Care Quality Commission

Direct Health (UK) Limited

Direct Health (Crewe)

Inspection report

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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

Overall summary

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

At the time of this inspection Direct Health (Crewe) provided a home care service to over 160 people in the Crewe, Sandbach, Alsager, Middlewich and Congleton areas. It is part of the Direct Health Group, which operate a number of branches around the country.

We gave the provider 48 hours' notice of our inspection. When we last inspected Direct Health (Crewe) we found that the provider was not meeting the regulations in respect of the care and welfare of people who used services (regulation 9), staffing (regulation 22), and complaints (regulation 19). The provider sent us an action plan stating that they would comply with these regulations by 30 April 2014. When we inspected Direct Health (Crewe) on this occasion we did not find that the provider had taken the action to make the necessary improvements in respect of the care and welfare of people who used services (regulation 9), and staffing (regulation 22).

Summary of findings

There was no registered manager in place at Direct Health (Crewe). The last registered manager left in January 2014. It is a condition of the provider's registration that there should be a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

At this inspection we found that the provider did not make suitable arrangements to protect people who used the service from abuse. They did not undertake all the checks which were required to make sure that people who are employed at Direct Health (Crewe) were suitable to do so. This meant that the provider did not comply with the relevant regulations relating to safeguarding people from abuse and requirements for workers. You can see what action we told the provider to take at the back of the full version of this report.

People who used the service told us that there was not enough continuity between the different carers who visited them at home. People said they could not always rely on the service provided by Direct Health (Crewe) because it was sometimes late or was cancelled sometimes without notice. This was partly because of lack of staff. The provider was not complying with regulations which require the provider to employ sufficient staff to provide the service safely. Care plans were not reviewed and there was little evidence that people were involved in or had agreed with them. The provider did not therefore comply with the requirement to plan and deliver care so as to promote people's care and welfare. You can see what action we told the provider to take at the back of the full version of this report.

The provider did not have adequate systems required by regulations to quality assure the service being provided. The provider did not comply with the regulation which requires the provider to assess and monitor the quality of service provision. You can see what action we told the provider to take at the back of the full version of the report.

Training arrangements for staff at Direct Health (Crewe) were good. When we saw carers providing care to people who used the service we saw that they did so in a caring way but inconsistent staffing arrangements meant people using the service sometimes had care delivered to them by staff that were not known to them.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe because the provider did not always notify the local safeguarding authority or the Care Quality Commission (CQC) of events where there had been an allegation of abuse in relation to a service user.

The provider did not always operate effective recruitment processes to ensure that people were suitable to work in the service provided by Direct Health (Crewe). Where people were unable to consent to their own care we did not see that the protections of the Mental Capacity Act 2005 were observed.

Care staff had a good understanding of what to do if they saw or suspected abuse during their visits. They were clear that this must be reported to the managers of the service.

Is the service effective?

Requires Improvement

The provider was not effective because there was not sufficient continuity of care for people who used the service. People told us that when they received care from staff that they knew and who knew them that care was effective but it was less so when new or unfamiliar staff were substituted. Care documentation was incomplete and was not reviewed regularly.

We found that there were robust arrangements for staff training at Direct Health (Crewe) and that this engaged staff who said that they found it helpful.

Is the service caring?

Requires Improvement

The service was not caring because people who used the service could not always be sure that the carer sent to them would know sufficient information about them or be familiar with their individual care requirements. We did not see sufficient evidence that people had agreed to their own care plans.

When we visited people in their own homes we saw that those care workers who knew the people they provided care to well that they related to them with dignity. They did so in a way that maintained the privacy of the person who used the service.

Is the service responsive?

Inadequate

The service was not responsive because it was not reliable. People complained to us that calls were sometimes missed or were later than scheduled. The provider did not always warn people if their scheduled care was to be interrupted or changed in some way. The provider withdrew the service at short notice from some people because they did not have sufficient staff.

People told us that complaints were not always responded to. We were unable to reconcile the provider's complaints log with the comments we heard from people who used the service and their relatives.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led. It is a condition of the provider's registration that there should be registered manager and no registered manager was in place at the time of our inspection. The provider had not formally notified the Care Quality Commission as it is required to do.

