Direct Health (UK) Limited

Direct Health (Preston)

Inspection report

2A Moor Park Avenue
Preston PR1 6AS
Tel: 01772 883822

Date of inspection visit: 25/02/2015 & 06/03/2015
Date of publication: 22/05/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Direct Health (UK) is a limited company providing domiciliary care throughout the country. Direct Health (Preston) is a local branch situated on the outskirts of Preston City Centre. The agency provides personal care services to support people to live independently in the community. At the time of our inspection there were 153 people using the service and 70 care workers appointed.

We last inspected this location on 11th July 2013, when we found the service to be compliant with the regulations we assessed at that time. This inspection was conducted on 25th February 2015 and 6th March 2015. The provider was given 48 hours notice of our planned visit. This meant someone would be available to provide us with the records and documents we requested.

A registered manager was not in post at the time of our inspection. However, there was an acting manager appointed, who was in the process of applying for registration with the Care Quality Commission (CQC). The acting manager was on duty on both days we visited the agency office. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

New employees were provided with an induction programme and were supported to gain confidence and

Summary of findings

the ability to deliver the care people needed. However, our findings demonstrated that the registered person did not always protect people against the risks of receiving inappropriate or unsafe care or treatment, by means of managing risks relating to people's health, welfare and safety. We have made a recommendation about infection control measures.

Records showed that staff had completed training in safeguarding adults. The staff team were confident in reporting any concerns about a person's safety and were competent to deliver the care and support needed by those who used the service. Records showed that staff who had been recruited more recently had gone through more robust recruitment practices. This helped to ensure that only suitable people were appointed to work with this vulnerable client group.

The staff team were provided with a range of learning modules. This helped to ensure they were trained to meet people's health and social care needs. However, records demonstrated that formal supervision for staff was irregular and appraisals were not currently being conducted. This did not promote a well monitored staff team.

Staff were kind and caring towards those they supported and people were helped to maintain their independence with their dignity being respected at all times. However, plans of care were not person centred and people who lived in the community did not always receive care and support in a consistent way, because care workers were often changed, late for visits and in some cases did not arrive at all. This was a recurring theme from discussions with people who used Direct Health, their relatives and from the evidence we gathered. This demonstrated unreliability of the service and reflected a breach of regulations.

Our findings demonstrated that the registered person did not consistently protect people against risks associated with the unsafe management of medicines, by means of making appropriate arrangements for proper recording and safe use of medicines.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These related to safety, the management of risk, staff support, record keeping, care and welfare, medicines and infection control arrangements. These breaches of regulations corresponded to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for person centred care, safeguarding service users from abuse and improper treatment, good governance, staffing, safe care and treatment.

You can see what action we told the provider to take at the back of the full version of this 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

This service was not safe.

People we spoke with said they felt safe using the service and records showed that staff had received training in safeguarding adults. However, there was evidence to demonstrate that people's safety was compromised due to poor moving and handling techniques and inconsistent care and support for those who used the service.

Recruitment practices were recently more robust, which helped to ensure that people appointed were suitable to work with this vulnerable client group.

The management of risks was not always robust and therefore people were not always protected from harm. Records showed staff had completed training in infection control. However, infection control policies and procedures were not always followed in day-to-day practice.

The management of medications put people at risk because medicines were not always given as prescribed and medication records did not ensure a robust system was in place to safeguard people from medication errors.

Is the service effective?

Requires improvement

This service was not effective.

Staff appointed received an induction programme, which helped them to understand the policies, procedures and practices of the service. However the induction records could have been more detailed.

The staff team completed a range of training modules, which helped them to improve their personal development and to better support those in their care.

Although we found staff to be observed at work, formal supervisions and appraisals for staff were sporadic. However, the new manager had recognised this area was in need of improvement, so had plans in place to develop more structured staff evaluations.

Is the service caring?

Requires improvement

This service was not consistently caring.

People who used the service could not always be sure that the care worker allocated to each visit would be adequately knowledgeable about their specific care needs. We gathered sufficient evidence to show that staff were changed regularly and therefore continuity of care was not always promoted.

We spoke with staff members about the support they provided for people they visited regularly and we found they were able to discuss the needs of those they knew well. They were fully aware of the importance of promoting independence and respecting privacy and dignity.

Summary of findings

Is the service responsive?

Requires improvement

This service was not responsive.

