missed visit on 29 January 2015 which had not been appropriately addressed by the operational staff. There had been a scheduling issue on another occasion that had led to no visit being scheduled for one person. This had resulted in another missed visit that the service was aware of.

Prior to this inspection we were contacted by a family of a person who started to receive support from the service on the 26 January 2015 and did not have a care plan in their file at their house. Family told us they were having to explain what was required of the care staff at each visit. The care plan was not in this person's file at the office. It was on the computer at the office on the day of inspection. This was eight days after commencement of the package of care. It stated in bold lettering on the front of the care plan "Do not let the cat out" and "Please encourage fluids and food as I need to put on weight, please allow me to do as much as I can." Staff who had visited this person were not aware of these specific issues. They told us; "We had no instructions at all" and "the daughter (of the person) told us what to do." This meant the person was being cared for by staff who were not directed and informed as to the person's specific needs or the risks associated with providing their care. The provider continues to breach this regulation.

All the above is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010 and the corresponding regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the September inspection we had concerns regarding the staffing levels at the service, people were not always receiving two carers where they had been assessed as requiring two staff to meet their needs safely. We found the service was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010. We issued a compliance action in this regard.

At this inspection we checked if improvements had been made to comply with this regulation. The PIR stated 94 staff had left the service in the last 12 months. The service currently had 55 staff to meet the needs of 100 service users. People who required two carers to meet their needs were mostly receiving this level of support at each visit. One person told us; "I have two carers to help me with my walking in the house. They usually come together but on the rare occasion one is late the other will start to walk me

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to the bathroom with the commode behind me" and "It is particularly good when the husband and wife team come to us, we can relax as we know they do a good job, and can be relied upon to always turn up on time. It's a bit different when they are not working though, as we don't always get carers on time or two together."

People reported a drop in the availability of staff at weekends, one person reported only having one carer instead of two at weekends due to shortages and told us "the wife doubles up, to help the singe staff member that came." Staff reported they felt 'less pressured' and had more time to provide care for people as there was a lower number of visits to be made in a shift and sufficient staff to cover. We reviewed the care visit schedule for the week of the inspection. One member of staff was off sick, and the service had a plan to get this staff member's visits covered. The rota for the week following the inspection was completed in advance and there were sufficient staff available to provide all care visits. This was an improvement from the findings at the last inspection. The provider was meeting this regulation.

The service operated safe recruitment procedures. We checked the personnel files for new staff. All the relevant checks had been carried out by the provider in order to ensure the person was safe to work alone with older people in their homes. New staff attended a two day induction and, together with a period of shadowing experienced staff, were supported to feel confident before visiting people alone. New staff found this period supportive and helpful and had been provided with additional training to enable them to provide skilled care to people.

People felt safe with their care staff. Carers who did shopping for people were trustworthy and always produced receipts and correct change. Staff had received recent safeguarding training and were clear about how to recognise abuse and raise concerns to the registered manager. Some staff knew where they could raise their concerns outside of the service if necessary. Training records showed staff had undergone training with regular updates arranged as needed.

Some carer visits were to prompt people to take their prescribed medicines from blister packs dispensed from their local pharmacy. These packs showed the date and time for each medicine that was due to be taken. This helped ensure compliance with people's medicines directions and enabled care staff to check if medicines had been taken at the correct time. Some families reported the need for the carers to keep the person's medicines in a safe place, to ensure the person for whom they had been prescribed did not access them at the incorrect time. Families reported staff were able to manage people's medicines. People told us; "Hartley has improved in this area, they now give me my medication at the appropriate time on getting me out of bed. I tell them what to get and they do that. The staff know what the medication is for and as I cannot lift my arms they put the tablet in my mouth and then the water" and "The carers help me with my medication and make sure I take it usually after I have eaten. They know exactly what I have to have." Most staff had undertaken training recently in medicine administration. A number of staff were in the process of completing this course.

Available care plans contained information about what action should be taken in an emergency and whom the person, or their representative, should contact if necessary. Contingency plans were in place to manage severe weather conditions that would prevent carers reaching people who required assistance. The service had access to 4 x 4 vehicles, and some carers were able to walk to people in their own areas. On the day of the inspection there was snow and ice on the ground and the service was experiencing delayed visits due to the carers not being able to travel easily around the area. These incidents were well managed by operational staff and by lunchtime all planned morning care visits had been provided. The service confirmed people who had scheduled visits that day had received a carer visit and had been contacted to be made aware of any unavoidable delays.

