Direct Health (UK) Limited

Direct Health (Stockton on Tees)

Inspection report

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Date of inspection visit:
30 March 2016
04 April 2016

Date of publication:
09 August 2016

Ratings

Overall rating for this service	Inadequate ●

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

Summary of findings

Overall summary

We undertook an announced inspection of Direct Health Stockton on 30 March 2016 and 4 April 2016. We told the provider two days before our visit that we would be inspecting, this was to ensure the manager would be available during our visit.

Direct Health (Stockton) provides personal care for people in their own homes in Stockton, Billingham, Eaglescliffe and Yarm. It is a large service, providing care to approximately 700 people and employing approximately 200 staff at the time of this inspection.

The service had appointed a manager in January 2015, who at the time of inspection had applied to become registered with the Care Quality Commission. 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.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. Improvements were needed in many areas where the provider was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In September 2015 we completed an inspection and issued a formal warning telling the registered provider that by 1 February and 1 March 2016 they must improve the following areas.
- Regulation 12: People did not receive safe care and treatment due to the registered provider failing to effectively assess and mitigate the risks to service users.
- Regulation 17: The registered provider was failing to operate and establish effective systems or processes and to assess, monitor and improve the quality and safety of services provided and mitigate risks relating to the health, safety and welfare of service users.
- Regulation 18: The registered provider was failing to ensure that staff receive appropriate training as is necessary to enable them to fulfil the requirements of their role.

We reviewed the action the registered provider had taken to address the above breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also checked what action had been taken to rectify the breaches we also identified of regulation 9 (Person-centred care) and regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following our last inspection The registered provider sent us an action plan stating they would be compliant by 1 March 2016.

During this inspection we found

No improvements had been made to the medicine management systems since the last inspection in fact the administration of medication was worse. For example we found that the registered provider failed to ensure staff obtained information about changes to people's warfarin medication and at times the staff we administering the wrong doses. We found that the service was failing to provide safe care and treatment by the proper and safe management of medicines.

Clear and accurate records were not being kept of medicines administered by care workers. Gaps in the medicines administration records meant we could not be sure people were always given their prescribed medicines. Details of the strengths and dosages of some medicines were not recorded. Care plans and risk assessments did not support the safe handling of people's medicines.

Although some risks were identified at initial assessment both from the local authority and Direct Health, care records gave staff limited or no guidance about the ways to meet people's needs and minimise risks.

The service had one quality monitoring audit which had taken place in February 2016. Areas needing action from this audit had to be completed by March 31 2016. However we found that the staff had not completed all of the actions. No further audits took place, which meant that the registered provider had not checked that the actions were either completed or effective.

There were no processes for recording accidents and incidents for people who used the service.

We found that the information the management team gave us about who the people the service supported was incorrect and we phoned people who no longer used Direct Health provision.

We found the service did not have enough staff and there was insufficient capacity to consistently deliver people's care. Many staff had left employment and there were pressures on care workers to work extra hours. People who used the service did not always receive a rota and when they did the rota contained a number of unallocated calls or where a named carer was listed another carer would turn up. Management of the staff rotas was not effective and the management information around times staff called differed from the actual time the staff went to the person's home. The managers could not provide information to show when staff could not come to work evidence that other staff had covered their work.

We saw the services training chart and a selection of certificates. The services training policy stated that moving and handling, safeguarding and medication training was to be refreshed yearly. Over 30 percent of staff had not received this refresher training.

Staff did not receive regular supervisions and a yearly appraisal. The services supervision policy did not reflect the local authority contract. We could not confirm that the service performed regular spot checks on staff, to make sure they were working within safe practices.

Staff said they did not feel supported by the manager.

Staff knew the people they were supporting regularly well, however where they were covering other people's calls they did not know enough about these people to be assured that all of their needs were met. Care plans and phone records provided limited information.

Care files we looked at had limited person centred information and due to the lack of continuity of care not many people were receiving a personal service.

The area manager and staff had an understanding of the Mental Capacity Act 2005 and had received training in this area to meet people's care needs. Care staff had also received awareness training in the Mental Capacity Act. We found the mental capacity form within the care plan to have typographical errors which could cause confusion. We found that staff incorrectly completed mental capacity assessments and failed to accurately determine when someone lacked capacity to make decision. We saw that staff did not complete best interest in line with the requirements of the Mental Capacity Act 2005. Thus they did not involve external healthcare professionals in the decision making process and were making best interest decisions for people who had capacity. For example staff routinely hid people's medication and only shared the storage place via text with each other. Staff told us this occurred for everyone but could not explain why or if people had given permission for this to happen.

We looked at the complaints and compliments file, eight of the 47 complaints listed had been closed. Several complaints were awaiting outcomes and there was no indication whether those that had been closed were resolved to the satisfaction of the complainant.

Recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work. This included obtaining references from previous employers and we saw evidence that a Disclosure and Barring Service (DBS) check had been completed before they started work at the service. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. To help employers make safer recruiting decisions and also to minimise the risk of unsuitable people working with children and vulnerable adults. We found employment gaps in one person's record and we made the area manager aware of this.

The registered provider had policies and procedures in place which were there to protect people from abuse. Staff we spoke with understood the types of abuse and what the procedure was to report any such incidents. Records showed staff had received training in how to safeguard adults. A whistleblowing policy [where staff could raise concerns about the service, staff practices or registered provider] was also in place. Staff we spoke with demonstrated what process to follow when raising concerns.

Staff we spoke with said they had access to plenty of personal protective equipment (PPE).

