Direct Health (UK) Limited

Direct Health (Sheffield)

Inspection report

Unit 2, 1 Arena Court
Attercliffe Road
Sheffield
South Yorkshire
S9 2LF

Tel: 01142566480
Website: www.directhealthgroup.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 16 and 17 March 2016, and was an announced inspection. The area manager of Direct Health (Sheffield) was given 48 hours' notice of the inspection. The service was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that the manager and some care workers would be present to talk with. We also wanted the service to make initial contact with some people, who we had identified we would like to visit, to ask them if we could visit them in their own homes.

Direct Health (Sheffield) is a domiciliary care service. The agency office is based in the Attercliffe area of Sheffield. They are registered to provide personal care to people in their own homes in the Sheffield, Barnsley and Rotherham areas of South Yorkshire. At the time of our inspection the service was providing personal care for approximately 380 people. There were approximately 160 staff employed by the agency. There were approximately 2,800 hours of care provided each week by the service.

The service was last inspected on 25 and 30 June 2014 and was found to be in breach of one of the regulations we inspected at that time. People were not protected against the risks associated with medicines because some people were not supported safely with their medication. The provider sent a report of the actions they would take to meet the legal requirements of this regulation which stated they would be compliant by 8 August 2014. We checked whether this regulation had been met as part of this new approach comprehensive inspection.

It is a condition of registration with the Care Quality Commission that the service has a registered manager in place. 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. A week before the inspection was due to take place we were informed the registered manager had resigned. The area manager of Direct health (Sheffield) was managing the service on an interim basis.

The provider did not have adequate systems to ensure the safe handling, administration and recording of medicines to keep people safe.

People did not have their needs met by sufficient numbers of deployed staff resulting in missed, short and late visits.

Risk assessments for people who received a service were either missing or incomplete. Risk assessments which were present in the care plans did not provide detailed person specific information to mitigate the risks.

Some staff did not receive regular supervisions, appraisal or training updates.

Some people were not supported to eat sufficient food and drink to ensure they maintained a well-balanced diet due to late or missed calls.

Most people felt most staff were caring and respected their privacy and dignity. However there were examples where this was not the case.

People's needs had been assessed when they started to use the service but a care plan was not in place for one person we visited. We found other care plans had not been reviewed for some time and were not up to date.

Some people felt complaining did not improve the service they received as any concerns they raised weren't acted upon.

There were some systems in place to assess and monitor the quality of service provided. However these were not effective or acted upon to ensure care provided was adequately monitored, risks were managed safely and the service achieved compliance with the regulations.

We found 10 breaches in six regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were breaches in; Regulation 9; Person-centred care, Regulation 12; Safe care and treatment, Regulation 10; Dignity and respect, Regulation 16: Receiving and acting on complaints Regulation 17; Good governance and Regulation 18; Staffing.

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

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's medicines were not managed safely and the safe administration and recording of medicines required improvement.

People did not have their needs met by sufficient numbers of deployed staff resulting in missed, short and late visits.

Risks to individuals were not managed and updated in order to keep people safe from avoidable harm.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received training updates as required and had not received regular supervision or appraisal from their manager.

People confirmed they were asked for their consent before any care, treatment and/or support was provided.

Some people were not supported to eat sufficient food and drink to ensure they maintained a well-balanced diet due to late or missed calls.

Is the service caring?

Requires Improvement

The service was not always caring.

Most people felt most staff were caring and respected their privacy and dignity. However there were examples where this was not the case.

There was a lack of personalised and person-centred information in care records.

Is the service responsive?

Inadequate

The service was not always responsive.

People's care plans varied in detail and did not reflect all their wishes and preferences. One person we visited did not have a care plan in place, two people we visited had care plans which had not been reviewed for some time.

Some people felt complaining did not improve the service they received as any concerns they raised weren't acted upon.

Is the service well-led?

Inadequate

The service was not well led.

People and staff said they were not listened to and felt unable to speak with the managers at the office or within service to effect change.

There were some systems in place to assess and monitor the quality of service provided. However these were not effective or acted upon to ensure care provided was adequately monitored, risks were managed safely and the service achieved compliance with the regulations.

Direct Health (Sheffield)

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over two days on 16 and 17 March 2016.

The provider completed a Provider Information Return (PIR). 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.