We saw support plans were retained in people's own homes and an assessment of people's needs had been conducted before a package of care was arranged.

The plans of care had been developed with the person who received the care and support or their relative. However, not all sections were completed and they lacked information in some areas. Vague statements were regularly used and information was lacking.

Therefore the plans of care were not person centred and did not provide staff with clear guidance about how care and support needed to be delivered. People we spoke with were un happy about the reliability of the service.

Is the service well-led?

Requires improvement

At the time of our inspection of this location a registered manager was not in post. However, an acting manager had been appointed, who was in the process of applying to the Care Quality Commission (CQC) for registration as manager of this service.

Meetings for staff were not routinely held on a regular basis. However, the new manager had arranged some during the coming months.

Recent surveys had been conducted, so people could provide their feedback and a quality audit had been conducted by the company, which highlighted 30 recommendations, some of which were in line with areas we identified as in need of improvement at the time of our inspection.

Record keeping was disorganised, making information difficult to find. Some records were poorly maintained and lacked significant information.

People who used the service who we spoke with were not happy about the consistency of care workers, which were sometimes unreliable.

Direct Health (Preston)

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. We also looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

This inspection was carried out on 25th February 2015 and 6th March 2015 by two Adult Social Care inspectors from the Care Quality Commission. At the time of our inspection of this location there were 153 people who used the service. We spoke with 23 of them or their relatives and we visited three people in their own homes. We also spoke with seven staff members, the acting manager and two regional managers during the course of our inspection.

We visited three people who used the service, when we were able observe one member of staff at work. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed. We also looked at a wide range of records, including the care files of ten people who used the service, the personnel records of four staff members, a variety of policies and procedures, training records, medication records and quality monitoring systems.

Prior to this inspection we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us since our last inspection. Some concerns had been raised about missed calls, the high turnover of staff and male care workers being allocated to attend to the personal care needs of females who used the service. We took this information into consideration when planning this inspection.

Requires improvement

Is the service safe?

Our findings

People we spoke with said they felt safe whilst using the service. Records showed that some areas of potential harm had been assessed within a risk management framework, with reviews being conducted every six months. These identified potential hazards and control measures implemented in order to reduce the likelihood of harm within these specific areas. Action plans were then developed from this information and dates recorded on completion. We saw that risk assessments had been completed for those at risk of falling. However, these were vague and lacked detailed information about supporting people to move around safely. For example, there was no direction for staff about the use of equipment, ensuring a safe environment free from unnecessary obstacles or ensuring good fitting footwear.

Risk assessments had not been developed around areas, such as mental health needs, medications or equipment, so that staff were fully aware of how to safeguard those they supported and one risk assessment just read, 'Blackouts' and 'Epileptic.' This was insufficient and needed to be more informative, providing staff with clear guidance about action they needed to take, should this person become unwell.

We had received information about staff not carrying out visits to people in the community as planned. We established that on one occasion a member of staff had failed to attend five visits in one day and although cover was eventually arranged, this was later than expected. When asked about this situation we were told by the branch manager that there had been a communication failure between the agency office and the care worker. Other missed calls were identified during our inspection. For example, two calls for the same person had not been set up on the booking system and four calls were missed to a person who was blind within one week. This did not promote a safe service and could have potentially put people at risk.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of this report.

The complaints record highlighted concerns that two members of staff had operated a hoist inappropriately and unsafely, which had resulted in the person who used the service sustaining some injuries. These concerns were reported by the service to the commissioning authority under safeguarding procedures and to the Care Quality Commission (CQC). An internal investigation was conducted and appropriate disciplinary action taken in relation to the two members of care staff. Records showed that both members of staff had done moving and handling training within the last year. However, additional training had been arranged, but this was several weeks later. This delay could have resulted in further issues around moving and handling techniques, as they were both still providing care and support for those who lived in the community.

A further incident had occurred, which resulted in injury to one person following a fall during the night, which was not reported at the time by the care worker, who was supporting the individual. This was later reported to the appropriate authorities and action was taken against the staff member for failing to report an incident, which could have resulted in injury.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The medication policies and procedures of the service were detailed and included how people should be supported to manage their own medicines. Clear definitions were also provided for staff, which outlined the differences between instructions, such as 'prompt', 'assist' and 'administer'. Areas that care workers must not attempt were also highlighted. For example, they must not give injections or administer rectal medications.