Is the service effective?

Our findings

People told us staff supported them at their preferred pace and staff spent time helping people as required. However, care staff did not always spend the length of time with people for which they had been assessed, in order for carers to provide adequate care and support. People's care logs and the office electronic visit monitoring system showed people's visits were not always for the time stated in the care plan. For example, one care plan stated the person should have had visits lasting 45 minutes in the morning and 30 minutes in the evening. During the period of 11 days from 23 January 2015 to 2 February 2015 this person received morning visits lasting from 16 to 43 minutes, with eight visits being less than 30 minutes. The evening visits, for the same period, lasted from 16 to 31 minutes with five visits being less than 20 minutes. Another person should have had one hour visits. Nine consecutive visits made to this person lasted between 30 and 45 minutes. Another person had been assessed as requiring an extra hour twice a week for housework. On 10 occasions when housework was scheduled, from 1 December 2014 to 2 February 2015 housework was carried out on three occasions. This person also required an additional 45 minutes to have their hair washed once a week. From 4 December 2014 to 15 January 2015, they should have received seven visits to have their hair washed. The person had not had their hair washed on any of these occasions. People were not receiving the care that they needed or had paid for. The vast majority of people using the service were funding their own care packages and told us; "We are paying for a service that we are not getting" and "We have been trying to get our money back for things we have not had, it's not easy."

The provider stated in the PIR "electronic rostering and monitoring ensures team members provide services at agreed times." However, people experienced visits that were not at the time of their choosing and the time agreed in the care plan. Families told us; "I have a business to run and cannot leave till (the person) has had their call, I have had to get very angry with them (the service) to get them to come at the time we agreed", "We wanted to know carers had arrived to see to (the person) before he (the family member) leaves for work. They are now coming much later 8.30am to 9am and we are not happy with this." and "(the person) has to call us (family) to take them to the loo as they get desperate when the carers are late and cannot go on their own." People told us "I have to miss going to church on Sundays even though they know it is important to me, they rarely get here on time to help with my personal care" and "There are times like today when I need to go to the doctors and no one came. I cannot shower without help."

Relatives of one person had experienced delays in the carers arriving for visits which affected the person's mealtimes. This person was required to wait for a period of time following medicines, before eating a meal. The late visits to this person meant they were unable to have their meals at the appropriate time. Another person had been assessed as requiring visits at 9.45 am. Over a period of nine days from 17 January 2015 to 26 January 2015 this person was visited over an hour earlier than this agreed time on six occasions. Health and social care professionals told us early visits were a contributing factor to why this person regularly refused care, as they were still asleep in bed when the carers arrived and did not like to be rushed in getting up. This meant people were experiencing poor outcomes due to late visits.

People were asked what time they wished to have their visits and this was clearly recorded on the front page of their own care plan. However, this was not always respected and people regularly received visits at times that were not of their choosing.

People had requested a specific gender of carer to provide them with personal care, this was not always respected. Comments included; "I don't want male carers. I have told them, why are they still sending them?" A family member was very concerned that the service had sent a young male carer to provide personal care for their very elderly family member without asking her, or informing her about this change, "which had caused distress and anxiety". This did not respect people's dignity, wishes and choices.

The provider incorrectly stated in a report to the local authority that care staff could not provide care and support without the person's explicit consent or guidance from a best interests meeting. This meant the provider was not aware the Mental Capacity Act 2005 (MCA) provided protection from liability for health and social care staff. This section provides legal protection to persons providing care to people who lack capacity where reasonable steps have been taken to assess capacity and where the care provider reasonably believes the recipient of care lacks capacity but

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that such care is in his or her best interests. The provider's misunderstanding of the law on capacity meant some people receiving care who lacked capacity did not always receive care that was in their best interests.

All the above is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010, and the corresponding regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The service provided inspectors with a record of staff supervision and appraisal. Supervision is an opportunity for staff to spend time with their manager to discuss work related issues. Most staff received regular supervision. Most staff received an annual appraisal from their manager. This was an opportunity for staff to review the year's achievements and plan any training or development needed. Information about staff supervision and appraisals provided to CQC during this inspection was incomplete. For example, we were provided with the records of staff supervision and appraisals. Whilst there was increased supervision support for staff since the last inspection, the records contained the names of 31 of the 55 staff working for the service. This meant the provider did not have an accurate picture of when each member of staff would require supervision and appraisal.