Prior to the inspection we reviewed the PIR and other information we held about the service, we looked at previous inspection reports and the notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

Prior to our inspection, we spoke with the local authority care services team and the local authority safeguarding team.

We sent out 50 questionnaires to people who used the service and 50 questionnaires to Direct Health (Sheffield) staff. Twenty four people and 18 staff returned questionnaires to us.

The inspection team was made up of four adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in supporting people to use domiciliary care agencies.

We visited and spoke with five people in their homes and three of their relatives. We also saw any care records which were kept at people's homes.

During the inspection we contacted 46 people who used the service. We were able to speak over the telephone with 22 people who used the service or their relatives. We contacted 50 Direct Health (Sheffield) staff and were able to speak with 13 care staff including care coordinators.

We visited the agency office on 17 March 2016 and we met and spoke with the nominated individual, area manager, acting operations lead and head of human resources, transition manager and two care coordinators. A nominated individual acts as the main point of contact with the CQC. The nominated individual must be employed as a director, manager or secretary of the organisation. They must also be in a position which carries responsibility for supervising the management of the carrying on of the regulated activity (i.e. they must be in a position to speak, authoritatively, on behalf of the organisation, about the way that the regulated activity is provided).

We spent time looking at written records, which included four people's care records, four staff records and other records relating to the management of the service such as training records and quality assurance audits and reports.

Inadequate

Is the service safe?

Our findings

The service was last inspected on 25 and 30 June 2014 and was found to be in breach of one of the regulations we inspected at that time. People were not protected against the risks associated with medicines because some people were not supported safely with their medicines. The provider sent a report of the actions they would take to meet the legal requirements of this regulation which stated they would be compliant by August 8 2014. We checked whether this regulation had been met as part of this new approach comprehensive inspection.

At our last inspection we found that one person was not protected against the risks associated with medicines because staff were not administering their medication at the correct times and some medication was not being administered at all. The person's medication chart was not being accurately completed by staff. This was a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010, Management of medicines.

During this inspection we looked at medicines management for people and found that medicines were not handled safely.

We asked people about the support they received with their medicines. The majority of people we spoke with told us they were happy with the support they received. However three people and their relatives said they were concerned about themselves or their relatives receiving their medicines on time or at all. Comments included, "Carers are sometimes late, coming at nearly dinnertime and giving medications when your call should be in the early morning," "Myself and my sister are concerned about staff not getting there on time due to her (relatives) medication. They really do try but they really do need to be there on time as morning medication should be given" and "Staff didn't visit once so I never got my eye drops, I hope it doesn't matter missing once."

Staff raised concerns about the times medicines were administered, they said, "Some calls are very close together, which means people are getting there medication at the wrong times, it happens a lot and I worry in case someone gets overdosed."

Stakeholders raised concerns about the management of people's medicines by the agency staff. Comments included, "The main weakness of the agency is medication with poor inconsistent auditing, staff administration (drug errors) and timing" and "Medication errors remain a concern although additional training programmes have taken place with staff and competency assessments are being undertaken."

We checked staff records and spoke with staff. We saw staff had received regular medicines training and the service had a medicines policy in place which stated, "Support workers must not carry out tasks that have not been authorised by their line manager and/or stated in the service users' personal service plan."

Staff said, "I had all my medication training when I started and we all get checks now and again."

We visited five people in their homes. Three people were supported by Direct Health (Sheffield) staff to take their medicines. We checked the Medication Administration Records (MAR) and care records for the three people and found these incomplete, inaccurate or not in place.

The only records one person had in their home was an A4 sheet of paper with basic care instructions in place and a daily log book. There was no MAR in place and no medicines risk assessment. The sheet of paper where 'care instructions' were recorded stated, "Prompt to take medicines, [Name] self-medicates but prone to drop them (tablets) so observe." The person said they could not self-medicate anymore and staff were administering their medicines. The relative who was present at the time of our visit confirmed this to be correct.

We checked the persons daily log book and saw staff were regularly documenting, "Meds (medicines) from [brand name of a monitored medicines dosage system] given, eye drops applied," "Given [name] meds" and "Administered meds." As there was no care plan in place at the person's house we checked the persons file when we visited the agency office the day after our home visits. We found a care plan and assessment for the person above. The assessment dated August 2015 stated, "Able to take medicines independently."