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not always safe.

People were at risk because appropriate arrangements were not in place to handle and administer medicines safely.

Risks relating to the health, safety and welfare of people had not been properly assessed and responded to.

There were shortfalls in respect of the number of suitably qualified, skilled and experienced staff.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of safeguarding vulnerable adults procedures.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Staff were not adequately trained or supported to deliver effective care.

Supervisions and appraisals were not taking place.

People's capacity to make decisions and best interest decision were not completed in line with the requirements of the Mental Capacity Act 2005.

People consent was not sought in respect of the way their care was provided.

Is the service caring?

Requires Improvement ●

The service was not always caring.

People who used the service were very happy with the care staff.

Regular staff were respectful of people's privacy and dignity. However the constant change in staffing did not respect people's privacy and dignity.

Care plans did not always contain useful information to help staff build positive relationships with people.

Is the service responsive?

Inadequate ●

The service was not always responsive.

Complaints were not always dealt with in a timely manner and people and staff were not listened to when they expressed their views about the care they received.

Not all care plans were person centred. People new to the service had no care plan in place.

The central team failed to have an accurate list of who they supported.

Is the service well-led?

Inadequate ●

The service was not well-led.

The manager was not yet registered with the Care Quality Commission.

The absence of effective quality monitoring had a significant impact on the health, safety and welfare of people.

The culture of the service was poor. Staff were apprehensive to raise concerns due to fear from office staff.

Direct Health (Stockton on Tees)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection of Direct Health Stockton took place on 30 March 2016 and 4 April 2016. Both inspections were announced. We told the registered provider before our visit that we would be coming to inspect to make sure management would be there for the inspection. Two adult social care inspectors and one pharmacy inspector undertook both days of inspection. Two experts by experience telephoned people in their own homes to gain their views of the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses a service, on this occasion a domiciliary care service.

The provider was asked to complete a provider information return (PIR) and we received this. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. During the inspection the manager was asked to provide information on achievements made with the service and plans for improvement.

Before the inspection we reviewed all the information we held about the home. The information included reports from local authority contract monitoring visits, enquires and notifications and any concerns, complaints and safeguarding information we had received.

During our inspection we went to the registered provider's office and spoke to the area manager, manager, three care coordinators and two care staff. We reviewed the care records of 14 people that used the service, reviewed the records for eight staff and records relating to the management of the service. We also looked at the medicine records of people who used the service. We spoke with staff about medication and reviewed the provider's medication policies.

Of the 12 medication records we looked at, we visited five of the people in their own home to make sure that appropriate arrangements were in place to manage medicines safely. During and after the inspection visit we undertook phone calls to 83 people that used the service and 14 relatives of people that used the service. The service emailed all members of staff a set of questions to respond to on our behalf and we received 21 back.

Inadequate 🟥

Is the service safe?

Our findings

At the September 2015 inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued warning notices because people did not receive safe care and treatment due to the registered provider failing to effectively assess and mitigate the risks to service users.

At this inspection we found that arrangements did not always ensure that the administration of people's prescribed medicines was accurately recorded. Care workers did not always clearly demonstrate exactly which medicines had been administered on each occasion. Details of the strengths and dosages of some medicines were not recorded. We also found gaps in all of the records we looked at, where some dates had not been signed for the administration of medicines. It was therefore not always possible to confirm if people had been given their medicines, or what medicines had been given.

We looked at the current medicines administration record for two people prescribed a medicine with a variable dose, depending on regular blood tests. There was no written confirmation of the current dose and the records of the dose given were not clearly made. Some of the medication for example warfarin if given incorrectly could have caused harm to the individual. The management team had failed to obtain the latest prescription for these variable medications. Therefore neither they nor the staff could be assured the medication was being administered at the correct dose. This meant that arrangements were not in place for the safe administration of this medicine and posed the potential to cause serious harm. We shared these concerns with the local authority safeguarding team.

The provider had a detailed medication policy in place, reviewed January 2016 which stated the different levels of medication support that was provided for individual people. However the definition of the different level of support was not clearly documented, for example level 3 support in the policy was administering medicines in circumstances where medication needs to be given by specialist techniques however in the risk assessments and care plan documents level 3 support was administering medicines but did not necessarily involve specialist techniques.

The level of support that individual people needed was not accurately documented in their care plan. For one person their care plan stated that the person self –administered their medicine; however care staff were now fully supporting this person with medicine administration and the care plan had not been updated. For another person care staff were fully supporting them with morning medication but were leaving out other medication for the person to take at a later time. There was no risk assessment to show that it was safe to leave out the dose of medicines for this person to take at a later time or they were able to independently take the medication. This information would help to ensure people were given their medicines in a safe, consistent and appropriate way.

We asked people who used the service if they were happy with the way staff supported them to take their medicines. People said they were happy, however one person said, "One of the carers who comes, sits outside and has a cigarette before they comes in. Then they come in and get my tablets without washing their hands. They don't put gloves on or tip them into a beaker, they just take them out with their fingers and

I hate the smell of the smoke." Another person said, "The carer forgot to give me my care call button and my tablets, I was very worried going to the bathroom in the night without it [call button]."

We looked in detail at fourteen care records for people receiving personal care. We found significant shortfalls in how risks relating to health, safety and welfare had been recorded. Identified risks during assessment had no risk assessments documented, and where there were risk assessments these provided limited detail and information. For example, On arrival to the office we asked the manager if they had anyone they cared for with a Percutaneous endoscopic gastrostomy (PEG) and we were told no. The manager then said 'yes but just for flushes.' On reading this person's care file we found they had a PEG in-situ for use with fluids to avoid dehydration, not for flushes. There was no risk assessment for this PEG and the PEG was not mentioned on the hydration risk assessment.

