Direct Health (UK) Limited

Direct Health (Oldham)

Inspection report

Unit 4 Whitney Court
Southlink Business Park, Hamilton Street
Oldham
Lancashire
OL4 1DB

Tel: 01616249510

Date of inspection visit:
23 May 2016
24 May 2016
25 May 2016

Date of publication:
09 August 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 23, 24 and 25 May 2016, and was an unannounced inspection.

Direct Health (Oldham) is a domiciliary care service registered to provide personal care to adults living in their own homes in Oldham and Rochdale. The service's office is based in the Glodwick area of Oldham. At the time of our inspection, the service was providing personal care and support to 100 people and employed 44 members of staff. At the time of our inspection some staff and people using the service had transferred to Direct Health (Oldham) from another provider.

We lase inspected this service in October 2014, where the service was found to be meeting the standards assessed.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager registered with Care Quality Commission in February 2016.

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

People were not protected against the risks associated with the management of medicines. Medication records did not contain important information about the medicines that people were taking and care plans did not show what support people needed with their medicines. This meant that there was a risk that people might not receive the medicines they needed as prescribed by their doctor.

The provider did not have adequate systems in place to ensure the safe handling, administration and recording of finances to protect people from financial abuse.

Risk assessments for people who received a service were incomplete or lacked detail. Where risk assessments were in place they did not provide detailed person specific information to mitigate identified risks. We saw no risk assessments identifying hazards in the environment such as working in people's home

or when out in the community.

Improvements needed to be made to ensure all staff receive regular supervisions and appraisal.

Refresher training had been identified for all staff and a twelve-month training plan was in place. All new staff undertook an in-house induction programme when they started work at the service including the 'Care Certificate'.

People had their needs met by sufficient numbers of deployed staff. An ongoing recruitment plan was in place and additional staff had been employed to manage business growth.

Where the service supported people to eat and drink we found care plans were in place for staff to follow. However, the care plans did not identify if the person was at risk of malnutrition and what steps were to be taken to mitigate any risks. We have made a recommendation that where people require support with their nutritional needs, risk assessments are in place clearly detailing the steps to be taken to mitigate risks.

People told us staff were caring and respected their privacy and dignity.

The service had safeguarding and whistleblowing procedures in place and care staff were aware of their responsibilities.

Staff told us that they sought people's consent prior to providing their care. Where people were assessed not to have the capacity to consent to their care and treatment. There was a record of how the care provided had been agreed.

People's needs had been assessed prior to the commencement of support. Information about peoples likes dislikes and preferences were included so staff had the relevant information to assist them when supporting the person. However, the care plans we reviewed were basic and lacked detailed information about the person's needs, their past history likes and dislikes. Care staff told us that not all the relevant information was available to them in the care plans. We have made a recommendation about care records needing to be more person centred.

There were some systems in place to assess and monitor the quality of service provided. People told us that they completed a questionnaire to provide feedback on the service.

Staff told us that they found the new management approachable and felt that they were listened to.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

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

Risks to individuals were not managed and updated in order to keep people safe from financial abuse. Risk assessments did not provide sufficient detail or identify hazards to people.

People had their needs met by sufficient numbers of staff. The service had robust recruitment procedures in place.

People told us they felt safe with staff from Direct Health (Oldham).

Is the service effective?

Requires Improvement

The service was not always effective.

Staff and had not received regular supervision or appraisal.

Not all staff had completed refresher training to meet the needs of people who used the service.

Staff sought people's consent prior to providing their care.

People were supported to eat sufficient food and drink to ensure they maintained a well-balanced diet. However, risk associated with malnutrition

Is the service caring?

Requires Improvement

The service was not always caring.

Most people we spoke to felt most care staff were caring and respected their privacy and dignity.

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

Where people did not receive support from their regular care staff, their individual routines or needs were not always known.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People told us that they were involved in developing their care plan.

A complaints procedure was in place, all complaints were logged, investigated and the outcome of the investigation recorded.

Care records were reviewed annually or as required. However, people's care needs and any risks had not been thoroughly assessed and documented.