We looked at the Medication Administration Records (MARs) of two people who used the service. We found all entries were hand written, but none had been signed, witnessed or counter signed to reduce the possibility of any transcription errors. The letter 'T' was repeatedly entered on the MAR charts, where a signature would have been if the medication had been taken. However, 'T' did not correspond with any symbols identified in the key grid to show a medication had been omitted and the management team could not explain the reason for the letter T being inserted.

Requires improvement

Is the service safe?

The instructions on the MAR chart for one person stated, 'Codeine Phosphate 15mgs one or two tablets four times a day.' This medication was only signed for twice a day and it did not always indicate how much had been taken. Lactulose was prescribed once a day, but it was taken twice a day. One entry on the MAR chart was illegible, but staff had signed to indicate the medicine had been taken. Therefore, this person was at risk of receiving inappropriate and unsafe management of medications.

The support plan for one person who used the service provided contradictory instructions for staff in relation to medications. Some records instructed staff to prompt and witness medications, but others told staff to administer medicines. This information was confusing and could potentially result in the individual receiving inappropriate or unsafe care and support. A medication risk assessment for this person had not been completed.

Records showed one person was receiving oxygen, with instructions for staff, 'To remember to turn it (the oxygen cylinder) on at 4pm.' This instruction lacked clarity and did not provide enough information for staff about the reason for oxygen being given, how many litres of oxygen was to be administered and for how long. There was no risk assessment in place about safety when administering oxygen or safety in relation to the equipment used.

Oxygen must be considered as a medication and therefore it must be prescribed. The use of oxygen must be clearly documented. Therefore, if care staff are responsible in any way for the administration of oxygen, then the Royal Pharmaceutical Society of Great Britain guidance must be followed and adequate education regarding safety of oxygen therapy should be established.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that staff had completed training in safeguarding adults and those we spoke with were fully aware of whistle blowing policies, to ensure any actual or potential allegations of abuse were appropriately reported without delay. Accident records were retained in line with data protection guidelines. This meant personal details were kept in a confidential manner.

Staff members we spoke with told us they were often required to travel distances to visit people, when local calls were available. This could often results in care workers running late, because of distance and traffic congestion. They also told us that they were provided with duty rotas, but these were often changed without notice. People told us there had been a high turnover of staff within the last 12 months. Records we saw indicated that 40 care workers had left employment within the last year. However, the new manager confirmed this record was inaccurate and the number actually leaving the agency during the last twelve months was 25, which was still considered to be excessive.

A business continuity plan had been developed, which helped to ensure continued service in the event of a variety of emergency situations, such as flood, severe weather conditions, flu pandemic or power failure. Staff we spoke with were aware of action they needed to take in the event of a medical emergency, such as a person collapsing or if there was no response when they visited someone in the community, who would have been expected to be at home.

Some staff members talked us through their recruitment and selection process. They confirmed that they had submitted completed application forms, had formal interviews and that references and police checks had been conducted before they started to work in the community.

We looked at the personnel records of four staff members. We found recruitment practices for two who had been employed several years ago were not robust. Written references were dated after people had started work with the agency. One staff file had only one reference included and the criminal record check in another had been received after the person had started work. However, the two more recently appointed members of staff, recruited last year had been thoroughly checked before they started work. Detailed application forms had been completed and recorded interviews were conducted. Two written references had been received and Disclosure and Barring Service (DBS) checks carried out. A DBS allows the provider to check if a prospective employee has been involved in any known criminal activity. The health status of prospective employees had been explored and appropriate identification was produced.

We discussed recruitment practices with the regional managers during our visit to the agency office. We were told staff members used to commence their induction

Requires improvement

Is the service safe?

programmes before checks were validated, such as references and police disclosures. The regional managers confirmed that staff did not visit people in their own homes until all checks had been received.

Records showed staff had completed training in infection control and those we spoke with confirmed this to be accurate. However, several people who used the service reported some staff did not wear protective clothing when attending to people's needs, so that the risk of cross infection was minimised. We recommend that additional training is provided for staff about the importance of wearing Personal Protective Equipment (PPE) and that the provider monitors it's use by staff.

Requires improvement

Is the service effective?

Our findings

Staff members spoken with confirmed they had completed an induction programme, which was recorded and which included safeguarding adults. We looked at the personnel records of four members of staff, which showed they had completed a period of induction when they started working for the agency. However, the standard of recording information varied. Some induction records provided a breakdown of topics covered, but others did not show auditable evidence of any learning modules completed during the induction programme.