People who had key safes outside their homes which staff used to enter, there was no risk assessment. One person said, "Last night the carer let herself in the house using the key safe, and has now lost the key, I am very worried about that." We passed this onto the area manager and it was resolved. Another person said, "My key safe has been left open on several occasions and only being noticed by the next visitor. I am bedridden and worry that the key is available to anyone, it's not safe for me." Risk assessments for bathing people were in place for scalds and burns but just said, 'get the client to consent to the water temperature.'

Another person needed food that was soft and easy to eat and could not eat without support. Their nutrition risk assessment stated 'care support workers to report and record any concerns to the office." No consideration to the possibility of choking and the support needed. This does not follow Nice guidelines NG 21 published September 2015, Home care: delivering personal care and practical support to older people living in their own homes 1.3.14 which states: When assessing risk, balance the risk of a particular behaviour or activity with how it is likely to benefit the person's wellbeing and help improve their quality of life. The named care coordinator, or other practitioners planning home care, should: complete a risk plan with the person as part of the home care planning process and include this in the home care plan, ensure the risk plan includes strategies to minimise risk, for example specialist equipment, use of verbal prompts, use of support from others, ensure the risk plan includes the implications of taking the risk for the person and the care worker, carry out risk assessments as part of home care planning and at relevant intervals, such as when significant factors change.

One person who used the service had a condition called Parkinson's and had a risk assessment on file that had been completed by an occupational therapist. The occupational therapist had identified the person as high risk for moving and handling. The Direct Health risk assessment was a slide sheet and hoist risk assessment which stated 'care workers must follow policies and procedures at all times.' The person's service plan included a question asking if the person had any medical or health conditions, Parkinson's was not mentioned. We were told verbally that this person had communication difficulties. This was not noted in the person's care plan.

Care records did not provide information on certain conditions such as diabetes. There was no information available to staff on any diabetic complications and what staff would need to do if they entered someone's home and they were experiencing a hyperglycaemic or hypoglycaemic attack [high and low blood glucose levels]. This had been highlighted at the inspection in September 2015.

We asked people who used the service if they felt safe with Direct Health. One person we spoke with said they felt safe with the regular carers, but did not feel safe with the younger, less experienced carers. They were not happy with the inconsistency of carers visiting. Saying "I worry when I have a younger less experienced carer helping me to wash, particularly in the evening when my husband is at work." Another person said, "Some are better than others, regulars are good but they send new people who don't know what they are doing." And another said, "On the whole they are very good, they arrive on time, and I feel safe with them here to help me wash." Another person said, "I feel safer with the female carers, and I have asked that they don't send male carers but I still get them." And another person said, "I have between 10 and 12 different carers, many who are inexperienced and unable to transfer me I feel very unsafe with some of them." And "One carer left the brake off the commode on two occasions, and laughed when I told her it was moving, I don't feel safe." Other comments included, "I wish they'd let me know who is coming because I don't like it when a strange person arrives at my back door. I feel uneasy." "Staff don't seem to know what they are doing. The ladies who come are excellent but they send men sometimes and they don't seem to be trained properly at all. One man who came helped me to get into the shower and then he left me and said, 'right, I'll go downstairs and make your coffee.' I'm not steady on my feet and the shower is slippery. He shouldn't have left me on my own. What if I'd fallen?" and "I feel safe with them but it's not nice having strangers."

One relative we spoke with said, "We made a point of saying that my relative did not want any male carers. The carers have access using a key safe and she was dozing in the chair one day. She woke up to find a man standing over her and it was one of the carers. I was really angry because she was frightened."

We passed on everyone's comments to the Registered Provider and with the local authority safeguarding team.

We asked to see accident and incident records. We were provided with the accident and incident reporting books. These only contained incidents involving staff (both support staff and office workers.) We asked for the log of accident and incidents involving people using the service and we were told there weren't any records. The only information we were given was a report and photographic evidence of an incident in which a stainless steel sink was scratched by cleaning with a brillo pad. We expressed concern that of the 700 people using the service there had been no falls, accidents or incidents to report. The area manager agreed that this could not be correct however was not able to produce any records or statistics. We followed this up on the second inspection day. But the area manager confirmed there were no records. This does not follow their own health and safety incident management policy, which states, 'In any circumstance an incident or accident should be reported on the accident and incident report form, it is advisable to record all incidents and near misses however apparently insignificant. The manager will advise on any subsequent action to be taken and will keep a regular check on the record of incidents for individual service users.'

Environmental risk assessment for people's property had been completed. However, information relating to the mobility support equipment such as ceiling track hoist, wheelchairs, shower chair and lift had not been completed. There was no record of supplier, serial numbers or when the items had last been serviced despite records stating this must be checked if staff are using the equipment.

This was a breach of regulation 12 (1) (Safe care and treatment). The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked care staff if they thought there was enough staff to cover calls. One staff member said, "In my opinion staff don't get breaks and enough time to get to each house, it's really bad service, which gives less time for each service user. Short cuts are made." Another staff member said, "The overall consensus from the care co-ordinators is that there is not enough carers. I am not sure if this is because they do not put their carers in permanent runs or calls as permanent allocations to carers, or if there is a general dearth of carers. I suspect it is a combination of the two." And another staff member said, "No I receive phone calls to work on days off as well as many other carers." Another six staff members said there was not enough staff to cover calls, one staff member said yes there was and another said, "In general, yes, if they're allocated efficiently and accurately."