The provider did not have adequate systems in place for assessing and monitoring the quality of service provision. Although we saw that the provider was introducing new measures to do this we did not see evidence that these were in place and were protecting service users, and others against the risks of inappropriate or unsafe care.

Direct Health (Crewe)

Detailed findings

Background to this inspection

The inspection team was made up of an inspector and two experts by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service or who uses it themselves. The inspector visited the offices of Direct Health (Crewe) on 18 and 21 of July 2014.

When we inspected Direct Health (Crewe) in March 2014 we found that the provider was not meeting the regulations in respect of the care and welfare of people who used services (regulation 9), staffing (regulation 22), and complaints (regulation 19). The provider sent us an action plan stating that they would comply with these regulations by 30 April 2014.

The provider sent us a pre-inspection information pack which we used to prepare for the inspection. We contacted the local authority which had responsibility both for safeguarding and commissioning services from Direct Health (Crewe) and we met with them on one occasion. We took the information they provided into account when we wrote this report. We reviewed the information relating to this provider held by the Care Quality Commission.

We undertook this inspection by visiting the offices of Direct Health (Crewe) where we reviewed documentation. We looked at ten care plans, four staff files and other documents such as supervision records and audit checks. We talked with the area manager and interim manager, as well as two other senior staff with responsibility for quality control and eight care staff.

The Experts by Experience were provided with a list of 60 people who received a service from Direct Health (Crewe). We chose the names from a full list of people supplied by the provider but asked the provider to advise us of anyone we should not contact because they might be too ill or where contact might upset or alarm them. Where this was the case we chose another person to contact. We wrote to all these people advising them that we would like to speak to them and that they could decline to do this if they preferred. As a result in some cases relatives contacted us to offer their views.

The Experts by Experience interviewed 37 people who used the service or their relatives in this way. In addition the inspector visited three people in their homes and spoke with them and their relatives where they were available. The inspector also spoke with the four care staff providing the service in these people's homes and looked at the care plans that were kept there.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

'The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Inadequate

Is the service safe?

Our findings

People who used this service were not safe because safeguarding procedures were not always followed and safeguarding incidents were not always reported and acted upon. This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were also not safe because staff recruitment practices were not robust enough to ensure the suitability of staff to work with vulnerable people. This was a breach of Regulation 21 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

None of the people we spoke with or their relatives had direct concerns about abuse in relation to the service provided by Direct Health (Crewe). Most of the people who used the service to whom we spoke said that they felt safe. However sometimes they qualified this. One person said "I feel safe with the carers who come into my home on a regular rota but I am not happy when they send someone who has not been introduced". Another person told us "I feel safe especially with the carers I know".

There were different reasons why lack of continuity of staff made people feel less safe. This included unfamiliarity with routines such as making sure the house was locked at night and drawing the curtains so that people would feel secure. People felt less safe with a carer who they did not know or were not expecting or to whom they had not been introduced. One person told us "Sometimes I dread who is going to come in. I worry about who they are sending instead (of the regular carer)". Staff told us that where they were attending in pairs one was not allowed to enter the person's home without the other. This meant they had to meet up outside the person's home. One relative told us that this had made them anxious when they were not familiar with the carer who was waiting outside their house.

We looked at the staff rotas for the month of our inspection. We looked at the carers who had visited the people who we saw at home. We saw that a total of 22 different carers had been involved in providing care to these three people although one person required two carers at a time. Each person who had been visited by a single carer saw an average of seven different carers during this period. Of the 14 different carers who provided care in pairs there was little consistency about how they were paired and care was provided for this person by 11 different combinations.

Because care can often include intimate and personal procedures this inconsistency could cause anxiety for people particularly if they were not given warning of any change in the identity of their carer.

All the care staff we spoke with had a good understanding of safeguarding. They were able to explain to us the sorts of risks of abuse that the people they cared for might be vulnerable to. They accurately described the signs that might lead them to suspect this. Staff were clear about what they would do if they suspected safeguarding issues and told us that they would report these through their line management. Documentation on safeguarding was available in the care plans stored in each house.