We saw recorded assessments of staff competencies, on site observations and spot checks on staff member's work performance. Together these assessments covered areas, such as medication awareness, time keeping, appearance, conduct, communication, health and safety and use of equipment. However, although records showed some supervision sessions were held for staff, these were sporadic and. appraisal records were not seen. The new manager confirmed that supervisions and appraisals for staff were not well organised, but that it was her intention to develop a structured approach to formally monitoring staff work performance and training needs through regular supervision sessions and annual appraisals.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The system for staff signing in when they arrived at a person's home and on leaving was explained to us. This enabled office managers to monitor the length of visits and be aware of any late or missed calls. One member of staff spoken with told us mobile phones and fob security systems were regularly not working. However, the fob system we noted was operational in the homes we visited and care workers we contacted by mobile phone answered promptly.

Records showed people had been asked for their consent in several different areas, including sharing of personal information with medical professionals and staff use of telephones in the case of an emergency. People we spoke with and those we visited had capacity to make decisions and therefore implementation of the Mental Capacity Act was not needed on this occasion.

Staff members we spoke with told us all new staff shadowed senior staff when they first started working for Direct Health. Staff were also issued with a range of information to help them to do the job expected of them, such as job descriptions relevant to their role, terms and conditions of employment and a staff handbook. One member of staff said, "I had everything I needed before I started work. My induction lasted about two weeks. I did quite a few shadowing shifts before I did visits on my own."

Training certificates showed staff had completed a range of learning modules, in areas, such as moving and handling, infection control, health and safety, safeguarding adults, dementia awareness, medication, tissue viability, food hygiene and the Mental Capacity Act. Some areas of learning were supported by detailed workbooks for some members of staff. We noted that a good percentage of staff had achieved a recognised qualification in care. This helped to ensure the staff team were well trained. However, we noted that the training matrix, which was designed to show at a glance training that had been completed by individual staff, was not up to date and significant gaps were evident. This did not help the manager to effectively audit training programmes for staff and therefore accurately evaluate their personal development. Members of staff we spoke with gave some examples of training they had completed in accordance with the certificates seen. One staff member told us of additional training he had completed, such as dementia awareness and uridom management.

Requires improvement

Is the service caring?

Our findings

When asked about involvement in her husband's care one relative commented, "Yes I do feel involved. In fact I feel in charge of my husband ` 's care. I can call the manager at any time to discuss anything I am not happy with."

Another relative we spoke with said, "I must say when the carers come, they are very patient and caring with my husband. They all love him. They talk to him all the time even though he cannot talk back and that's nice."

People we spoke with felt it was often difficult to develop relationships with staff members, because they changed so frequently. One person said, "We get to know a carer well and she gets to know us. We chat about our families and anything that is going on in our lives and then they are gone to look after someone else or they leave. It is quite sad sometimes." This situation needed to be addressed by the provider.

We visited one person in the community, who was receiving care from an agency worker at the time we called. This member of staff demonstrated a gentle and friendly approach towards the person she was supporting. She was very polite, well-mannered and kind and completed all the required tasks during her visit, to the satisfaction of the person who used the service.

Policies and procedures of the agency covered areas, such as equality and diversity, principles of care, confidentiality, dignity and wellbeing. These helped staff to understand the importance of respecting people as individuals and aided in protecting their privacy and dignity.

The statement of purpose provided people with information about Direct Health, as well as the services and facilities available for people in the community. The mission statement of the agency included in the Service Users' Guide read, 'Our aim is to enable our customers to live independently at home, by delivering personalised care and support tailored specifically to their individual needs.'

We spoke with staff members about the support they provided for people they visited regularly and we found they were able to discuss the needs of those they knew well. They were fully aware of the importance of promoting independence and respecting privacy and dignity.

Staff members explained to us how they always informed people of what they were going to do before any activity was carried out. They also said they ensure people are happy with how they do things for them. One said, "Each and every one of the service users has their own preferred ways of doing things and we need to respect these."

We saw many letters of thanks had been received by the service. One read, 'Over the past twelve months the care that you all gave to (name removed) was exemplary. Every carer who came to the house brought happiness in with them.' And, 'Thank you so much for all your help and kindness. We will miss you all so very much.'