People were asked for their consent prior to care being provided. Available care plans and risk assessments were mostly signed by the person, or their representative in agreement with the content. One person told us; "I have no concerns as they only have to apply cream to my legs. They always ask me if it is okay before they apply it." The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. Most staff received training on the MCA on 27 November 2014. Staff confirmed their awareness of the MCA although the implementation of this legislation in practice was not consistent. One file we reviewed contained details of a capacity assessment and another contained records of a best interest meeting that had taken place to support a person to make a specific decision.

Staff received regular opportunities to attend a variety of training. People reported; "Staff are knowledgeable about my deteriorating condition and my needs. My main carer is an ex medic," "Most are okay but one or two don't know what they are doing" and "Most certainly, they do whatever jobs I ask them to do." The registered manager told us specific training sessions were taking place, both on the day of the inspection and in the forthcoming weeks. Training records were held on a subject basis, showing names of staff, dates of training attended and when updates were due. Staff had attended additional training to the mandatory subjects, in order to meet the needs of people using the service, such as dementia care and Mental Capacity Act courses.

The service provided people with support with their meals, this included preparing meals. Although some people reported delays in visits for meals, most people reported staff provided good support in this area. People told us; "They ask what I would like for my breakfast and tea, as I get my lunch delivered. I have a healthy diet and they ensure I am well hydrated and always leave drinks for me throughout the day," "The carers always tell me that I must eat" and "They are so helpful. They always get our breakfast."

People were confident care staff would arrange the appropriate support for them from a professional such as a doctor if they required this. People told us; "Not all that long ago when the night carer came I was very trembley and she called the paramedics who dealt with me" and "If they are worried about me they talk to me about it and will call the doctor to visit me if after our discussion we think I need someone." Care files contained details of where carers had referred to a health or social care professional to meet a person's needs. For example, requesting a GP or district nurse visit or contacting a social worker to discuss a person's change of needs.

Is the service caring?

Our findings

At our last inspection we found the service was not caring. We had concerns about people having poor outcomes from their visits. We took enforcement action against the provider in this regard. At this comprehensive inspection we also checked to see what action the provider had taken to address this concern.

People were treated as individuals. People were happy with the carers who visited them and most spoke positively about them. Most told us they felt their privacy and dignity were respected. People told us; “I can’t fault my carers they always knock on the door before coming in, wrap towels around me, shut the door and they know I like to have a cup of tea first thing and they make one as soon as they arrive,” “I am always pleased to see my carers they make my day” and “They encourage me to do what I can for myself but I can’t walk or go out as I live upstairs”. However, one family told us of their family member being undressed and washed in front of them in the living room of the home. They said “We felt we should leave the room to give them some dignity.” The feedback we received from people indicated most staff closed doors, and pulled curtains when they helped people with their care. Generally people's privacy was maintained.

People felt involved in their care and their individual needs were met, they told us; “They do meet my needs, they are good”, “I can’t fault my care”, “My wife and I were involved in the discussions as we felt that I needed extra time for medical reasons” and “My husband was involved in the discussions. We feel very lucky to have the care we are getting and hope it will continue.”

Some people reported having regular carers who they got to know well. People stated; “We have a lot of fun. We have a laugh and a joke and if I am in a grumpy mood they always cheer me up” and “I have two carers regularly since I started with Hartley a year ago and they are excellent.”

Two carers who always worked together, were particularly well thought of by a number of people. Many people told us how caring and helpful these two carers were. They told us; “if only the service could clone those two they would be laughing”, “You can just breathe a sigh of relief when you see them both arrive, it’s lovely, they are so caring and kind” and “They are marvellous, just great.” Staff communicated well with people during care visits. People told us “We have an excellent rapport and I love a bit of banter” and “they do communicate quite well with my husband.”

Staff we spoke with on the telephone following the inspection spoke fondly of the people they visited regularly. Staff understood people’s personal preferences, and knew how people wanted their care provided.

Is the service responsive?

Our findings

At our previous inspection on 3 September 2014 we found the service was not responsive to people's needs.

Some people felt the service did respond to their needs and wishes effectively. The service had made some improvements in this area. A new electronic journal for each person using the service was used at the office. This brought together all telephone messages received and telephone calls made, requests for changes to visits and any other information relating to the person, in one easily accessible record.