None of the staff we spoke with said that they had experienced a safeguarding incident during their current period of employment. We saw that the provider made safeguarding training available as part of the staff induction programme and was putting arrangements in hand to update this training for those staff who had completed it some time ago. The provider is required to notify the Care Quality Commission of any safeguarding concerns. We reviewed those that we had received since the last inspection and satisfactorily cross-checked one of these with the local authority which has the responsibility for safeguarding. Only one of the staff we spoke with handled finances for people who used the service. They were able to explain the system which was followed to ensure that this was done correctly.

When we visited people who used services in their own homes we saw that within the service guide supplied by Direct Health (Crewe) there was guidance about what to do if there was a safeguarding concern. We saw that the provider had a policy relating to Dealing with Reported or Suspected Safeguarding Issues. The policy was robust and had been reviewed within the last nine months. However we saw that the staff handbook only addressed the way that financial matters should be handled for people who used services so as to safeguard their interests. Apart from this the handbook only reproduced the Care Quality Commission guidelines. The provider told us that this limitation was being addressed in the revised version of the handbook.

One of the people we spoke with told us about a recent incident which had resulted in the agency changing their carer. This person also told us about a second separate incident in which their security had been put at risk. These

Inadequate

Is the service safe?

incidents both separately constituted grounds for raising safeguarding alerts with the local authority which has responsibility for this. However when we checked with the local authority they told us they had received no safeguarding concerns about these incidents in the relevant period. The provider is also required to notify the Care Quality Commission of certain incidents of this type. We checked our records but could not find any notifications in respect of these incidents. The relative of another person who used the service also complained that they had had concerns about the security of their relative's home during visits by Direct Health (Crewe).

We asked the provider if they were currently providing care for anyone who did not have the capacity to make some decisions for themselves. They told us that there was only one person who used the service who was in this position. We saw that key documents had been signed by this person's next of kin on their behalf. When we looked at this person's file we could not find any mental capacity assessment. This meant that care staff had no guidance as to how to adjust the care provided to take into account this person's current mental impairment. We saw that the provider included Mental Capacity Act 2005 training in its arrangements for dementia training and that staff records showed they had received this training.

We checked the arrangements that Direct Health (Crewe) made in order to make sure that only suitable people were employed to work there. Some of the checks that should be made are outlined in the relevant regulations. Staff we spoke with confirmed that they had not been allowed to work with people who used the service until the recruitment process was complete, a Disclosure and Barring Service check had been received, and they had undertaken induction training.

We looked at a number of staff files both for staff who had recently started working for the provider and for those who had worked there for some time. We found that four of the files we looked at were incomplete in at least one respect. In one instance there was no application form so we could not see any evidence that the provider had checked the employee's past employment history. In other instances there were no records of some of the references which would help the provider to decide if a person was of suitable character.

In the files of more recent appointments there was no evidence that the provider had enquired as to the health of the employee. The provider told us that they had ceased to ask this because they thought it was not legal to ask this question under equality legislation. However equality legislation identifies the circumstances in which such enquiries can be made but restricts the use that can be made of this information. This allows the provider to seek and record this information in connection with this type of employment. There was therefore no evidence that the provider had obtained the information required by the regulations.

We saw that the provider had already completed its own audit of staffing files and identified some of these gaps and was taking steps to ensure that the information held complied with the necessary regulation. The provider told us that they had centralised much of the recruitment process across the company which owned Direct Health (Crewe) in order to try and make sure that recruitment was undertaken to a satisfactory common standard.

Requires Improvement

Is the service effective?

Our findings

The service was not effective because the provider did not take steps to plan care so as to ensure the welfare and safety of people who used the service. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The service did not always provide effective care for people because there were insufficient staff. This was a breach of Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most people told us that they felt that their care needs were met by the provider and that "the staff know what they are doing and have had sufficient training to do this". However other people told us "I do not feel that they always send people who know what they are doing" and "some are not sufficiently trained, new ones are sent into service too soon". Some people felt that there were sufficient staff but more people who used the service or their relatives expressed concerns. Comments included "No. I get the impression they are short staffed" and "They are very hard worked, they need more staff".

The staff we spoke with told us that they made around 12 visits to people each day. Some staff told us that they felt that the scheduling was realistic and they were allocated enough time to undertake the care they were to provide. One member of staff told us that they sometimes spent longer with people but they were not paid for this. Two other staff told us that visits had to focus on practical tasks such as making a drink or meal, toileting and administering medicines sometimes within 15 minutes. They said "We would like to chat (with people)" but the allocated time did not allow for this.