Is the service well-led?

Requires Improvement

The service was not always well led.

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.

People and staff said they were listened to and felt able to speak with the managers at the office or within service to effect change.

Direct Health (Oldham)

Detailed findings

Background to this inspection

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

This inspection took place over three days on 23, 24 and 25 May 2016 and was unannounced.

The inspection team was made up of one adult social care inspector 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.

Prior to our inspection, we reviewed the information we held about the service, including the previous inspection report and notifications the provider had sent to us. We contacted the local authority safeguarding team, the local Healthwatch organisation and the local authority commissioning team to obtain their views about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. None of the organisations we contacted raised any concerns about Direct Health (Oldham).

During the inspection, we spoke to thirteen people who used the service and three of their relatives over the telephone. We also spoke with twelve members of care staff.

We visited the service's office on 23 May 2016 and spoke with the operations area lead manager, the registered manager and three care coordinators.

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

Requires Improvement

Our findings

Some of the people we spoke with told us that they felt safe when receiving support from care staff. One person told us, "I do feel safe, they come three times a day and one care staff is enough. It is more or less regular care staff which I like." Other comments included, "I do feel safe but sometimes when I open the door I don't recognise them" and "Yes we feel safe, we have made friends with the care staff and they are regular like clockwork." One relative told us, "[Person] feels safe and loves the girls to bits. They come two at a time which is enough and she loves staff."

We reviewed the services systems for ensuring the safe management of medication and found that some people were not being supported safely. Staff administered people's medicines for them. This included removing medicines from a blister pack, placing them in a container and then giving the container to the person. Some people also required prompting to take their medication. In these circumstances, national guidelines determine that a full record must be kept of all medicines that are administered. Medication Administration Record (MAR) charts are a formal record of administration of medicine, and provide information about each person's current medicines prescription, including dose, formulation (i.e. whether in tablet or liquid form) and time of administration. These records should be legible and signed by the person providing the medicines. The provider was not keeping such records as required and the records that were kept were incomplete and at times inaccurate. We also found that prescribed creams had not been documented on Medication Administration Record (MAR) charts.

During our inspection, we reviewed ten peoples MAR charts and found eight people's records were incomplete. We saw there were gaps in recordings and charts had missing signatures. On one person's MAR chart staff signatures were missing at times of the day when medicines should have been administered. We found five gaps on the MAR between 23 and 30 March 2016. Another person's MAR chart we looked at was not signed by care staff on nine occasions during February and March 2016. We also found records for a person, which indicated staff were administrating eye drops but this was not recorded on the MAR chart. This meant that records indicated that people were not receiving their required medications in the prescribed way or at the correct times. Staff who administer medication must ensure that prescribed medicines are taken as per the prescription to prevent the person becoming unwell and to ensure accurate documentation is completed and signed for.

The registered manager advised that they had implemented MAR charts to record the information in more detail and to provide a record of what medicines people had taken. We saw that audits had been carried out to check that staff were accurately completing the MAR charts. We were told that the registered manager

had taken action when gaps in recording on the MAR charts had previously been identified during audits. Staff had received additional training, discussions had taken place in team meetings and supervisions had been held around the importance of accuracy when completing MAR charts. However, gaps were still identified in further audits carried out in April 2016 following the action taken by the registered manager. The registered manager advised us that staff performance issues in relation to medication was being monitored closely under the service's disciplinary process.

The registered manager told us that following initial medication administration competency checks completed during induction training, no further competency checks were undertaken to assess staffs ongoing competency. If staff competencies are not maintained this poses a risk to people. The registered manager told us they were going to introduce regular six-monthly competency checks to ensure that staff were able to safely administer medication to the people they were caring for.

The above examples demonstrate medicines were not managed and administered safely.

This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe Care and Treatment.

The registered manager told us that they provided a service to 100 people and at the time of our inspection employed 44 staff. We reviewed the way that staffing was organised. The registered manager and the operations area lead manager confirmed that the current staffing levels meet people's needs and were confident there were enough staff to provide the service with additional capacity to cover any absences. A weekly report was produced which demonstrated there had been no missed visits. The registered manager told us they reviewed capacity on a weekly basis and said they would only provide new services to people when sufficient numbers of staff had been recruited. The records we reviewed confirmed an on-going recruitment plan was in place.