In one person's care plan there was no instruction for staff to administer the person's medicines. The plan stated, "Self-administer meds." Staff were regularly recording in the person's daily records, "Eye drops in." The person and their relative confirmed staff were administering the person's medicines. They said "Yes the last three nights staff have put my eye drop in." We checked the persons care plan held at the office which had not been reviewed since March 2014.The care plan stated, "Self-medicates."

Staff were not following the medicines policies of Direct Health (Sheffield) or Sheffield City Council, the later being a policy specific for home care agencies providing care and support in people's own homes. As previously highlighted we found no medicines risk assessments or a care plan instructing staff to administer medicines for two of the people who we visited, yet staff were still administering people's medicines which is an unsafe practice.

During the home visits we checked two people MAR and at the office we checked a further five people's MAR.

We found there were numerous gaps in Medication Administration Records (MAR), where there were missing staff signatures.

On one person's MAR staff signatures were missing at times of the day when medicines should have been administered. We found five gaps on the MAR between 6 and 11 March 2016. Another person's MAR was not signed by staff on nine occasions during March 2016.

This demonstrated there were times when medicines were not administered and/or MAR charts were not completed.

During the visit to the agency office we checked a further five people's MAR. These MAR had already been audited by a manager or care coordinator of Direct Health (Sheffield) to check for errors. The findings in the audit records we saw identified no issues or concerns had been identified. However when we checked the same MAR we found 10 gaps in staff signatures during one month.

Another person's MAR had not signed to state Metformin (a drug used to control diabetes) had been given on one particular day.

These examples showed the auditing of MAR did not ensure people's safety was promoted and any errors in medicines administration and record keeping were identified and acted upon.

The provider had failed to have proper and safe management of medicines. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The managers' present at the inspection told us there was an ongoing recruitment drive in place. They said Direct health (Sheffield) were still using approximately 10 % agency staff but his was reducing every week as more permanent staff were recruited.

We were told the agency was currently supporting 387 people with 165 care staff providing support to people. This added up to approximately 2810 care hours per week

The managers' confirmed that they could meet people's needs and felt confident improvements would be made to the service when all permanent staff were in place.

Stakeholders told us, "Continuous recruitment of front line staff is required to maintain safety of staffing to deliver the contracted services, in the interim agency use is required."

Some people we spoke with by telephone and three of the five people we visited raised concerns about the timing of the visits by care staff. People said, "One (care staff) came at 5.30pm to get me ready for bed which is much too early," "I don't know when they (care staff) are going to turn up, it can be any time between 7.15 and 9.45 in the morning and between 3.00 to 8.00 in the afternoon," "Times they visit are all over the shop," and "We had a breakfast call at 11.45 am."

Relatives raised concerns and said, "There is no continuity of care workers due to shift changes, absenteeism and leavers. No introduction of new carers before they start. My mother sometimes does not know who her carers will be from one visit to the next" and "You never know which agency carer would turn up."

Some people were more positive and said, "You can set your watch by him (care staff) at dinnertime," " There is more consistency with staff who visit now particularly over last month" and "I get four or five staff that regularly come, they are good but sometimes the calls are late."

Only one person said they had ever been notified if the visit is going to be significantly delayed.

People and their relatives said their main concerns was around on the length of the calls made to people and missed calls.

Staff also raised concerns over their 'deployment' to care for people and said, "There is an over reliance on agency staff and a change of rotas for some staff without notice, particularly at the weekend," "There is an over reliance on agency staff. They get our usual calls then and we get ours changed, it`s not right" and "I told them (care coordinators) my availability and then they changed it all, so my rota is all messed up."

During February 2016 the agency declared to the local council contracts and commissioning unit there had been five missed calls. The service was required to submit this information as part of their contractual agreement. However through our auditing of only two peoples records, we noted there were no entry's in people's daily records on nine occasions in February 2016 to say that staff had made the call. One person we visited had a missed call In February 2016.

People and their relatives said , "One of the support workers gave the impression that she really didn't want to be here and was generally in and out in 5 minutes on many occasions," "The times are still inconsistent and the allotted visit stay is very short between 5-7 minutes, not all the time, depends on their schedule," "[Name] is not getting the full hours of help," " It was recorded (in the person's daily log) that the carer spent six minutes on one call, the meal left for mum to eat needed cooking for 11 minutes, how is that right" and "Staff rarely stay longer than 15 minutes. It should be 30 minutes, they are in and out."