Staff we spoke with said there was a high turnover of staff. Comments included, "There are not enough staff due to very high staff turnover due to poor treatment from care co-ordinators." One staff member said, "Carers should be given more realistic times between calls, they should take more notice of geographical areas during the planning of rotas. Extra calls should not to be added to rota's without the carer's knowledge. Carers should be able to refuse extra calls without trepidation. Office staff should have the courtesy to get back to carer's when they say will."

People who used the service said, "I think they are short staffed and a number of people are off sick. This week it was another lady again who came who I've never seen before and she seemed a bit aggravated because she was rushing about." Another person said, "I feel quite safe with the carer. Sometimes, if she has time when she's done everything she'll stop and have a little chat with me which is nice. The trouble is they don't get enough time. When she's here they'll be phoning her telling her to get to the next job." And another person said, "Some of the carers are very good, but there is only one carer who comes regularly. The rest are all different and some don't know what to do. They just make too many mistakes." Another person said, "There are three or four different ones [carers] but it's always those same people."

This does not follow Nice guidelines NG 21 published September 2015, Home care: delivering personal care and practical support to older people living in their own homes 1.4.7 which states Ensure continuity of care so that the person knows the home care workers and the workers are familiar with how that person likes support to be given, and can readily identify and respond to risks or concerns, by: introducing people to new home care workers, and building teams of workers around a person and their carer, and informing people in advance if staff will be changed and explaining why, and working with people to negotiate any changes to their care, for example when visits will be made, and recognising that major changes (for example moving from home care to use of personal assistants) can make people feel unsafe.

We were told by a member of staff from an external company that one carer was nervous and quite reluctant to go their next call. They thought this person needed two carers but only had one carer down for support. When they arrived at the person's home they could not lift the person. They rang the external company who operates the call alarm system and they were under the impression the person had fallen and said the carer would need to get an ambulance. The call alarm staff member said, "On arrival the ambulance service asked why they were called instead of Direct Health as it cost £750 to support a carer to put a person to bed." We saw evidence of a record on 29 March 2016 where a carer called the office to say that they needed another carer to go out and help them to get this person on the commode. A staff member told the carer to call 111; they will go out and help.

This was a breach of regulation 18 (1) (Staffing) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with understood their responsibilities around safe guarding vulnerable adults. However, 49 percent of staff needed updated safeguarding training. A safeguarding policy was available and staff explained that this and the whistleblowing [telling someone] policy was in their handbook. Staff were knowledgeable in recognising signs of potential abuse. Staff we spoke with said, "My understanding of safeguarding is the protection of service users from harm that may come through poor standards of care, negligence, or abuse from providers of care or others who have input in their lives. Safeguarding starts with reporting, continues into an investigation, and carries on with systems put in place to protect or prevent abuse." Another staff member said, "This procedure describes the manner in which the organisation deals with concerns, protection from abuse, neglect or self harm." Staff were also aware of the relevant reporting procedures. Staff we spoke with said, "I would report any concerns to the office and other outside bodies as necessary directly report to line manager as soon as possible, at all times. Even in confidence. But must not at any time, keep the information to myself." Another staff member said, "I would record and report to the office, someone high up so that I knew the information would be seen to."

We looked at the recruitment records for eight staff members. We found recruitment practices were safe and relevant checks had been completed before staff had worked unsupervised in people's homes. We saw evidence to show they had attended an interview, had given reference information and confirmed a Disclosure and Barring Service (DBS) check had been completed before they started work in the home. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers to make safer recruiting decisions and also to minimise the risk of unsuitable people working with children and vulnerable adults. We did recommend that reasons for gaps in employment were recorded.

Staff we spoke with said they had access to plenty of personal protective equipment (PPE). However one person who used the service said, "Some of the carers are dirty, their uniforms are dirty and their hygiene isn't good. They never wear gloves, and I worry that they are preparing my meals."

Requires Improvement ●

Is the service effective?

Our findings

At the September 2014 inspection we found breaches of the Health and Social Care act 2008 (Regulated Activities) Regulation 18 Staffing of (Regulated Activities) Regulations 2014. The registered provider was failing to ensure that staff received appropriate training as is necessary to enable them to fulfil the requirements of their role.

At this inspection we examined staff training records. The services training policy stated that moving and handling, safeguarding and medication training was to be refreshed yearly, all other training was two yearly. Out of 196 staff listed 48% needed updated moving and handling training, 42% needed updated medicine training and 49% needed updated safeguarding training. Medicine training was taking place on the 30 March 2016. Nine staff were due to attend, two staff attended. This meant that due to staff not being trained appropriately people were at risk of receiving inappropriate care.

Specialist training in subjects such as dementia, diabetes and Parkinson's had taken place.

We asked people who used the service if they thought the staff had the skills and the knowledge required to meet their needs. Nearly everyone we spoke with told us that staff did not seem to be well trained or really know what they were expected to do.

We asked staff if they felt they had received enough training and had the required skills to carry out their role. Staff we spoke with were happy with the training provided. Staff we spoke with said, "I have just done moving and handling and a medication course. It was revision of how to dispense medicines and dispose of unwanted medicines." Another staff member said, "My training is comprehensive and I have a varied skill set that I have accumulated over the years."