Another person told us that their carer was contacted during their visit and allocated to another call. When we asked one relative if they thought there were sufficient staff they said "No. They are still short staffed. Even the carer from the office has to come out and do visits sometimes". We looked at the work patterns for the staff who work for Direct Health (Crewe). We saw that most of the staff included in the rota we looked at undertook an average of nine calls per day.

However we saw that on occasions some staff had undertaken many more than this number of calls. In one instance a member of staff had made 24 calls over a 15 hour day ending at 10.30 p.m. The following day they started work again at 8.00 a.m. and undertook 20 calls in 13 hours. We could not see how the quality and timeliness of care could be assured by Direct Health (Crewe) if staff were undertaking such a large number of calls. One member of staff told us "I love the work. I hate the hours".

Most people expressed confidence in their care staff saying "Yes, the new carer is really good" and "Yes, there are always some that will go that extra mile". We looked at arrangements for training and saw that this included safeguarding, medication, and mental health as appropriate. The training records confirmed that staff had completed an induction programme and we checked that this was recorded in the staff files.

We were told that staff were encouraged to maintain their training and that if an element became out of date the electronic rota system could cease to include them on duty until this was rectified. Most staff we spoke with felt they were up to date with their training but one care worker felt that theirs was becoming overdue. Staff told us that they thought that training "was good".

The provider showed us copies of the workbooks which they had created to support staff training. Staff used these to work through learning with a trainer and recorded their answers and observations. We saw that certificates were awarded for successful completion of these topics and that these were recorded in the staff files as well as on the training records. We saw that these covered the key topics required to provide care to a person and were mapped to the Skills for Care standards for induction as well as to the current Care Quality Commission guidance.

The provider told us that relatively few calls were now concerned with domestic tasks such as shopping or cooking. Where care staff were involved in preparing a meal this would usually involve the preparation of convenience foods or making sandwiches. Where care staff were engaged in these tasks people who used the service and their relatives told us that they were satisfied that carers washed their hands, prepared the food, and cleared away afterwards when they could.

When we looked at the care plans we saw that there was some information provided by other professionals such as social workers, occupational therapists, and physiotherapists. This meant that carers were able to take their views and requirements into account when providing

Requires Improvement

Is the service effective?

care. We asked people if care was easy to restart if it was uninterrupted for example by having to go into hospital for a short period. One relative told us that this had been "very smooth – it resumed the same day". On the other hand we saw a complaint about care not being provided on return from hospital because the provider did not have sufficient staff to provide this. The person's relative had not been informed of this in advance of them returning home.

Requires Improvement

Is the service caring?

Our findings

The service was not caring because the provider did not take proper steps to make sure that people were protected against the risks of receiving care that was inappropriate. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People did not always find the service caring because they could not be guaranteed consistent staff who knew them and understood their preferences and needs. This was a breach of Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked people who used the service if they found it caring. One person told us "The care is perfect and thoughtful when it is the regular carer but not when they send replacements".

We visited three people in their homes and talked with two relatives as well as observing how care staff related to people who used the service. On the day of our visit each person was receiving care from care staff that they knew well. We saw that care staff treated people with respect. We saw that they considered privacy and dignity when talking with people and explaining what they proposed to do. One person told us "I definitely get the care I need. Marvellous. Very nice people" and their relative added "Our carer is an absolute star". Another relative said "These two (regular carers) are brilliant. They know exactly how to care for (my relative)".

However people said that this was not always the case when an unfamiliar carer was allocated. One relative told us that because they were not always told about this in advance the person they cared for would sometimes become anxious and ask them "Who is coming in the morning?" We were told that even where two carers were regularly allocated to a call sometimes both carers would be substituted rather than retaining at least one which was familiar with the person using the service. This was confirmed when we examined the sample rotas. A relative told us that when a different carer attended it meant that their own standards might not be observed. They told us "Occasionally carers do not realise that this is someone's home – they forget that this is my home".