People and relatives felt that there were enough care staff and they had the skills and knowledge to meet people's individual needs. One person we spoke with told us "I have them every day and I have one regular care staff". We were told by a relative that Direct Health was consistent in providing the same care staff and they knew when they were coming to their family member's home; this helped to provide continuity for people and consistency in the care provided. However one person said, "It's sometimes difficult to get through on the phone I think they are very short staffed and thin on the ground."

We spoke, by telephone, to some people who use the service and they raised concerns about the timing of visits by care staff. People told us, "It changes a lot we never know who is coming it is taking time to settle down since Direct Health took over," and "I don't like not having a regular carer sometimes I don't know who is coming or what time; it's like a lucky dip." Another person told us "Yes generally okay but the timings are erratic sometimes, especially if someone calls in sick."

Relatives raised concerns and said, "We have regulars now and we feel safe. At first it was horrid when Direct Health took over, but things are settling now and the care has improved" and "I call up to check who is coming on a daily basis because I hate not knowing whose coming, I get a rota but sometimes they change it at the last minute so I call up the office to check."

Another person told us, "They come in four times a day and we have regular care staff and they are fabulous we couldn't do without them. They are like friends" and "I have the care staff comes 4 times a day. I feel safe everything is fine. I don't have a bad word about them; they are regular and well trained."

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 within 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, such as anti-coagulants or epilepsy medication.

We reviewed the service's call log information, which detailed planned calls vs. actual calls. The information compared the planned care and support hours against actual care and support hours provided. We found the timings corresponded to the information we found in people's daily log records.

The care coordinators and staff we spoke to told us that they 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 did not use it. The care coordinator said, "We ring the staff and log them out from the office manually but this happens only if our system is down." An on call system was also operated outside of office hours for staff to access support and advice and for reporting staff absence so that cover could be arranged.

We saw that weekly rosters were planned using an electronic system and sent directly to care staffs work mobile phones. This enabled instant communication and ensured updated relevant information was always available. The information relayed to care staff included times and duration of visits, second carer staff details, if needed to deliver care, and additional important information about the person being supported.

We looked at the staffing levels compared with the number of contractual hours to evidence there were enough staff to keep people safe. The weekly roster was flexible depending on the needs of the people being supported and was met by sufficient numbers of deployed staff.

We looked into the safekeeping and management of people's money and found care plans did not give explicit guidance on the extent of support people needed with managing their money. Financial transaction records were available but we found there were occasions where transactions undertaken by care staff on behalf of people had not been documented. There was also no routine checking of the transactions to monitor whether people's money was being handled safely. We found records were not robust and did not contain detailed information regarding transactions made. For example the transaction book did not clearly document money withdrawn, the cost of items purchased and who kept the remaining monies, as on occasions the person being supported had kept their remaining change but this was not clearly documented in the transaction book.

We reviewed the financial records of four people supported by care staff to withdraw money and pay for goods such as shopping and bills. We found for one person a receipt for £274.99 had not been recorded and two further receipts for the amounts of £22.11 and £24.43 had also not been recorded. The registered manager did confirm the items purchased on behalf of the person and we found that there were no discrepancies. However, the service had no formal arrangements in place to protect people from the risk of financial abuse.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014

Staff told us that basic risk assessments were carried out when people first started to use the service. However we found that people using the service who had transferred from another provider, their care records and risk assessments were documented on the previous provider's paperwork and they needed to be updated. Risk assessments reviewed were either incomplete or lacked detail, 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 identified risks. The registered manager told us that they were in the process of reviewing all care records, which included all risks assessments. We reviewed one care record, which had recently been updated with new risk assessments and found improvements had been made in detailing the risk and how to mitigate the risk.