We visited five people in their homes.

Two people and their family raised concerns that staff did not turn up for one of their planned visits in the last month. They said, "The carer just didn't turn up, we had no contact from the office" and "Last week staff missed my call. I waited until 10.45pm then locked my door .I never knew if they tried to visit. Next day the office staff just said 'Sorry'."

We checked the daily records for one person who had a planned 30 minute call each morning.
It was recorded in the person's daily log that during the last 10 days, six visits were of 15 minutes duration or less with one visit lasting just 10 minutes. During this time the person needed help with a wash, to dress and to have breakfast prepared.

We checked the length of visits for another person over a random three day period in March 2016.The persons planned call visits were four visits lasting a total of 90 minutes a day. The visit times recorded by staff over these three days showed durations of 40 minutes, 40 minutes and 37 minutes respectively. All less than 50% of the planned length of visits.

We saw evidence in daily logs that some people received calls later in the morning. These calls were not identified as time critical. Time critical calls are calls made by staff that need to be made in a short time window, when, for example a person needs assistance to take certain medicines that must be given at the same time each day.

We looked at information in call logs and held on a spread sheet of planned vs. actual calls. This spread sheet compared the planned care and support hours against actual care and support hours provided. We found the timings did not correspond or tally to the information we found in people daily log records.

For example, records showed, over a four week period in February and March 2016, one person's planned care equalled 16 hours and the actual care delivered was 15 hours 09 minutes a (94%) achieved visit time rate. Looking at the same person's daily log, over 10 days in the same period we calculated only 63% of planned care was delivered.

Similar data checked for another person showed Direct Health (Sheffield) planned vs. actual records delivering (95%) of actual care when the information from the persons daily log records suggested the figure over a three day period was nearer 42%.

The care coordinators and staff told us staff used an electronic call monitoring system to identify when they arrived and departed from a person's home. We asked a care coordinator how the system worked and what would happen if care staff didn't use it for any reason. The care coordinator said, "We ring the staff and log them out from here." We asked if that identified the time staff left the persons home and were told, "No it identifies the time we manually logged them out."

We asked for clarification on the planned v actuals data as the length of visits we saw in people's daily logs

was clearly significantly different to the actual hours of care delivered recorded on the computerised records provided by Direct Health. The care coordinators could not explain why the figures did not tally. This meant the service could not evidence that staff were deployed to ensure people were receiving safe care which was delivered in a timely manner.

These examples showed that people did not have their needs met by sufficient numbers of deployed staff, which resulted in missed, short and late visits.

The provider had failed to have sufficient numbers of suitably qualified, competent and experienced staff deployed in order to meet the requirements of the service. This is a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments for people who received a service were either absent or incomplete which placed people and staff at risk. Risk assessments which were present in the care plans did not provide detailed person specific information to mitigate the risks.

We found that individual risk assessments had not been regularly reviewed or updated for two people we visited to ensure that they were still relevant to people's needs.

One person we visited had no risk assessment in place in their home. The person's family were concerned that the person's mobility had 'worsened' recently. The risk assessment for this person, kept at the services office, did not contain sufficient detail and take into account the specific changes in the persons identified risks surrounding mobility and environmental factors such as pets and floor surfaces.

We found another person's risk assessment had not been updated since March 2014. The person and family confirmed their mobility had decreased over the last year. The risk assessment in place stated they were independent around the house when the person was actually nearly bed bound and did not mobilise around the house at all. This meant the assessment was not relevant to the person's needs.

This showed that risks to individuals were not managed and updated in order to keep people safe from avoidable harm.

The provider had failed to assess the risks to the health and safety of service users receiving the care or treatment. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives we sent surveys to indicated that they or their family member felt safe from abuse or harm from staff.

People and relatives told us they felt safe when staff were in their homes and when they provided care and support. One person said, "I do feel safe." Another person said, "All the staff that have been sent have presented as trustworthy. I have always felt safe with them."

One person did say that on one occasion they were anxious when two carers visited. They said, "I had never seen them before and one was a man. When I got speaking to them they were lovely, but the office should have warned me they were coming."