One relative said "New carers arrive but they do not know where everything is" and "I am not knocking the (care staff) but I have to stipulate that if a new person is coming, they (someone familiar with the person) come with them". Another relative told us that they had tried to stipulate that they did not wish a particular carer to visit again where the care provided had been unsatisfactory. They told us that this carer continued to be scheduled despite this request. The provider told us that they did not have a sufficiently wide pool of staff to respond to such requests if they were specific.

We looked at care records which included detailed accounts of individual preferences and choices such as for how people liked to be addressed. The care files contained detailed routines for care workers to follow so that these could be agreed with the people who used the service, would be familiar to them and would coordinate with other aspects of their lives such as the contribution of other carers and established routines.

These personal service plans included space for a mental capacity assessment along with an assessment of standard risks in relation to skin integrity, continence, and sensory aspects. Further risk assessments were added according to the individual circumstances and requirements of each person. Extracts of recent daily log books (kept in each person's house) were also included which contained a detailed note of what had happened during each visit with information about any medicines or nutrition taken. However as the log which was included was not always the most recent one they did not provide an up to date picture of the care being provided for that person.

The care plans retained in the office were not always signed by the person using the service. to show that they had participated in and agreed with it. They were sometimes signed instead by a relative and usually a next of kin but since all these people had the capacity to agree their own care they should have been signed by the person who used the service to show their agreement. Three of the plans were not signed by either the service user or their representative and so it was not possible to determine whether they had been involved with putting them together.

All the care staff talked about the people who used the service in a way that suggested they were caring and enjoyed friendly relationships with people. They were keen to emphasise that people had rights which should be observed and that should be cared for in the same as they would wish their own relative cared for. One said "We do the best as if it is for our own Mum". This is called "the Mum

Requires Improvement

Is the service caring?

test" because people should not have to experience poor care that other people would not accept for their own relative. Staff emphasised that people who used the service had choice about how the service was provided and that they would respect this in relation for example as to what people ate or how they dressed. One said "It's (the person's) choice – I give people choices and they can say 'no'. I might encourage the person and then explain why something is important". Staff said they would report refusal of something important such as medication to the office.

We asked staff how they ensured that they maintained the privacy and dignity of people who used the service. They gave us examples such as making sure that the curtains were drawn at night so that a person would feel secure when they went to bed and making sure that they were covered with a towel when using a commode. They told us that they used the form of address chosen by the person and could find this from the care plan that was kept in people's houses. When we visited people in their own homes we saw that staff treated them in this way. However some relatives also told us of instances where rushed or late visits or attendance by unfamiliar staff had led to this dignity not being respected.

Inadequate

Is the service responsive?

Our findings

The service was not responsive because it was not reliable. People could not be assured that the service from Direct Health (Crewe) would provide them with care as agreed. This was because Direct Health (Crewe) did not employ sufficient staff. This was a breach of Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our inspection we saw that one person had become distressed because their carer had not arrived at the correct time. They were unable to get out of bed without assistance and so were still in bed when we telephoned them at 11 a.m. We contacted the provider to find out what had happened. In the meantime when we called this person back they told us that the carer had arrived. This was approximately 30 minutes after the allocated time. One relative told us "The service is not responsive to the needs of my mother".

When we last inspected Direct Health (Crewe) we were concerned that the provider did not always meet its commitments to visit people as arranged. Because some people who used the service relied on these calls for essential care such as with medication, or toileting, or with eating and drinking, a missed call could mean that person was placed at risk. The provider has recently reported an incident to us in which a person cancelled their call because it was late. This resulted in that person not receiving their medicines.

During the current inspection we were told that the provider had had to "hand back" a call. This happens when a provider is unable to fulfil a commitment to the local authority which has commissioned it to provide a service. The provider had not given adequate notice of this change in order for the authority to make alternative arrangements. In this instance the provider had given no warning or other information to the person who used the service about this change. The person only became aware of the change when the expected visit did not materialise. The local authority had to intervene to make sure that this person received the care they required. This included attending a hospital appointment which would otherwise have had to be cancelled.

After the last inspection the provider sent us an action plan which included a commitment to contacting service users to inform them of any delays to their call times due to staff absence at short notice. This included contacting next of kin and updating them of any changes to service. This had not taken place in this instance.