We saw no evidence of regular supervisions, appraisals and spot checks. Staff were receiving two supervisions a year. Direct Health's policy stated that 'supervision sessions will take place at least twice a year, plus additional supervision a year will be observed practice [on site supervision. If in Wales it was four times a year and Gateshead was six times a year.' We questioned why different frequencies for different areas. We were told by the head of customer engagement they go on the contract with the local authority. We asked Middlesbrough Local Authority what they ask for and they told us 'we request four times a year' and Stockton Local Authority sent CQC copy of their contract which states 'The providers staff will receive appropriate supervision on an appropriate frequency but at least six times per year.'

At previous inspections we have told the service that staff were not effectively meeting people's needs and competency checks need to be completed. Clearly this had not triggered any action to increase supervision or complete spot checks of staff practice. The failure to adhere to their own policies and address the identified risks posed because staff were not adequately supported meant that staff were still not receiving the appropriate amount of supervisions.

This was a breach of Regulation 18 (2) (Staffing) of The Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

We saw staff received an induction. One staff member said, "Yes, it was of one week duration, and comprised of how to complete paperwork, moving & handling, medication, and other various aspects of Care related issues."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

During our last inspection in September 2015, we noticed that the form used by staff to determine people's mental capacity was poorly designed and contained typographical errors and these needed to be corrected. We pointed these out to the manager who agreed improvements were needed. During this inspection we found improvements had not been made.

It was difficult to establish if all care staff had received up to date training on the Mental Capacity Act 2005 (MCA). We were told that this training would be refreshed two yearly. The dates on the training matrix said a month and a number. For example July 19. If this was 2019 it would suggest that refresher training was not due for three years which contradicted what we had been told.

We asked staff what their understanding of the MCA was. One staff member said, "My understanding of the mental capacity act is that we are to deem that all service users have capacity unless an assessment of their capabilities has proven otherwise. The act protects and provides a pathway for those who have some capacity issues regarding their care and decision making. It provides guidance with best interest's decision making." Another staff member said, "To protect individuals who may lack mental capacity to make their own decisions about their care and treatment, for example those with dementia." This showed that staff did have an understanding of MCA and DoLS.

People's care plans had records to say if the person had ability to give verbal consent. We saw in the majority of care plans we looked at, this had not been ticked. The care plans were signed but not by the person whose plan it was and there was no record to say who had signed it.

One person's capacity assessment said that the person was able to make basic decisions about their care. But on the next page of the questions relating to whether the person was able to decide what to eat or what to wear had been answered 'no'.

We found that blanket procedures were put in place for example people's medication being hidden and the staff were the only people who knew where it was. We asked staff about these practices and were told that this was what they had always done. They could not explain why or tell us if people's consent had been obtained or for what purpose this was serving..

The registered provider did not act in accordance with the requirements of The Mental Capacity Act 2005 (MCA).

This was a breach of Regulation 11(1)(2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were supported at mealtimes to access food and drink of their choice. All food eaten was documented in the daily notes. The care plans did not provide much information on how many meals would be provided and people's likes and dislikes. One person had a peanut allergy but there was no guidance on how to manage this. Another person was allergic to sea food however received fish cakes for lunch. Where people needed food cut up small or soft food, there was no explanation why and a very limited risk assessment produced.

This was a breach of Regulation 12(1) (Safe care and treatment), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We asked people who used the service if staff supported them well with food. One person said, "It's nice when I get the same person most of the time because she knows where everything is and she gets lunch ready for me and leaves me something for my tea but it's very up and down whether I get her or not." Another person said, "'I think they would do anything I asked but I have ready meals so they just have to put them in the microwave. They do my breakfast for me and wash up as well." And another person said, "I'm supposed to have meals prepared for me but I do get missed calls sometimes so I always keep something extra in so that I can make a sandwich if they don't come." One relative we spoke with said, "Both my relatives are having care but they can't seem to link it up. Admittedly one of them has only just started needing care but they should be able to do things together. For example, one of my relatives is seen to at 7am and washed and dressed and given breakfast, while the other one's carer doesn't come until 9.30. He would like to be up at 7am and they would like to have their meals together – not be eating separately."

Requires Improvement ●

Is the service caring?

Our findings

Most people spoken with who used the service, told us that their carers were kind and compassionate. Most people we spoke to said that staff were respectful and polite and observed their rights and dignity. However people we spoke with said they were not happy that they were receiving so many different carers. They said they became confused with the different staff, and unable to form any relationships with them.

People we spoke with said, "I am very happy with the service I receive, they do their job and tidy up after themselves. They are always on time and are very friendly." And another said, "I'm very happy with them. I tell them what I need and they are always obliging. They are cheerful as well which makes a difference when you're on your own." And another person said, "I have insisted on having the same person. The only time it's somebody different is when she is on holiday. She is invaluable to me. I'm blind so I keep all my letters and she reads them for me and helps me to write replies if I need to. She is usually on time. I would say she is top of the pops."

Other people we spoke with said "I get lots of different carers, some are very young I think they do their best, but they wouldn't notice if anything was wrong with me." Another person said, "I don't know where I am. Yesterday the carer arrived at 7.30am – she should have come at 8am – so she was half an hour early but nobody had let me know and then she rushed around as though there was no tomorrow. Nobody ever lets you know what time to expect carers and all the staff complain about the office." Other comments included "It's always a surprise who comes but I don't mind because they are all really kind and thoughtful." And "The care staff are brilliant but they are banging their heads against a brick wall."