The provider stated in the PIR; "We have introduced a new system of compliments, comments and complaints with the ethos in ensuring each is recorded, actioned in the most appropriate manner and the outcome recorded and shared with the parties involved. Our clients are encouraged to speak with the care team and management to share their experiences of HHC services and this policy and our practices encourage their families to share information and feedback on both good areas and developmental areas should they exist". People were asked how the service responded if they raised concerns with them. Comments about this were mixed; "Anything unhappy with I will tell the office, they don't like it though," "I do complain sometimes especially about the missed calls and lateness. My son will ring and blast them off but nothing ever improves," "I have complained about the lateness we have had no response from managers about our complaints," "We have complained about the missed calls . They have been very off hand and we have never had an apology." More positively we were told "I complained, it got sorted out in the end to my satisfaction," "I have complained about various things, one carer we had was very rude and I asked them not to send her again. I feel they do listen to me and have made changes when necessary." These concerns had been raised verbally on the telephone, or face to face with staff. People who we spoke with had not made written complaints, however, they had not always received a satisfactory resolution to their concerns. People were not always receiving satisfactory responses to issues raised by them or their families.

The service had a complaints procedure which invited people to raise concerns with the provider. This policy was included in the Customer Welcome Pack given to people when they began receiving a service. It stated "Your compliments, comments and complaints, whether complimentary or otherwise are always welcome and we take pride in responding to them quickly, effectively and honestly in line with our policy of candour and our compliments, comments and complaints policy." The PIR stated the service had received 14 compliments and 14 complaints in the last 12 months. We asked the provider for their record of complaints and compliments received by the service up to the date of the inspection. This showed nine compliments, and one complaint had been received up until 31 December 2014. There were no records for 2015. This was inconsistent with the information given by the provider in the PIR. Also the complaints and concerns people told us they had raised were not on this record. We saw a formal complaint that had been received by the service in a person's care file. This had been responded to in accordance with the service's policy and appropriate action had been taken to address the issue. This complaint was not detailed on the compliments, comments, and complaints record. This meant people's complaints and concerns were not always recorded or adequately responded to. The provider was not always following their own complaints policy.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (regulated Activities) 2014.

We asked people if they had met recently with someone from the service to review their care needs. We received mixed responses from people, their families and representatives. They told us; "I have not had a review done by Hartley in the year I have been having care but the Council came and offered to move me to another agency if I wanted to, but I chose to stay with Hartley," "I haven't had a review or been asked for feedback except by you today," "Someone came recently and checked if I was happy with my plan which I am," "They did a review about two months ago. I told them I am unhappy about them allocating later times but they won't change it. Although they are not late so often recently" and "We had a review in October 2014 when I asked for double handed help for three nights. It has been provided."

Some people felt if they gave enough notice the service would be more flexible and change times to suit them and some people found the service had been responsive. People told us; "I feel they do listen to me and have made

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changes when necessary" and "We rang the office to say we didn't want (care staff name) again. We haven't seen her since." However, there were others who had made a request and then been let down. For example, one person told us "No one came today even though I told them I was going to have to go and see the doctor. They knew about it well in advance and I can't shower on my own that means I had to struggle to wash myself etc; It just adds the everyday stress when they let you down." This meant that although the service had improved since our last inspection it was still failing to consistently respond to people's request for changes to their care visits.

Following the last inspection the provider stated in their action plan that they had processes in place that enabled the service to 'react to late arrivals at customers' homes in real time and maintain the highest quality of care provision by keeping the customers informed as to changes in schedule…'. On the front of all new care plans there was a statement that people could expect to be contacted by the office if their care visit was going to be outside of the agreed times as stated on their care plan. We asked people if they were contacted when visits were late, they told us; "never get a phone call to tell me," "Only on the odd occasion," "Not always," and "If they are going to be very late they let me know." The management were not ensuring their own statement was always being actioned effectively.

The service had installed an electronic staff and visit monitoring system. This enabled operational staff at the office to monitor the service provided, noticing if visits were running late or missed. Operational staff told us they would ring carers whose visits were showing as late on the system to check on their progress. During this inspection, which was carried out on a day that was snowy and icy, staff could easily show us which visits were running late, and then see when they had been completed by staff. Staff who found it difficult to access specific people's homes due to the bad weather informed the office who then reallocated the visit to a carer who was able to reach the person. At the end of the day of our office inspection visit all visits to people had been confirmed as carried out. This showed the service could be responsive in adverse weather conditions.