On another occasion we were informed that Direct Health (Crewe) had given notice to a relative that it would not continue to provide care to a person. This person had the resources to arrange and pay for their own care. Although the provider had given the period of notice required in its contract this had meant that the relative had only a few days in which to make alternative arrangements because they were going on holiday. The reasons given by the provider to this relative was "staff shortage" and "lack of staff" and "due to staff shortage we are unable to continue meeting (your relative's) needs in providing a safe and time critical service".

A number of people who used the service and their relatives told us that they were unhappy with the reliability of calls. One relative told us that calls could be as much as three hours earlier or later than agreed. Where these calls included administration of medicines this could have consequences for the wellbeing of the person concerned because the medication might not be given at the correct interval and doses might even be given too close together. One relative told us "My relative is a diabetic and needs their medicines at a regular time and this does not happen if they are late" and another person who used the service said "I need my medication at the correct time. If they are late then it affects my health". One relative told us that prompt timing of visits was important because they had to organise other care tasks around them such as giving medicines at the right time.

Another relative described the person they cared for as having been "traumatised" because the provider used to telephone their relative to say either that they could not visit, would have to defer it to the next day, or even cancel altogether. However this relative also told us that "things have improved".

Other comments we received included "There is no regular time (for a call), not any more" and "The time (for my call) is booked at 9.00 o'clock but if they come at 8.00 o'clock I go along with it". Another person who used the service told us "They miss visits and they don't always stay as they should". One relative told us "The carers sometimes don't turn up. I quite frequently have to ring up when no-one has arrived".

Inadequate

Is the service responsive?

One relative explained to us how the timing of calls could be critical. Their family member relied on a call to help them go to bed which included closing the curtains and making sure the lights were on. On one occasion during our inspection the call was scheduled for 9.25 p.m. but did not take place until 10.20 p.m. This meant that this person was left sitting in the dark. They could not close the curtains for themselves and therefore could not enjoy privacy for this period of time. On another occasion a carer who had visited in the afternoon had drawn the curtains whilst the person received personal care and then afterwards had not opened them meaning that the person had to sit in the dark until the next call. We were told by one relative that a call was once so late that it was immediately followed by the next call whereas there should have been a gap between them.

We looked at the way in which calls were programmed by the provider. We saw that a care coordinator used a computerised system to do this. The provider told us that they were anxious to reach a position where people received a continuous service with as little unexpected disruption as possible. The provider was able to show us records that suggested that this level of certainty was gradually increasing. However currently we saw that only 62% of calls could be programmed with this consistency. This was confirmed by what people who used the service and their relatives told us.

We saw that the provider was able to bring the standard timetable of calls forward from the previous week which would allow continuity. They then made such changes as required such as if a care worker was unavailable or if the person who used the service had requested it perhaps because they expected a visitor or needed to attend hospital.

People who used the service and their relatives told us that they were able to make such changes easily although 48 hours' notice was required. If this notice was not given then they would be charged for the call. We were told that once completed each care worker's commitments were sent to them by mobile phone.

The provider told us that changes such as to the allocated care worker were sometimes unavoidable because of holidays and sickness absence. We were told that where a change was made like this the person who used the service or their family would be contacted by phone so that they would know. Not all the people who used the service and their relatives confirmed that this always happened. One person said "Yes, they let me know" and a relative said "They would but (my relative) would know all the carers". However one relative said "the office does not let people know if the carers are running late and at times the carers are unable to let them know because they are driving".

Another person who used the service said "If they would let me know when the (usual carer) is away it would be nice to say so and so is coming instead". None of the other people or relatives we spoke to said they were informed of these changes. One relative told us that the reason they were concerned about this was because the regular carer had a good knowledge of caring for people living with dementia and who benefitted from consistency. They said "sometimes they are that short of staff, different people keep coming, and they don't understand dementia". One relative described the situation as "sometimes you can get rag, tag and bobtail" to reflect the uncertainty they felt.

Relatives told us that they had requested that they be provided with rotas in advance so that they would know which carer was scheduled to visit and could see any changes to this. They said that they used to provide stamped self-addressed envelopes for this but told us that these rotas were no longer supplied. One person used to receive them by email which was free but told us that this had also ceased. This meant that people could not check on who had been scheduled to provide them with care and confirm the times of the visits.