Other person we spoke with said, "They [the care workers] are superb. I don't need a lot of help but I can't say more than that. They are brilliant and very kind. The biggest problem is not the staff who come, it's the office. I feel really sorry for the staff because they are being pushed from pillar to post. If my carer is late, I phone up and they always say, 'she is just around the corner, she'll be there in two minutes.' Then it will be at least twenty minutes before she arrives. She's not in the house two minutes when they're phoning her for somebody else and they tell them 'she's just around the corner'. I think that's a script they've got going." And another person said "Carers are wonderful but the office staff are awful and unhelpful. They say they will call back if you phone for anything but they never do. There is no fault at all with the carers but they get messed around. One person should have come at 9.15am but didn't arrive until 10.10am because the office had told her that was the time. She was really upset."

One relative we spoke with said, "I found my relative's carer sitting playing games on their mobile phone while they watched the washing machine. There was no need to sit watching it and they could have spent that time either doing some other jobs or just talking to my relative."

We found that that the staffing numbers and ineffectual manner in which they were deployed led to marked variations in the care people were receiving.

This was a breach of regulation 18 (1) (Staffing) The Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

We asked staff what they thought was important in terms of interactions with people and what people valued. Staff we spoke with said, "I think that it is important to treat others as you would wish to be treated." And another staff member said, "I think people value time spent listening to them and that they are made to feel that what they have to say has value. I think that they would like to know that their wishes are being respected." And another staff member said, "Loneliness is a bad feeling, talking to them as individuals and be open and honest asking them day to day if there is anything else they feel they might like to say, do. Trust, conversation and opinions. Making them smile."

We asked staff how they respected people's privacy and dignity. Staff we spoke with said, "I do not try to pry into a service user's private affairs. I ensure that I keep their information as confidential as possible, only involving others on a 'need to know' basis. I do not speak about them in a way that diminishes them in any way. "Another staff member said, "I always ask for a person's consent before doing anything, always explain what you are doing and why and if a person refuses it is their right to do so." Another staff member said, "Never divulge info about a user to unauthorised people, always ensure they are covered as much as possible during personal care, listening and reassuring them at all times."

Staff explained how they promoted people's independence. "I encourage them [people who used the service] to get involved with their care as much as they can." Another staff member said, "I encourage, praise and support service users to do as much as possible, within the risk assessment parameters set out."

One person who used the service said, "I feel safe and comfortable with the carers, they have helped me to improve my mobility by encouraging me to do things for myself"

We asked if people and their relatives were aware of, and were supported, to have access to advocacy services that were able to support and speak on behalf of people if required. We were told that this information is in the service user guide. However we were provided with a copy of the service user guide and there was no mention of advocacy.

Inadequate ●

Is the service responsive?

Our findings

After the inspection in September 2014 we asked the registered provider to update care plans to become more person centred and to receive and act on complaints. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person.

Staff we spoke with said they found the care plans easy to understand. However we received comments such as, "They are easy to follow, however they are very outdated some are from 2013." And another comment, "Yes they are easy to understand when they are up to date."

We looked in detail at 14 care files. On two of the care files we looked at work had started to make them become more person centred. Detail on life history, relationships, good day, bad day and hobbies were included.

However, we found that the majority of the care plans we reviewed did not provide sufficient detail and guidance for staff to provide care. Information about nutrition and hydration; skin breakdown; continence care; showering and shaving was not always included. One person's care plan said the person was non weight bearing and a rota stand was to be used for transfers into wheelchair, yet the equipment and resources sheet said, now bed managed in a hospital bed with sides, slide sheet and the mobility support plan listed rotary stand, wheelchair, commode and handling belt. It was confusing as to which page to refer to or what the person's current care needs were and how they were to be managed safely.

One person was identified as being at risk of developing pressure sores and skin tears but the risk assessment said this was due to incorrect equipment and a reassessment was needed. Phone records for this person said support [person's name] to get out of bed into a wheelchair using a rota stand. The care records did not contain information about the actions staff needed to take to ensure the correct equipment was used and we found no evidence to show the manager had taken steps to determine why staff had used incorrect equipment. We could not evidence whether the person was bed managed or not.

We called one person and their relative answered and explained a member of staff from Direct Health was at the house preparing a care plan. The relative said, "My relative has been receiving care for three weeks, its early days yet, the first week they didn't come at all, and since then they are often too late to accommodate his needs. The carers are always different, there isn't any consistency."

We found that one person's care records detailed the support they received from a relative but from a conversation with this person found this relative had passed away in late 2015.

Care was being provided to one person without any care records being in place. We were told by staff that no care package should start without a care file being in place. There were also signs around the office stating this. When asking the office staff for names of people who had started receiving care in March 2016 and for their care plans, one staff member said, "That is a bit early isn't it, they won't be done." We found for all of the people who had started to receive care in March 2016 their assessments, care plans and risk assessment were not complete and for some not in place.

We found that the management team did not have an accurate list of the people they provided a service to, as when we called people from their list we found that some individuals had stopped using Direct Health. For some of the people they had left the service months ago.

We asked care staff how quickly care plans were updated and if they were made aware of this. Staff we spoke with said, "To my knowledge, the care co-ordinators update the system immediately they are informed of changes from social services. The actual written care plan may not be updated immediately to reflect the changes. It depends on whether or not the assessors have been informed of the change, their availability, and their workload. I believe that in the past, updates were not dealt with how they should have been, due to lack of staff. We are currently trying very hard to update all plans." Another staff member said, "Until recently they have been really bad with some care plans not updated from up to four years ago." And another said, "New service users generally take a short while to have a care plan implemented. Any changes to an existing service users care plan are not verbally transmitted, but we are expected to read the care plan at the beginning of every call." Another staff member said, "I have never known care plans to be updated and have never been made aware."