Staff confirmed they had been provided with safeguarding training so they had an understanding of their responsibilities to protect people from harm. Staff could describe the different types of abuse and were clear

of the actions they should take if they suspected abuse or if an allegation was made so that correct procedures were followed to uphold people's safety. Staff knew about whistle blowing procedures. Whistleblowing is one way in which a worker can safely report concerns, by telling their manager or someone they trust. This meant staff were aware of how to report any unsafe practice.

One care worker told us, "I had safeguarding training during my induction so know about different types of abuse, I would report anything I saw."

We found a policy on safeguarding people was in place at Direct health (Sheffield) so staff had access to important information about their roles and responsibilities. A policy on handling people's money was in place and this described the responsibilities of staff to ensure people were protected. We saw staff completed financial transaction records and these were returned to the office for safekeeping.

There had been recent safeguarding incidents involving Direct Health (Sheffield). We spoke with the local authority, who told us there had been some safeguarding concerns which were raised late in 2015. The majority of these had been regarding late or missed calls and medicine errors. The local authority confirmed the provider had been attending safeguarding meetings to address these concerns.

The CQC had been notified of safeguarding concerns by peoples' family members, friends, other professionals and the service themselves.

We saw the company had a staff recruitment policy so that important information was provided to managers. We looked at the recruitment records for four members of staff. Each contained two references, proof of identity and a Disclosure and Barring Service (DBS) check. A DBS check provides information about any criminal convictions a person may have. This helped to ensure people employed were of good character and had been assessed as suitable to work at the service. This showed that recruitment procedures at the service helped to keep people safe.

Requires Improvement

Is the service effective?

Our findings

Some people we spoke with who received a service said they generally had confidence in the staff providing care. Comments included, "Staff have always got the time to ask me what I want and need doing, never rushed, they are flexible with their time leaving early if I want them to and staying over if I need them to."

Other people told us they were not as confident with care staff that were contracted to Direct Health (Sheffield) from another employment/care agency and said, "My regular carers are really good, but the agency staff don't seem to know what they are doing."

Stakeholders we spoke with felt Direct Health (Sheffield) staff were 'trying' but there was no real continuity of care and felt some staff did not have the skills to plan and meet people' s needs.

People's needs in relation to support with eating and drinking had been considered during their initial assessment and recorded. The care plans of these people highlighted the need to support people with their nutritional needs.

Staff said, "If any clients have special diets it will be in their care plans and they get reviewed by the assessors so they are up to date."

People told us they were usually supported to eat and drink sufficient amounts but there were times, due to missed or late calls, that people were not supported to eat at an acceptable time for them. One person told us, "I just cook things myself now, I don't wait anymore" and a relative said, "I do mum's breakfast now otherwise she would have it nearer lunch on some days" and "It was recorded that the carer spent six minutes on one call, the meal left for mum to eat needed cooking for 11 minutes, how is that right."

This showed the provider was failing to adequately meet people's nutritional and hydration needs.

Our findings meant that people did not routinely receive care and treatment that met their needs in relation to their nutrition. This was a breach of regulation 9(3)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked staff personnel files, the training matrix and talked to staff to see if staff received adequate induction at the beginning of their employment and ongoing training.

Staff said, "My induction was fantastic, really informative," "I thought my induction was good and got lots of training but I have had no training since" and "I`ve had training in moving and handling, safeguarding and medication but nothing around mental capacity."

The five staff records we checked identified they had received induction before starting their employment with the service. Induction training covered mandatory areas including safeguarding, infection control and people moving people. The area manager confirmed all staff received induction before starting

employment. The manager said new care staff's induction would be completed over several months and cover the 15 standards of the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

The staff training matrix showed that some staff were not up to date with mandatory training, five staff required updated moving and handling training, four required medication training, and five required safeguarding training.

A number of staff had attended workshops/training on the safe management of medicines in January 2016. These workshops had been arranged by the provider due to recent safeguarding incidents that were related to medicine errors.

Our findings during this inspection evidenced the medicine training was not effective in enabling staff to handle medicines safely and maintain appropriate medicine records. Some of the messages being relayed to staff during the training was also concerning. Records of the training identified that staff should not make errors because the provider would get into trouble and may be lose the contract with the local authority, rather than concentrating on the safe administration of medicines.

We found the service had policies on supervision and appraisal. Supervision is an accountable, two-way process, which supports, motivates and enables the development of good practice for individual staff members. Appraisal is a process involving the review of a staff member's performance and improvement over a period of time, usually annually.