We looked at the care plans in the office to see how the care provided was reviewed to reflect and respond to changes in people's wellbeing. Staff told us that they thought that the minimum period for review of care and risk assessment was every twelve months.

We saw on one care plan that it was due for review in February 2014 but there was no indication that this had taken place. When we looked in the file kept at the person's home we could not see evidence that care had been reviewed recently. We looked at another file for a service user who had been provided with care for a number of years and could not see evidence of a review since 2012. This person's risk assessment had not been reviewed since before that date. Some service users told us that they had received annual reviews but more said that they had either

Inadequate

Is the service responsive?

not had their care reviewed recently or not had it reviewed at all. One person told us that they had had a review but it had not been added to their care record. A member of staff confirmed that this was the case.

People told us that they knew how to make complaints. They said "I would ring the office - the number is on the front of the file. One relative told us "I have complained. They dealt with it". However other people and their relatives expressed less satisfaction. One person said "I have complained about different carers coming but nothing has happened" and another said "The agency is not very responsive – complaints are not dealt with quickly enough". One relative told us that they had made a recent complaint but felt that their treatment was "very rough and brusque". Another told us "I complained to the office about late visits but nothing happened". Some people and their relatives said that there were periods when the telephone in the office went unanswered. On two occasions during our inspection we made calls to the office during normal business hours which went unanswered.

The provider maintained a record of complaints and compliments made about the service. At the time of our last inspection missed or late calls had been a major source of complaint. We saw that there had been five complaints made since our last inspection. None of these related to missed calls though there were some complaints made about the inconsistency of carers and that calls were made other than at the time originally agreed.

We saw that of the complaints which were logged a record had been made of how they had been investigated. These complaints had been acknowledged. Where the complaint related to care practice rather than the calls themselves we saw that the provider had taken appropriate action including staff retraining. However we could not reconcile the low number of formally recorded complaints with the information we had received from the people who used the service or their relatives.

Inadequate

Is the service well-led?

Our findings

This service was not well led because it did not have a manager registered with the Care Quality Commission (CQC). This was a breach of the conditions under which Direct Health (Crewe) was registered to provide a service. The provider did not have effective quality assurance systems in place so that they could check on the quality of service being provided. This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At the time of our inspection there was no registered manager in place at Direct Health (Crewe). The last registered manager left in January 2014. In the meantime an interim project manager had been appointed but they were not registered with the CQC. We were told that there had been a delay in recruiting a replacement but that a new registered manager was due to be in place within the next fortnight. Immediately after our visit to Direct Health (Crewe) we became aware from discussions with local commissioners that this new appointment had not materialised and that the process of recruitment had been recommenced. Direct Health (Crewe) did not formally notify the CQC of any of these changes in the arrangements relating to the appointment of a registered manager.

In the information provided before the inspection the provider described a number of ways in which the quality of service provided was monitored. These included quality control questionnaires, and spot checks on the progress of individual care plans.

We asked the provider to show us how they assured the quality of care that their staff were providing in people's homes. We were told that spot checks were undertaken by a care coordinator visiting a care worker whilst they were working in someone's home. This meant that they could report on such items as timekeeping and appearance, and how the carer related to the person using the service. The provider was unable to show us any recent spot checks from the current year. The provider said that this was because the service usually had three care coordinators who carried out these spot checks and that for some time they had been operating with only one. The absence of spot checks meant that the provider was not regularly monitoring the quality of care being provided.

The provider had a policy relating to the supervision of staff. This stated that staff would receive three supervision sessions each year one of which would be in the home of a person who used the service. When we reviewed a selection of supervision records we found that almost all of them had been completed in the year before our inspection with only two records completed in the current year. The provider told us that this too also related to the shortage of care coordinators. They expected the recruitment of replacement care coordinators to be a priority for the new registered manager. This meant that the provider was not providing staff with appropriate supervision and appraisal.

We asked people who used the service and their relatives if they were ever asked to comment on the quality of the service they received from Direct Health (Crewe) by means of a survey or questionnaire. None of the people we visited could recall receiving one recently. When we telephoned people who used the service they told us they had not been asked about the service in this way for more than twelve months. One person said "we used to have survey forms to fill in but not now". During the inspection we were told that the national company of which Direct Health (Crewe) was part was due to undertake its annual survey of service users the next month.