We saw people's daily notes and found some hard to understand due to handwriting. One person's daily notes had times written which stated the carer had left before they arrived. For example the daily times were 8am – 9am, 12:39 – 12:25, 16:58 – 17:30, 17:35 – 17:40, 8:45 and no further times. For the last time on the sheet the whole visit had been crossed out, scribbled over several times to that is was impossible to see what had been written. We passed this onto the area manager to look into and to the local safeguarding team.

This does not follow Nice guidelines NG 21 published September 2015, Home care: delivering personal care and practical support to older people living in their own homes 1.3.22 and 1.3.23 which states 'Ensure a 'care diary' (or 'care record') is kept in the person's home. This is a detailed day-to-day log of all the care and support provided, which also highlights the person's needs, preferences and experiences. Offer the person a copy of it. And home care workers should ensure the care diary is completed routinely on each visit is detailed enough to keep people, their carers and practitioners fully informed about what has been provided. Record any incidents or changes. Read new entries if you have not seen the person recently.

One person we spoke with who used the service said, "I cancelled their calls for Good Friday and Easter Monday, but the carer still came, I was planning a nice relaxing lie in bed, and it was spoilt" And "They are often either late or early in the morning; it depends on which carer calls this can be very frustrating." Another person said, "They are either very late or very early. I don't know if I'm coming or going. Sometimes they are so early that I'm still in bed and I hardly have time to get myself together."

The examples we were told about and records we looked at did not support a person centred approach to care planning.

We asked staff how they knew what was important to each person. Staff we spoke with said, "This information will be included on the warnings which will appear on the carers' mobile phones. It will also be visible to the care co-ordinators." Another staff member said, "Because they talk to you and you must read the care plan." And another staff member said, "Usually by talking to the service user after looking over out of date care plans." And another said, "By simply asking them if they would prefer an alternative way of doing something to be able to learn what the client likes and dislikes" And another said, "If you build a relationship with a service user although you hardly get the same service users to build a relationship."

This was a breach of Regulations 9 (1) (person-centred care) and 12 (1) (safe care and treatment), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people who used the service if they were involved in updating their care plans. One person said, "I don't know anything about any care plan." Another person said, "I can't recall the last time my care plan was reviewed and I have been with them 11 years." Another person said, "I was involved in my care plan it was discussed and explained to me so I could understand."

This was a breach of Regulation 11 (Need for consent), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the services complaints file. This contained details of all the complaints that had been received since December 2015. The file contained a mixture of emails, handwritten notes and complaints forms. These were indexed, although not kept chronologically which indicated that they had not been logged as they were received. Apart from some almost illegible handwritten notes on some of the paperwork there was no record kept within the file of any investigation, action or outcome relating to each individual complaint.

It was not always clear within the file exactly what the complaint was – one entry was just a printout of visit times, scheduled and actual.

We were provided with a printout which showed the complaints received, acknowledgement letter sent, resulting action, outcome, outcome letter sent and date closed. Eight of the 47 complaints listed had been closed. Some complaints did have more detail listed in the actions but several were awaiting outcomes and there was no indication whether those listed as resolved, if this was to the satisfaction of the complainant. None of this information was recorded on the paper file so when referring to that alone there was no way to identify what stage the complaint was at.

We asked people who used the service if they had ever made a complaint. One person we spoke with said they had made several complaints, mainly about time keeping. They said, "If I ring the office to ask where the carer is they often hang up on me." Another person said, "They don't answer my calls unless I withhold my telephone number." And another person we spoke with said, "I complained on one occasion that the visit had been missed, the office said they would look into it, but they never called me back. The company is not very well organised." Another person said, "The company threatened me when I asked that a carer be removed from my calls, the office said I would not get a call at all. I was told, you have to have this carer."

We asked staff if people who used the service had ever complained to them. Staff we spoke with said, "If someone complains I inform the office, clients have phoned the office and things will be fine for a few weeks then things get bad again and the clients have a go at the carers. I have had a few complaints about times and two of our good clients left to go to another company." Another staff member said, "We get complaints about no schedules being sent out or if they are, they are incomplete with no carer allocated to calls."

This was a breach of Regulation 16 (Receiving and acting on complaints), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service well-led?

Our findings

The service did not have a registered manager in post. The previous registered manager left in December 2014. In January 2015 a manager was appointed, and they were going through the registration process.

At the September 2015 inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also provided warning notices for good governance due to audits not taking place; staff were not supported by management and people's views not being sought.

At this inspection we asked staff if they felt supported by management, 50 percent of staff we spoke with said no, one staff member said, "Definitely not." Another staff member said, "Only with great trepidation." And another staff member said "Yes, the regional manager in particular is excellent." One staff member said, "[managers name] does not support me, she cannot manage."

We asked people who used the service and their relatives if they felt the management team and office team supported them. Almost every person who used the service we spoke with, including some of those who claimed to be satisfied with the service were critical of the management and administration. People mentioned a perception of lack of training, short staffing and/or high levels of staff turnover. Nobody could describe any regular review of their needs or discussion of their care plan. The main and consistent complaint was the number of different carers, lack of information or inaccurate information about who would be coming and frequent time changes, late and occasional missed calls.