Direct Health (Sheffield) staff supervision policy identified there should be at least two staff supervisions a year plus an additional on-site observation once a year for all staff. Staff should also receive an annual appraisal.

Some staff were positive about the supervision and support they received. Staff said, "I have just had an appraisal talking about my performance and training and we do have a lot of spot checks by coordinators," "We do get supervisions so that`s always a good time to talk if you need to."

A number of staff said they did not feel supported or adequately supervised by their managers at Direct Health (Sheffield). Staff said, "I have only had one supervision in twelve months, I`d expect to have more than that," "Only one supervision and staff meeting a year. Spot checks are carried out a couple of times a year and competency checks on medicines are completed at the same time," "Office staff just give no support, if you ring an area co-ordinator and it's not their area, they will not help, they are unresponsive to any concerns raised," "Unhelpful almost obstructive care coordinators" and "I never see the manager, no one is bothered in the office, not interested."

We checked five staff files and found within the last 12 months, one of the five staff had been provided with at least four supervisions/spot checks and an appraisal in line with the written procedure.

In the other four files we checked we found none of the staff were supervised or appraised as outlined in services own policy. One member of staff had only had two supervisions with a manager in two years. One member of staff had not had an appraisal for two years. One member of staff had only had one supervision and one spot check in the last 12 months with no appraisal and one member of staff had received three monthly supervisions but no appraisal in the last 12 months.

Our findings meant the staff were not provided with adequate training, supervision or appraisal to carry out

their jobs roles safely.
This was a breach of Regulation18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken. Where someone is living in their own home, applications must be made to the Court of Protection. We saw the provider included MCA and DoLS training in its arrangements for staff induction and safeguarding training and the majority of staff records showed they had received this training. Staff we spoke with were able to describe the main principles behind the MCA 2005, one member staff said they would like more training around mental capacity.

People told us they were asked for consent before any care and support was provided by staff.

We found the service to be acting within the Mental Capacity Act 2005 (MCA) legislation. In care records we looked at, in people's homes or at the services office, we saw that people had signed the 'terms and conditions' of the service, demonstrating people had consented to receiving care and support from Direct Health (Sheffield). However, as highlighted in other areas of the report, people's care plans and other documentation needed reviewing and updating. Where people were unable to sign to give their consent, documents were signed by an advocate on their behalf.

Requires Improvement

Is the service caring?

Our findings

We asked people who used the service how they felt about staff. All of those questioned were positive about their 'regular support staff' and made comments such as, "We always talk about my care and what is going on. Lovely well trained carers," "The actual care and carers I would recommend," " I am satisfied as the care staff who come to me are extremely good and caring," "For the most part I was helped when I needed it and the support workers were lovely, kind people" and "The carer who visited this morning was brilliant."

Staff gave us examples of how they promoted and upheld people's privacy and dignity. They said, "Some calls we go to have key safes fitted but I always shout out my name before I go in so the person knows it`s me," "Could not get a better place to work, some carers have been here a long time and really do care," "Things aren`t always right and calls get changed at short-notice sometimes but I think we all care, well I do" and "I always ask clients what they want and make sure they have everything they need before I leave."

There were less positive comments about the care people received from the staff who were not their regular care staff. People said, "Regular ones (care staff) are nice and have a bit of a chat but the agency ones don't know me so they don't chat as much," "I think the care from agency staff is poor," "It's mixed with the regular ones it's really good care but when they go off sick or something it's not good. It seems that some of them don't know what to do and others don't seem to want to do anything."

One relative told us "Mum was not treated with respect. Staff undressed her at night and left her to sleep in a soiled nightdress. There was faeces left on the floor and it was trodden through the house."

People told us office staff did not always act respectfully when they contacted the office to ask for information or to check who was providing care for them. They said, "I had to ring three times because staff had not turned up. The staff in the office was abusive toward me." Another person said, "I contacted the office four times when a carer had not turned up, nobody got back to me so I rang again, they (office staff) were 'short' with me. I was told 'not their patch'."