Requires improvement

Is the service responsive?

Our findings

The service was not consistently responsive because people could not be guaranteed staff who knew them well or who understood their individual needs and preferences. One relative told us that a new care worker had been sent to provide support for her husband who had swallowing difficulties and was at risk of choking. She said the carer was very nice, but had no knowledge about how to care for someone with swallowing difficulties.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A common theme when talking with people was that staff were quite often late for a visit and on several occasions, staff did not turn up at all. We were told some staff did not call people to advise them they were going to be late and people said different care workers attending was a regular occurrence. Those we spoke with said they would much prefer the same care workers. This would promote continuity of care and would enable people to build up trusting relationships with their care workers.

Additional comments received from people who used the services of Direct Health, or their relative included: "Different carers come in, which is not great I don't think. I have asked for the same carers several times, but they still have not got back to me so I don't think it is going to happen."

"They're not always on time, but they ring. We don't always get the same carers, but I still think they are brilliant. They work so hard."

One relative told us of her frustrations with the inconsistency of staff. She said she was 'sick' of getting different carers and swapping times. She told us, "If you say anything you get told, 'It's what we give you or nothing at all.' Staff are always on sick or are leaving, so it's a continual thing. It's up and down all the time and you don't know half of the carers." She gave an example of an 8.30am call being altered to 7am, which was not suitable for the person who used the service. We saw a lot of evidence to demonstrate care and support was inconsistent.

People who used the service and their relatives were not happy about the consistency of care workers, which were sometimes unreliable, as they were regularly changed, late or sometimes did not arrive at all. People were sometimes notified if care workers were going to be changed, late, or if a visit could not be covered, but often this did not happen in sufficient time. This put people at risk of receiving unsafe or inappropriate care and support.

The support plans included the importance of promoting people's privacy and dignity and supporting them to maintain their independence. However, not all sections were completed and they lacked information in some areas. For example, there was no reference to health conditions, such as Alzheimer's disease, epilepsy or depression for those who had been diagnosed with such conditions. Therefore, staff were not provided with any guidance about how to manage people with these illnesses. Some vague statements were recorded such as, 'Poor mobility', 'Uses walking aid' and 'Prone to falling.' These did not provided staff with clear guidance about how people were to be supported.

Some information provided in the support plans was not person centred. For example, one record stated, 'Make sure (name removed) has eaten and help her make breakfast. If not make her a cup of tea.' These directions did not tell staff what this person liked for her breakfast and how she liked her tea. Another support plan read, 'Help her to dress', but guidance about how this person liked to dress was not evident. For example if she preferred casual or smart attire, or trousers instead of a skirt. And a third recorded, 'I require oil on my legs to prevent my skin from tearing', but the type of oil needed was not documented.

These shortfall in the service provision amounted to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the course of our inspection we looked at the care records of ten people who used the service. We also spoke with 23 people or their relatives by telephone and visited three in their own homes. One person we spoke with told us, "I am quite impressed with the carers. Any problems I am the first to know. I am thinking of something I could complain about, but honestly I can't. I wouldn't go anywhere else."

Requires improvement

Is the service responsive?

We saw support plans were retained in people's own homes and care staff generally completed a diary sheet on every visit. However, we noted one support plan was not up to date. Records we saw showed an assessment of people's needs had been conducted before a package of care was arranged. This helped the staff team to be confident they could provide the care and support people required. Care files gave a good summary of people's life history. This helped staff to understand individuals better and to instigate interesting conversations with those in their care.

The support plans recorded people's allergies and preferred terms of address and they had been developed with the person who received the care and support or their relative. It was evident that females who used the service were asked which gender of staff they would prefer to support them. For one person a section headed, 'special instructions' had been developed for their pet dog, Suzie, which was important to Suzie's owner, as this instructed staff to ensure the pet dog had sufficient fresh water to drink.

Records showed people's needs had been reviewed every six months, or more often if circumstances had changed and the person who used the service or their relative had agreed in writing with the content of their plan of care.

A system was in place, so people could make a complaint if they needed to do so. Records showed two complaints had been made this year in relation to negligence. These had been followed up by the service, although additional moving and handling training for two staff members could have been more promptly addressed. One person who used the service told us, "I have complained in the past but I must say it was sorted out in no time at all. They were very good." Staff spoken with told us they would know how to deal with a complaint, should someone in their care be dissatisfied with the service provided.