One relative we spoke with was concerned that their relative's mobility had 'worsened' recently. We reviewed a copy of this person's risk assessment, held at the service's office, and found that it did not contain sufficient detail in relation to this person's mobility or take into account environmental factors such as floor surfaces, adequate lighting or pets. We alerted the registered manager to this and an urgent review of the care service was carried out during the inspection.

The above examples demonstrate a breach of Regulation 12 (1) (2) (a) (b) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a safeguarding people policy in place, which provided care staff with information on their roles and responsibilities in protect people from harm. Care staff we spoke to confirmed they had been provided with safeguarding training and could describe the different types of abuse. They were clear of the actions they should take if they suspected abuse or if an allegation was made to ensure people's safety. Care staff knew about whistle blowing procedures. Whistleblowing is one way in which an employee can safely report concerns, by telling their manager or someone they trust. This meant care staff were aware of how to report any unsafe practice.

One care worker told us, "I had safeguarding training during my induction; I would report anything I saw that I felt was not right and if my manager did not take it seriously I would then go to the local authority or the police."

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 helps to ensure people employed are of good character and had been assessed as suitable to work with vulnerable people. This showed that recruitment procedures at the service helped to keep people safe.

Care staff told us they received infection control training and were able to tell us the infection control precautions they take when supporting and caring for people to prevent the risk of cross infection. All care staff wore uniforms and had access to personal protective equipment (PPE), such as vinyl gloves and aprons when completing personal care tasks and cleaning.

Requires Improvement

Our findings

Some people we spoke with who received a service said they generally had confidence in the staff providing care. One person told us that "I don't think trainees are trained long enough and they need more training in [my medical condition] and they should shadow the regulars more: about eight or nine times to know what to do. [The registered manager] has sorted it now for us". Other people, who had previously been supported by another provider told us they were not as confident with care staff from Direct Health (Oldham) and said, "My regular carers used to be good, but some of the younger one's don't know the job, so I will not let them shower me. I preferred it when [care staff] was coming regularly."

We checked care staff personnel files, the training matrix, and talked to care staff to see if they received adequate induction training and on-going training. On the second day of inspection we observed the induction training for two newly recruited care staff who told us "My induction was great, really informative," "I thought my induction was good and got lots of training, it's all really intense and you get to learn loads more than expected" and "I`ve had training in moving and handling, safeguarding and medication but I still have a few more days of training to go through."

The registered manager confirmed all staff received induction training before starting employment. We looked at six staff records and found records to confirm staff had received induction training before starting their employment with the service. The service's induction training covered mandatory topics including safeguarding, infection control and people moving people. The registered manager confirmed that the service's induction covered 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 had not received refresher training in mandatory topics, we found that five staff required updated moving and handling training, four required medication training, and five required safeguarding training. Due to issues identified through medication audits and medicine errors, the service had in January and February 2016 arranged for a number of staff to attend workshops/ training in the safe management of medicines. Our findings during this inspection evidenced that this training had not been effective in enabling staff to handle medicines safely and maintain appropriate medicine records.

We found the service had policies on supervision and appraisal. Supervision is an accountable, two-way process between a member of staff and their manager, 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

(Oldham) staff supervision policy identified there should be at least two staff supervisions a year plus an additional on-site observation once a year. Staff should also receive an annual appraisal. We looked at the supervision matrix and found that all up and coming supervisions were held in line with the service's policy. The registered manager told us they were working to ensure supervisions were up to date and carried out on a regular basis.

Care staff were positive about the supervision and support they received. One care worker said, "I have just had supervision, but you can call the office any time and speak to [registered manager] and she will always try and help you," and "We do get supervisions and things have improved since the new manager has taken over." Another care worker said, "If there is a problem I go and see them, I had a meeting a few months ago to discuss things. I don't think I've had an appraisal as such."

The registered manager told us that unannounced spot checks were carried out on staff. This was to assess how well they provided care. If they were wearing the correct uniform and using appropriate personal protective equipment such as gloves and aprons and to check the competency of staff in the support they provided. The care staff we spoke with said they had received a spot check. Records we looked at confirmed what we were told. The registered manager acknowledged that an on-going programme had been developed so that all care staff will eventually receive a spot check.