Our findings meant that some people were not treated with dignity and respect this was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care records that were in place and we looked at evidenced that people and/or their relatives had been involved in their initial care and support planning. We saw care plans contained signatures, evidencing that people agreed to their planned care and support. Each care plan, when available, contained details of the person's care and support needs and how they would like to receive this, although these were not always reviewed and updated. We found there was limited information to assist with providing personalised and person-centred care and support. For example, we found little or no information in care records regarding people's life histories and preferred past times and interests. One care plan was not available in a person's home meaning staff would have no knowledge at all of the person's life, family or interests. This meant information to provide personalised and person-centred care was not made available for staff to read.

Our findings meant that people did not routinely receive care and treatment that met their needs and reflected their preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People we spoke with said their care needs were initially assessed by a manager at Direct Health (Sheffield) and they were involved in discussions when planning their care. People said, "I'm new so I haven't had a review but I was involved in my care plan," "I was given the choice of male or female but I told them I wasn't bothered," " Managers said the regular carers would chat with me and if things needed changing they would make notes and take it back to the administrators" and "When they come in they sit and have a bit of a chat to find out what I need and if it's something new they write it down and take it back."

One person said their preferences weren't always adhered to, and they didn't always know the staff who visited .They said, "I would prefer female workers, at the beginning I told them that ,but people came once including men" and "Someone came a few weeks ago to review it (care plan) but they haven't left anything."

Staff we spoke with told us how they responded to people's needs and in the main they were positive about the information available to them to help support people. Staff said, "If I arrived on a call and the client was not very well I would ring a doctor or an ambulance if I had to and then call the office," "The assessors do all the care plan reviews," "I am an assessor and I have just done eight reviews and always include the family" and "The assessors do all the pre-assessments and update them when they do reviews."

Staff did raise some concerns about the lack of information available to them when they visited people .They said, "I have had a few new calls and left to go on my own , I had to let myself in using the key safe and tell people who I am, I think that`s awful," "The first thing I always do is read the care plan, but some new clients don`t have care plans in place when we arrive so I let the office know" and "The majority of care plans in service users home do not accurately reflect the current needs of the service users, are out of date and are missing information. This has repeatedly been reported to the office by several members of staff and it is still not fully been corrected."

We checked four people's care plans, with their permission, when we were invited to visit them in their own homes.

One person's care plan contained clear guidance for staff on what type of support the person needed and how this should be delivered. This care plan presented a clear picture of the person and contained sections for health and mobility, communication needs, medication and additional information that the person wanted staff to know. The care plan showed evidence of a review taking place within the last six weeks. The person said, "Somebody from the office had been and talked to me about my care."

The other three care plans we checked were inadequate. Two of the care plans had not been reviewed for over two years. The person and their family confirmed the person's needs had significantly changed and they were not actually receiving one of the visits highlighted in the care plan. The relative said, "She stopped getting the evening visit over a year ago, that is how long it is since the care has been reviewed."

Another person had no care plan in place at their home. The person had been receiving support from Direct

Health (Sheffield) for over six months. We asked the person and their family if any plan was available and they said no. The person handed us an A4 piece of paper that was not signed or dated. They told us staff looked at the instructions on the paper before assisting them with care. On this paper was a list of 'care instructions' which instructed staff on 'tasks' to carry out such as 'get up ,dress, help onto commode and serve breakfast.' This was very much a task centred instruction to tell staff what to do rather than a care plan formulated to meet the person individual needs and respect their preferences.

We saw a care plan for this person in the office which did contain more information. However we could see from the records and what the person had told us the needs of the person had changed in the last six months. This meant the office copy of the plan was not up to date.

The provider had failed to ensure that care plans reflected people's assessed needs, preferences and remained up to date. The above is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The complaints procedure was incorporated into people's welcome pack, contained within the folders kept in their own homes, although not everyone we spoke with was aware of this or had a copy.

Seven people and three relatives said that they had made a complaint but there were varied opinions about the value of the outcome. Some had a positive response, "I complained about them sending to men to put mother to bed, this happened a couple of times but since I complained they apologised and since then they have sent a man and a woman which we don't mind."

Other people and relatives said they had negative responses and said, "If you complain you never know the result," "I told the manager about a jar of hand cream, a Christmas present, disappearing but I don't know what happened. I haven't heard anything," "I've had no response from the office to my concerns. I don't think staff take any complaint seriously," "Timing is an issue, staff turn up late but it doesn't seem to matter how many times I complain about this it carries on" and "May as well not bother (complaining), fed up of telling them."