People who used the service said, "The staff in the office are not very helpful, they don't seem to care." Another person said, "The office mess the carers about they have a very busy workload." And another person said, "There is no co-ordination with the office staff and the carers." Another person said, "The company was always changing the carers daily calls. The carers felt under pressure, and there was insufficient travel time allocated." Another person said, "I had a meeting arranged with the company, my social worker and myself, and the representative of the company did not turn up, we waited 30 minutes and called the office and was told they couldn't get here due to the snow. There was very little snow fall, but they didn't even ring and cancel" This person also said that some of the staff had worked for the company for several years, and these staff had told them they had noticed deterioration in the management and felt that recently it was not a good company to work for. "They send members of staff to meetings who do not understand the issues." Another person said, "The care staff are brilliant but the office staff are crap. It's difficult to get through because they often don't answer the phones. It just rings and rings and then you try again and it is engaged. I think they just take it off the hook."

Other comments included: "I get a rota some weeks, and the spaces say unallocated instead of the carers name, it's a waste of time" And "I am not happy with the company, the office staff have been very rude, I have cancelled their service and I am very pleased to have done so" and "They send out rotas but I don't know why they bother. Half the slots are shown as 'unallocated' and the ones which are filled in are never right." And "They could save a lot of money if they didn't bother typing out rotas and sending them out because they are useless. Half the visits are shown as 'unallocated' and it's just a joke when they put names in because it's either not them or they come at a different time." And "'It can be anything from 8am until 11am before somebody comes. I would say that they are late 8 out of 10 times. I never know who is coming or what time. I don't know what time to get up because if I get up at 8am they don't come until late and if I stop in bed, they come early and are shouting to wake me up." "They don't provide rotas at all but there is a reason. If they don't send a rota then I can't complain if they change things or change the times because I don't know what it should be." We passed all these and more comments onto the registered provider.

The lack of rotas was an issue at our last inspection in September 2014. We again discussed this with the manager but found there was still no clear plan of how to solve the issue.

We asked the manager how they monitored the quality of the service. We were provided with a file of 'snappy questionnaires.' This are completed during a review. The file contained only ten questionnaires and they were all from February 2016. Ten was a very small example from a service providing support to 700 plus people. The feedback was generally good although out the ten, two mention the change of carers and one mentions the lack of rotas so even in this tiny sample there were issues. There was no evidence to show that the feedback had been followed up.

We asked people who used the service if they have been asked for feedback. Every person who used the service and relative we spoke with were unable to tell us about any regular reviews conducted by the managers or any surveys they had been sent about the quality of the service.

During last year's inspection in September 2015 we were told that that year's survey would be taking place in October 2015. We asked to see this survey but were told this had not happened.

The services policy stated that internal quality audits would take place twice a year. We were provided with a copy of an audit that had taken place in February 2016. The audit highlighted that 57 people who used the service were without assessment documentation and this was to be rectified immediately. However we still found people without assessments and care being provided. Several assessments were over 12 months old some dating back to 2009. We also found assessments dating back to 2014. The provider's internal audit found risk assessments were missing and where they were in place they were not always complete, relevant or personal. The registered provider action plan from the audit said the issues identified with the risk assessments were to be rectified immediately. We found that this had not happened.

Each person who used the service had a monthly log book with an audit checklist at the back. We were told that as from November 2015 all log books would have a 100 percent audit on medicines. For other records in the books a 10 percent audit would be done each month. We looked at the audits that had taken place. Medicine audits were not being audited 100 percent, where an audit took place this did not highlight any issues. For example, one person's book had been highlighted with a yellow fluorescent highlighter all the gaps on the MAR chart, but the audit said no significant gaps. In books where they had said there were gaps no action or next step were put in place. The majority of audits were blank.

We asked to see the March log books for one person who used the service. These had not been collected and were still in the person's home. A carer brought them in along with another four log books dating back to November 2105. No reason could be provided why the log books had not been collected. We highlighted that any concerns or errors taking place in November 2015 could still be happening due to no one checking. We found that the system for monitoring the service was not effective

We did not see evidence of regular staff meetings taking place. We asked staff about staff meetings. Staff we spoke with said, "The office has recently, on return of the manager, started having weekly meeting on

Monday morning which has been a good start to the week. It helps to address what is ahead, raise any issues from over the weekend, and bring everyone together as a team." Other staff said, "Don't know about staff meetings." And "I have worked 13 months with direct health and had one but there was only five people told about it." And " Staff meetings are very infrequent, and often chaotic." And "None while I have worked there."

We found that the registered provider monitoring system had not identified that there was a problem ensuring consistency in the allocation of staff or that staff had sufficient time to undertake the visit. People were allocated a minimum of 15 minutes for each visit but found at times staff were only in their property for five minutes.

We found that there was no effective system in place for maintaining an accurate list of people who received a service or for maintaining accurate care records.

We found that the monitoring of the performance of the service was wholly inadequate and this had led to people receiving unsafe care and being placed at risk of harm.

This was a breach of Regulation 17(1) (Good Governance), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk because appropriate arrangements were not in place to handle and administer medicines safely. Risks relating to the health, safety and welfare of people had not been properly assessed and responded to

The enforcement action we took:

We served a section 31 Notice of Decision preventing the service taking or extending care packages unless this was agreed by CQC.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The manager was not yet registered with the Care Quality Commission. The absence of effective quality monitoring had a significant impact on the health, safety and welfare of people. The culture of the service was poor. Staff were apprehensive to raise concerns due to fear from office staff.

The enforcement action we took:

We served a section 31 Notice of Decision requiring the provider to supplyeach week information from their review of the number of missed care visits, cancelled and aborted care visits; unallocated care visits and the action that has been taken in respect of these visits in order to ensure the safety and welfare of service users.