We checked six staff files and found within the last 12 months only one member of staff had been provided with at least two supervisions/spot checks and an appraisal in line with the written procedure. Three members of staff had only had one supervision with a manager in twelve months. Two members of staff had not had an appraisal or supervision ever recorded. These members of staff had transferred to Direct Health from a different provider and a detailed supervision and developmental programme had been developed to support the staff.

The above examples demonstrate a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure all staff received adequate training, supervision and appraisal to carry out their jobs roles safely.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. 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 that all care 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 their consent before any care and support was provided by care staff. One person said "Oh yes they always give me choices and always ask if they can come in to the room. My carer always asks before doing any personal care if I need help, she's very good."

We saw that, where necessary, arrangements were in place to assess and monitor the nutritional needs of people who used the service. People's needs were identified during their initial assessment and records

updated as needs changed. One care worker told us, "If any person has a special diet it will be in their care plan and they get reviewed by the management team, we only provide care that is documented in the care plans." We reviewed the care plans of eleven people who required support with their nutritional needs and found that the plans did not identify if the person was at risk of malnutrition and what steps needed to be taken to mitigate the risk. We recommend that the service reviews nutritional plans to ensure all people who are risk of malnutrition have a risk assessment in place.

People told us they were supported to eat and drink. One person told us, "We are 92 and 94 [years old] and rely on care staff to cook our meals, otherwise our health would deteriorate and we wouldn't be able to have hot meals, so we rely on the care staff to cook for us." A relative told us, "Yes they warm up frozen meals for my relative, so that a cooked meal is given at least once a day, this service is valuable" and a person told us "They can't always make a meal from scratch because it takes far too long but will warm up basic foods like soup or make a sandwich, sometimes If I fancy fish and chips [staff] will pick this up for me on their way here."

People told us that they or family members organised their health appointments. One person said, "The care staff will call the GP or the district nurse if I need them too". A care co-ordinator told us they gathered information about health care professionals involved in people's health including their contact details and role. The care co-ordinator confirmed that all care staff would ensure people's health needs were monitored and would contact health care professionals directly if needed. Advice from health professionals were also incorporated into care plans to help maintain people's health and wellbeing.

Requires Improvement

Our findings

We asked people who used the service if staff were caring. Comments included, "Care staff are caring" and "Oh yes they are caring and very friendly" and "[Staff] is such a caring person I couldn't ask for more"

One relative told us "They [staff] are very caring; I make a new list of things to discuss if the care plan needs changing and they do this immediately. Things are okay, I have no problems with the care staff". Another relative told us "They are brilliant with him. They always talk to him. He never used to smile but now he laughs and it's down to the girls". However, some people we spoke with told us that when their regular care workers did not attend they had to tell the carers what they needed to do. One person told us "It is more or less regular staff, which I like but it gets a bit haphazard at weekends. Another person said, "Yes, my needs are catered for but I sometimes have to jog their memory about emptying the bins," and "I want a Carer who I know not someone I don't know knocking on my door." One relative told us "Some are more caring than others. The younger staff do not cope as well with what is needed." and another relative told us "Only one lady just does the book before she does anything and then she does task and she is off."

Staff gave us examples of how they promoted and upheld people's privacy and dignity. One care worker told us , "Some calls we go to have key safes fitted but I always call out and say hello when I enter the door," and "I help them if needed giving them privacy and allow them to dress themselves if they want. I stay out of the room if they want and when showering I cover them or move away. I'm always nice and smiling and polite". Another care worker said, "I promote independence and respect my client's dignity and privacy. If they have a bath, I will ask people if they want support if they want me to stay, I do; it is up to them. It's their choice but I do encourage them to do things".

People told us the office was not well staff so when they attempted to contact the service the phones can be ringing a long time before anyone picked up. They said, "I ring the co-ordinator but when I ring it is sometimes a long wait for an answer but it's getting better." Another person said, "I ring but sometimes I don't get an answer and they don't ring back." We raised these concerns with the registered manager who informed us additional office staff had been recruited to support the existing team.