When we last inspected Direct Health (Crewe) the service had undergone a period of disruption. Staff told us that it had been a difficult time but they felt that the provider was beginning to "get back on track" and that communication was improving. They said that the reintroduction of staff meetings was evidence of this "You need a meeting so that carers can air their concerns and management can air theirs".

We asked people who used the service and their relatives about their recent experiences of the care provided by them. Some people felt that the service provided by Direct Health (Care) had begun to improve. One person said "Yes, it seems to be improving but you can still have a variety of carers" and another said "Yes, I'm pleased with it". Another service user said "The service is running better now but I still don't think much of the management". Another service user felt the improvement had not been sustained when they commented "It's back to square one".

Inadequate

Is the service well-led?

Other people expressed dissatisfaction with the administration and management of Direct Health (Crewe) when we asked them if they thought the provider had learned from recent experiences. They said "The carers are good but the office isn't" and "No. The office lets it down"

The provider showed us how they monitored the promptness of calls. We were told that the provider's computer system compared the care workers' check-in times with the rota and raised an alert if these differed. The provider told us that they were able to monitor these alerts during all the hours that it provided a service and take action appropriately. The provider gave us information that indicated that currently 12% of calls did not comply with the schedule but that this also included calls that were made late or were cancelled by the person who used the service.

However the provider also told us that they allowed a 30 minute period before a call was classified as late. Since the system was computerised we thought that the provider could monitor this more closely with a narrower time period so as to provide more robust quality assurance given the comments made to us by people who used the service and their relatives. We saw that the provider already had a computerised incident management system on which they recorded key events. We saw that this was being upgraded to allow better analysis of these so that lessons could be learnt. The provider told us that the new system would be "more integrated" and would be "proactive rather than reactive".

We saw that the provider was seeking to make a number of improvements by introducing new training arrangements and undertaking self-audits of staff files and care plans. The provider told us that this was because they knew that these required improvement. The provider felt that this had been a result of not having a registered manager in place. We asked the provider to show us any examples of the audits of care plans but they were unable to do so other than one instance in an electronic format. We did not therefore see evidence that these audits had yet been introduced on a widespread and accessible basis. We asked the provider to estimate when all these improvements might have taken effect and they replied that they thought it would take around six months.

We asked staff if they knew about whistleblowing. Whistleblowing takes place if a member of staff thinks there is something wrong at work but does not believe that the right action is being taken to put it right. Staff were able to describe the arrangements for whistleblowing including contacting the Care Quality Commission (CQC) which is an organisation designated to receive such complaints. We saw that there were clear arrangements for whistleblowing outlined in the staff handbook and that the provider had a policy relating to this. The CQC had received no whistleblowing complaints in the period since the last inspection.

In addition the provider also had a designated "Whistleblower's Friend" which was a member of senior staff within the organisation that owns Direct Health (Crewe). The "Whistleblower's Friend" told us that they were currently arranging for all staff to have the opportunity to meet with someone other than their own management. This would allow them to say something in private which they might not otherwise confide.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers How the regulation was not being met: People who use services and others were not protected because the provider did not always operate effective recruitment processes to ensure that people were suitable to work in the service. Regulation 21(a)(b)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: People who use services and others were not protected against the risk of receiving inappropriate care because care planning and risk assessment processes were not robust. The provider had not made adequate arrangements in the event of lack of availability of staff. Regulation 9

The enforcement action we took:
We have served a warning notice to be met by 1 December 2014.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: People who use services and others were not protected because the provider did not always operate effective processes to monitor and assess the quality of service provision. Regulation 10

The enforcement action we took:
We have served a warning notice to be met by 1 December 2014.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse How the regulation was not being met: The registered person did not respond appropriately when it was suspected that abuse had occurred or was at risk of occurring including notifying the local safeguarding authority and the Care Quality Commission. Regulation 11

The enforcement action we took:
We have served a warning notice to be met by 1 December 2014.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: The registered person did not take appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation 22

The enforcement action we took:
We have served a warning notice to be met by 1 January 2015.