Operational staff were happy this system had made the service more effective in monitoring carers visits in real time. Operational staff told us, "We are not having to play catch up so much now," and "It's much better."

The provider had reviewed most of the care needs of people whose files we checked, and had adopted a new model of care plan which had been developed by the service. This new care plan was individualised and contained specific information and detailed guidance for staff. Information in the care plans was very detailed and enabled staff to provide care in the way the individual wished. People and their families or representatives, had been given the opportunity to sign in agreement with the contents of their own care plans. There was evidence of the person's preferences and dislikes in the records, along with their preferred term of address. People told us staff used their preferred term of address.

The new care plans contained information relating to the person's life history. This was helpful to staff as it assisted them to understand the person's background and experiences and how that related to who they were today. The service provided care to people with a diagnosis of dementia, and life history information supported staff with making connections with people.

Some people requested a copy of their rota in advance which the provider arranged for them to receive. This showed them which carers had been allocated to them for each visit. One person told us; "I now have a rota sent to me a week in advance and if there is a name on there of someone I don't trust to handle my care needs I ring and get it changed." Another person had a specific need for a type of glove to be used by care staff due to an allergy. The service had responded to this issue by providing the person with the correct type of gloves for care staff to use. This showed the service was responding to some people's requests.

Accidents and incidents were recorded at the office of the service. These were audited and actions had been taken by the provider to address any patterns or trends that had been recognised.

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Our findings

At our previous inspection on 2 September 2015 we found the provider did not have adequate processes in place to effectively assess and monitor the service it provided. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. As part of this comprehensive inspection we checked to see what action had been taken to meet this regulation.

The provider had made some improvements in this area and people spoke highly of the care staff who provided their care. However, some families and people who used the service spoke negatively about the management of the service. Comments included; "They need training on how to manage and retain staff," "I have nagged the office when carers are not good and slapdash but they are slow to get rid of those ones." Another person told us;"I need them to give specific access information to new carers so they can get in easily. I keep ringing them [the provider] to speak with them but they don't respond to my messages, they seem to just ignore me." Others were positive, and recognised there had been some improvements in the management of the service saying; "I think things are better than they used to be" and "We are on first names with managers."

Providers have a responsibility to comply with the Health and Social Care Act 2008 regulations and submit statutory notifications to the Care Quality Commission (CQC) when any event which may impact on their service provision occurs. At the last inspection in September we raised concerns the provider had not met this responsibility. On the 9 January 2015 the local authority advised the provider that a safeguarding alert had been raised regarding the care of a person who was receiving a service from the provider. At the time of the inspection the provider had failed to notify the CQC of this safeguarding alert.

This is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The service carried out regular quality assurance checks of care files. Information recorded by care staff was reviewed and the person and/ or their family or representative were asked about their experience of receiving care. The PIR stated;"quality assurance procedures we have in place ensure each of these aspects of a customers' care and support package are monitored closely and changes can be negotiated." We saw positive comments from some people however, one quality control check in September 2014 for one person stated, "needs 8.30 (visit) as goes to day centre" The family of this person told us they were regularly experiencing late visits which meant the person could not attend the day centre on time and delayed the family leaving for work. We saw a further quality control check in January 2015 which repeated the request, "needs to have 8.30 (visit) as goes to day centre." The family confirmed the timing of this person's visits was still not always at the time they agreed and did cause stress and anxiety. This meant the quality control checks were not effective in bringing about improvements in the service delivered to some people.

The training records were held in subject categories such as health and safety, food hygiene and safeguarding adults. The provider stated in the PIR that 55 staff had received training in food hygiene and health and safety. However, the registered manager's records did not contain the names of all 55 staff. The records of both food hygiene and health and safety contained the names of 50 staff not 55. The safeguarding adults training records contained the names of 49 staff as stated in the PIR. However, this meant the service could not effectively monitor the training needs for all 55 staff as they did not have an accurate record for each staff member.

The service had commissioned the assistance of two consultants to support the service to meet the requirements of the regulations. One consultant had been working with the service since our last inspection in September 2014. Some improvement was seen as a result of this support. The quality of the information gathered and recorded at the office had improved. The service used a new electronic call monitoring system which had improved their ability to monitor the service provided. However, this information did not always reflect the experiences of people using the service, or their families. For example, missed or late visits where care at a later time had been declined for good reason, i.e care required was time sensitive, but was not clearly recorded as such.