We looked at ten care records for people which included an initial assessment, care plans, and risk assessments to see if 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, contained details of the person's care and support needs and how they would like to receive support. 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.
We recommend that the provider reviews their care records to ensure they are more personable so that staff can build a more meaningful relationship with the people they support.

Eight people we talked with and three relatives told us they had been involved in decisions about care planning and had taken part in care reviews with in the last year. The registered manager showed us that a review of all people using the service had been carried out to identify where care plans and reviews of care needed to be updated. As a result, a robust plan was implemented to carry out a review of all care records with revised new documentation from Direct Health.

None of the people using the service currently required an independent advocate to act on their behalf. Advocacy support is support provided to help people get the care and support they need and is independent of a local authority. An advocate can help people to express their needs and wishes and is there to represent the person's interests. The registered manager told us they were aware of and could refer people to an advocacy service if needed.

People we spoke with did not raise any concerns that their personal information was not treated confidentially by the service. Care staff were aware of their responsibility of maintaining confidentiality. Direct Health (Oldham) had systems and procedures in place that ensured confidential information was stored appropriately and only shared with relevant people.

Staff told us they were given time to build relationships with the people they were supporting when they first started supporting them. For example one newly recruited care worker told us " I shadowed until I got to know my clients, I got to know their routines and how they wanted me to support them, plus it gave them time to feel more confident in me too". One person told us "Yes new staff have been here to shadow and the office always calls up first to check if it's ok, I think it's really important new staff come and observe first that way they know what I want and how I want it".

Requires Improvement

Our findings

People we spoke with said an assessor or the registered manager at Direct Health (Oldham) initially assessed their care needs and they were involved in discussions when planning their care. Comments included, "Care staff have always got the time to ask me what I want and need doing, I never feel rushed, they are flexible with their time staying over if I need them too". People said, "I was involved in my care plan," "I was given the choice of male or female carer," and "They are very caring and things greatly improved in the last few months and the care plan is reassessed as and when it needs to be changed."

Staff we spoke with told us how they responded to people's needs and they were positive about the information available to them on their mobile phones especially if a change occurred and the office needed to get in touch with them. One carer said, "If I arrived and the service users was not very well I would ring a doctor or an ambulance if I had to and then call the office. I had an emergency about 6 months ago. A client had breathing problems so I rang an ambulance and told the office." Another care worker said "I am a care worker and an assessor so I go out and do the care plans and arrange quality care and do risk assessments in conjunction with the family or the person themselves, if any care plans need updating then I make sure this is completed as soon as possible"

We found care records were in place for all people receiving care and support from Direct Health (Oldham). The majority of records were completed using Direct Health documentation, however some peoples records were still documented on their previous provider's paper work. Copies of care records were held at the service's office and at people's own homes. We saw care staff completed a report book and a daily record of each visit they made, the latter reported on care provided and any changes in the person's condition. The report book included monitoring forms for the administration of medication, what the person had eaten and drunk, skin integrity and any financial transactions were recorded. Not everyone needed monitoring in these areas, but where required they had been completed. There was evidence of report books being checked by the co-ordinator and registered manager to make sure care staff had completed them correctly, and that there were no changes needed to the care plan. This meant that people who used the service and their care staff were able to consult the care records on each visit. Care records included information about what support people needed.

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,

which showed a responsive service to this person's changing needs.

From a sample of care records we looked at, we found improvements had been made to recently updated records; however some detail in the updated documentation needed to be clarified further and additional supporting documents needed to be developed. We found that people's care needs and any risks associated with providing their care had not always been thoroughly assessed.

Staff told us that they had access to care records that provided them with information. However, some staff expressed reservations about the detail included in the care records as some care records had not been updated following . Two members of care staff told us "When I support a new person sometimes the information I've received from the office is not always detailed so I have to ask when I go in for the first time."

The registered manager told us that care records were reviewed annually or more frequently if required. We looked at five care records that contained information-confirming reviews had taken place either annually or when the person's needs had changed and their care plan needed updating. The registered manager told us that a number of these reviews had taken place over the phone at the request of family members. We saw records that evidenced that phone consultations about the care and support a person required had taken place with people and any follow up actions were detailed with an outcome.