Staff said they were not very confident of their manager's responding to any concerns they raised. Comments included, "I don't bother saying anything now .Nothing changes" and "If I had any concerns or complaints I would ring the office and tell them, but they don`t listen to what we say, they are not interested."

We looked at the complaints file held at the service and found complaints had been logged on a concern form. Each form contained details of the complaint, the action taken and the outcome of any investigations. We did find some of the learning outcomes from the complaints were very defensive in nature rather than putting in measures to learn from mistakes. For example, an incident was recorded where a person had missed their visit and medication. The outcome recorded and passed onto staff read, "You need to be more careful than that. Sheffield Council are in a lot and if they see we aren't documenting anything we could lose the contract."

These examples showed the provider failed to act on complaints and responding appropriately to any failures identified. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

We checked the service demonstrated good management and leadership, and delivered high quality care, by promoting a positive culture that is person-centred, open, inclusive and empowering.

The service did not have a registered manager. The registered manager had left the service the week before our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The area manager was acting as interim manager at the service until a new manager was appointed and applied to be registered.

We spoke with stakeholders about how the service was being managed. Sheffield City Council contracts officers said due to concerns around quality and safety they were monitoring Direct Health (Sheffield) on an increased frequency of every two to three weeks Direct Health (Sheffield) had satisfactorily completed all actions of the contractual improvement plan. Stakeholders said, "We are closely monitoring the Direct Health as the provider needs to continue to make progress in all areas of key performance."

People told us they had little confidence in the management of the service and felt the service was not well managed.

Some staff said they felt morale was low, they felt unsupported and that the service was poorly managed. Staff said, "Some people in the office are fine, some aren`t and don`t help at all," "I have been to staff meetings where some good ideas have been put forward but nothing ever changes because managers don`t listen" and "I have been here a while now and only been to a couple of meetings, but they don`t listen anyway so some carers don`t bother anymore."

We saw the minutes of staff meetings and staff workshops which had been held in the last three months. The minutes showed there were general discussions about working conditions and forthcoming training. However some of the focus of the meetings was about 'warning' staff they must do things correctly so they and the organisation don't get into trouble with regulators.

Some people we spoke with said they had been recently asked to complete a survey or had been telephoned by a manager at the service to ask for their views as part of the quality assurance programme.

One person said, "Yes I was asked for my views, and I told them I thought things had improved recently."

The area manager said that they were trying to set up 'User Forums' to help improve communication between the provider and people who used the service.

Staff had access to policies and procedures via the office or their staff handbook. These were reviewed and kept up to date.

There were planned and regular checks completed by the senior managers within the service to check the quality of the service provided. We reviewed the quality monitoring audits completed by the provider over the last six months. The audits completed covered a range of areas including: staffing levels, medication management, infection control, premises safety, accident statistics, staff training, staff supervision, complaints, care plans and notifiable incidents.

Care coordinators had completed audits of MAR and daily log records. Of the five audits completed, the coordinators identified only a few minor issues that needed addressing.

We relooked at these records and found numerous concerns. These concerns that had not been identified by the care coordinators included, gaps throughout the daily records of one person and a MAR sheet contained no staff signatures next to prescribed medicines on 10 days over a one month period. One person's MAR had not been signed to state Metformin, a drug used to control diabetes had been administered on one day. On one person's daily log five calls were not recorded by staff over a two month period and another person had six calls that were not recorded in a period of one month.

Auditors from Direct Health Ltd had completed an audit of records and systems at Direct Health (Sheffield) between 26 and 28 October 2015. We saw the detailed report which identified 29 recommendations.

The findings in the Direct Health Ltd report identified medication was not being consistently recorded, medication charts were not consistently audited and therefore discrepancies were not being addressed within a timely manner. The report identified there were incomplete assessments in care files with missing dates and signatures, some care files were over 12 months old (2008/2011) and some risk assessments did not always cover all risks and none had been reviewed. The auditors also said staff were unable to locate one person's care plan that was requested.

It is of concern that the findings in the report mirrored many of the concerns and breaches in regulations found during our inspection some four months later.

The systems in place to assess and monitor the quality of service provided were not effective or acted upon to ensure care provided was monitored, and that risks were managed safely, and the service achieved compliance with the regulations and previous breaches in the regulations surrounding the management of medicines.

Our findings demonstrated the service was not meeting the requirements of the regulations in relation to assessing and monitoring the quality of service provision. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.