The service had a mission statement on their headed paper which stated "One day we'll all be cared for this way." Improvements seen at the office of the service were not always reflected in some people's experiences of receiving a service in their homes on a daily basis. We found there

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was a disconnect between the quality of information at the office and the effective use of that information in the practical provision of appropriate and timely care and support for some people who used the service.

This meant the service was continuing to not meet the requirements of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to the regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Daily visits were recorded by care staff in people's homes. Daily records were being returned from most people's homes regularly. These were found to have been audited in people's files. The audit record showed the daily notes had been read and any issues with what was recorded were noted. For example we saw one person was required to have their visit before a specific time in order to attend the day centre, and help ensure their family could go to work knowing their family member was safely cared for. This person's audit record stated the time of the morning visit was not meeting the person, or their families' needs. The family reported missing important business meetings due to having to wait for care visits to be made. The next audit note in this person's file repeated the same issue. This meant the audit was not effective in bringing about improvement in the service provided. There were a small number of daily records held at the office awaiting audit and filing. This meant the service was able to monitor the visits made to people by staff. This was an improvement from our last inspection when we found boxes of such records which had not been monitored, audited or filed. However, some people continued to experience missed shortened and late visits. This meant the quality assurance process was not effective. The service was not using its auditing and feedback mechanisms to consistently improve the service.

The registered manager and the provider were present at the office during each of our inspections. Staff confirmed they were present every day. Some people that used the service, and their families, told us they did not feel the leadership of the service was effective. They told us; "The chap in charge does not know what he is doing but he is still there" and, "No I don't I feel management staff are effective at all". One person contacted the Care Quality Commission to tell us of their frustration with not being able to contact the management; "I have been trying to speak to the management for ages, they won't speak to me". People did not feel the provider always responded to their attempts to speak with them.

Senior managers were adequately available to staff if needed. The registered manager was seen throughout this inspection working in the operational office areas supporting staff

The provider stated in the PIR; "We work in a co-productive manner to ensure where unmet needs can be met then they are to keep people who wish to remain in their own homes do so". The family of one person, who had experienced poor outcomes, told us the provider had never been in contact with the family to alert them to any missed or late visits previously. As reported in earlier sections of this report the provider did not always work with people and their families or representatives to ensure the service provided care that met people's needs.

There had been repeated concerns raised by people who received care about one particular member of staff. This person was raised as a concern by many service users at our last inspection in September 2014. We were told there had been problems with "a certain individual carer" they felt the office "were slow in removing and sorting it." We found the provider had met with the staff member on many occasions to discuss their conduct and the concerns people had raised with the provider. The provider was taking final warning action against this member of staff. At previous inspections we found that the provided had failed to take appropriate disciplinary action against staff when necessary. We saw that since our last inspection the provider had started to take disciplinary action against some staff. We saw one member of staff had been dismissed and another was subject to on-going performance management measures. The provider was taking adequate action to address this concern.

The number of people receiving support from the service had reduced since the last inspection from 137 to 100 with staffing levels remaining at a similar level. Staff told us they felt "less stressed" and "able to get things done at a reasonable pace". The rotas had improved recently and were easier to manage. Travel time was built in between most visits and this enabled staff to achieve more visits as scheduled for them. Staff reported being well supported by the management. They told us; "I get regular meetings with my manager and if we ring the office because we cannot

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manage a visit they take it off us." At this inspection the visit rotas were being written by a member of staff who had knowledge of the people who used the service and who had practical recent experience of working to a rota. They were aware of the time it took to travel from one person to another. This helped ensure the scheduling of visits was more effective, although missed, late and shortened visits remained a concern for some people using the service.

The service had developed a new Customer Preference Form which was going to be offered to all people who used the service to gain their views and wishes. A recent audit of a survey showed the responses from 14 people. It stated people were mostly satisfied with the service they received.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person must notify the Commission without delay of the incidents specified in paragraph (2) which occur whilst services are being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity. Regulation 18 (1) (2) (e)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must enable the registered person, in particular to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). Regulation 17 (1) (2) (a) (b)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe. Regulation 9 (1) (b) (i) (ii)