The complaints procedure was incorporated into people's welcome pack, contained within the folders kept in peoples own homes. At this inspection, we found the provider had implemented a more robust method of recording and responding to complaints. We looked at the complaints logged at the service and found complaints and all staffing issues had been logged on the 'Incident Management System 2' computer system. We looked at the complaints received since our last inspection. Each complaint had been logged; information recorded included the details of the complaint, the outcome of the investigation and action taken.

Requires Improvement

Our findings

The new manager was registered by the Care Quality Commission in March 2016. 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.

Staff told us they had confidence in the new management of the service and felt the service was well managed. One member of staff told us "Yes [registered manager] is okay and is approachable", and "I can speak to the manager or the co-ordinator if I have any problems" and "At first it wasn't great with Direct Health and [the registered manager] took over a mess but she is trying to make things better and trying to do her best and I can see improvements. She is understanding and is helpful."

We saw the minutes of staff meetings and staff training workshops, which had been held in the previous six months. The last three recorded staff meetings minutes showed there were general discussions about working conditions and forthcoming training. Meetings had also focussed on medication issues and late calls. The registered manager advised us that staff performance issues in relation to medication and late calls was being monitored closely in line with Direct Health (Oldham) disciplinary procedures.

Some people we spoke with said they had recently been asked to complete a survey or had been telephoned by a manager of 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 with the new manager." Feedback from this recent survey included 'The care staff are wonderful', 'Some staff are true carers', and 'Communication has improved over the last month but still needs to be addressed'. 70% of the people supported by the service rated the quality of the service as 'excellent' or 'good'. 93% of people said they felt staff 'always' respected their privacy and dignity. The feedback from these questionnaires was analysed using the service's incidental management system to ensure issues identified were action and service improvements made.

We spoke with the management team and were aware that some changes to the service had taken place and other developments were due that should improve people's experience of the service. We were advised by the registered manager that all documentation was being reviewed in line with Direct Health policies and procedures; this also covered refresher training being completed by staff that had transferred to the service from another provider. The registered manager said that they were commitment to making the required improvements, which would result in improved standards and a more consistent service person centred led

service.

The new registered manager had completed an internal audit of the branch, which highlighted areas of improvement. Following this audit, additional new assessors have been employed to carry out care plan reviews and risk assessments, an additional co-coordinator had been employed to support the office, and there was an on-going recruitment drive for care staff.

Staff had access to policies and procedures via the office or their staff handbook. These were reviewed and kept up to date. The policies and procedures included safeguarding, support with medication, whistleblowing, and recruitment and selection process. These policies were reviewed centrally and updated regularly, with any changes brought to the attention of care staff during staff meetings. These policies were developed to protect not only employees who work for Direct Health (Oldham) but all the people that use the service from unsafe care and treatment.

The senior managers of Direct Health Ltd completed monthly planned checks of the quality of the service. We reviewed the quality monitoring audits completed by the service over the last six months. The audits completed covered a range of areas including staffing levels, medication management, infection control, accident statistics, staff training, staff supervision, complaints, care plans and notifiable incidents.

The service had identified that 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, signatures, some care files were over 12 months old, and some risk assessments did not always cover all risks. To address the issues the registered manager had developed a 12 month action plan to ensure that all care records are reviewed and updated in line with Direct Health policies and procedures and that all staff attended medication workshops and additional training.

We found the registered manager to be open and helpful during the inspection. They were realistic in their assessment of the service and transparent in the way they shared information with the inspection team.

The registered manager is required to notify CQC of certain changes, events, or incidents at the service. Records showed that when necessary we had been notified and appropriate action had been taken by management to ensure people were kept safe.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a lack of robust systems to ensure the safe administration of medicines The provider had failed to assess the risks associated to people receiving care

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment No appropriate arrangements were in place to mitigate risk associated with finance abuse

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Care staff were not provided with adequate support through supervision or appraisals to carry out their job roles.