All three people we visited were generally happy with the service they received, but thought there was a high turnover of staff, which resulted in different carers calling to support them with their needs. One relative told us, "I just wish we could have the same carers coming more often. We just get used to them and then they either leave or are sent somewhere else. I don't understand that."

Requires improvement

Is the service well-led?

Our findings

We found paper work to be disorganised. Information was difficult to find and some vital details were missing from some records. It took some time for training records to be located. They were eventually found stored in boxes in a room within the agency office. Records in relation to persons employed at the service must be retained, so they can be located promptly when required.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (1)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "They (the staff) have made my life a lot easier. A few days back someone rang to ask how dad was, which was nice." Another commented, "I am very happy with the service. I know the manager; she is very nice, so if I had any problems I would just ring the office."

A relative we spoke with said, "The manager has been out and talked to us a few times. I live here with my mum and I see what happens and I am 100% satisfied."

At the time of our inspection of this location a registered manager was not in post. However, an acting manager had been appointed, who was in the process of applying to the Care Quality Commission (CQC) for registration as manager of this service. We had evidence of this being in progress. There was no gap between the previous manager leaving the service and commencement of the new manager. Staff spoken with said they could talk to their immediate supervisors if they had any problems or complaints to make. One member of staff told us, "It's good. I enjoy the work. I love my job." Another commented, "I enjoy it very much. I like working for Direct Health. It is the only agency I have actually been happy working for."

Some staff had not been made aware of a new manager starting at Direct Health. This did not demonstrate openness and good communication from the management team to all staff members.

Systems were in place for gathering feedback from people who used the service and their relatives or main carers. Questionnaires were circulated annually, which offered people the opportunity to express their views about the service provided. The results of these surveys were analysed by the company and published in a percentage format, for easy reference. A report was subsequently published showing areas of good practice and areas which needed improving. Also a 'snappy quality questionnaire' was sent out more frequently. Together the questionnaires covered areas, such as care planning, choices, involving people and communication. Several people we spoke with told us they had completed questionnaires from time to time.

We saw minutes of a probationary meeting with a member of staff, who had been late arriving for a visit to a person who used the service.

A wide range of updated policies and procedures were in place at the agency office. These included whistle-blowing procedures, health and safety, the Mental Capacity Act, complaints, disciplinary and grievance procedures, dignity and infection control.

We saw minutes of the last staff meeting, which was held eight months previously when three staff members were in attendance. The new manager told us there were no meetings currently held, but that she had scheduled several in over the next few months.

We saw records of a detailed quality audit, which was conducted in January 2015 by a company representative. This assessment highlighted 30 recommendations, which showed the agency was not operating efficiently. However, an action plan had been developed as a result of the audit and we were told this was being addressed by the new manager of the agency. This quality audit was designed in line with the Care Quality Commissions (CQC) five key questions and covered areas, such as care planning, medication, complaints, compliments, safeguarding adults, accidents, training and recruitment. This quality audit conducted by the company had highlighted many of the areas found to be in need of improvement at this inspection. The acting manager had started to work through the action plan developed in response to this quality audit.

An audit of staff files had been conducted, which identified where information was missing. A letter was then sent to the relevant employee requesting necessary documents to be forwarded. This system worked for people who were more recently appointed, where we found recruitment practices to be robust.

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 9 HSCA (RA) Regulations 2014 Person-centred care Proper steps had not always been taken to ensure people were protected against the risks of receiving inappropriate or unsafe care or treatment. This was because care and support was not person centred. Regulation 9(1) and (3)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who used the service were not protected against the risks associated with the unsafe use and management of medicines. This was because appropriate arrangements had not been made for the recording, using and safe administration of medicines. Regulation 12(1)and (2)(g).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who used the service were not protected against the risks of unsafe or inappropriate care because accurate records were not always maintained and records could not be located promptly when required. Regulation 17(2)(c)(d)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who used the service were not protected against the risks of inappropriate care because the systems for assessing and monitoring the quality of service were not robust, risks had not been well managed, the service was unreliable and some staff providing care and support did not have the competence, skills and experience to do so safely Regulation 12 (1)and (2)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Suitable arrangements were not in place in order to ensure that persons employed were able to deliver care to people safely and to an appropriate standard. This was because appropriate induction, training, supervision and appraisal were not arranged for all staff members. Regulation 18(2)(a)