Direct Source Healthcare Ltd

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Inspection report

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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

Direct Source is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults.

Not everyone using Direct Source receives a regulated activity; the Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

At the time of this inspection Direct Source were supporting 28 people. The majority of these people were living in the county of Gloucestershire.

We carried out a comprehensive inspection of this service on 27 April 2018. We carried out this inspection due to concerns raised by the local authority safeguarding team, contracts team and the police. This was Direct Sources' first inspection since they were registered with the Care Quality Commission (CQC). The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.'

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

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

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

A potential safeguarding event had been inappropriately managed by the registered manager. Their actions could have put other people who used the service at risk of experiencing harm. The registered manager had not consulted with the appropriate agencies and followed their advice. They had not checked or taken action to ensure that people were safe who received support from Direct Source. Staff also had a limited knowledge about the actions they could take to respond to safeguarding concerns about people potentially experiencing abuse and harm.

Required checks for new staff were not always completed. Staff did not have full employment histories with any gaps in their employment histories identified and explained. Sources of references were not clarified and other security checks were not in place, when staff started working at the service. Concerns raised did not alert the registered manager to review Direct Sources' recruitment practices.

People did not have full and detailed risk assessments with a detailed accompanying care plan for staff to follow. The service was not identifying all the risks which people faced with a good plan in place to enable staff to respond and manage these risks.

People were not being supported to receive their medicines in a safe way. The registered manager was not checking or responding to concerns when they came to light regarding the administration of people's medicines.

Staff did not receive a full and practical induction to their job. Training was very limited and often not provided. Staff did not have training in important areas of their work. The registered manager did not have systems to monitor what training staff had received. Staff competency was not being monitored or tested in any robust way. The registered manager did not have firm assurances that staff were competent and able to do their jobs.

The people who were being supported by Direct Source did not have person centred care assessments. People's assessments did not explore how people wanted to receive their care and live their lives. People did not have meaningful end of life plans in place when they had reached this part of their lives.

The service was not matching people to the staff who would be visiting them, in order to help people to have a more meaningful care experience. Some people had missed and late care visits and the registered manager did not have sufficient systems in place to manage and prevent this from happening again.

The registered manager and provider were not completing regular quality monitoring checks to review the quality of the service and make plans to make improvements. The leadership of the service had not responded in an open and transparent way to concerns raised about people's safety. The leadership had not considered or were open to the mistakes that had been made and made plans to rectify these mistakes and short comings.

The registered manager was not reporting all the events which they must do by law to us at the Care Quality Commission.

There was a complaints process in place. However, complaints were not processed in a robust evidenced based way.

These issues constituted breaches in the legal requirements of the law. You can see what action we asked the provider to take at the back of the full version of the report.

As a result of the late and missed care visits and the lack of an investigation into these it was unclear if the service had enough staff to meet people's needs. Given the lack of governance and systems and poor leadership issues, we concluded that these missed and late calls were the result of how staff were organised and monitored.

People told us that staff sought their consent to provide support. However, the service was not routinely gaining people's permission to share information about them with other agencies such as the local authority.

The service was not seeking the involvement of people, staff, and professional organisations into the development of the support they provided.

People spoke positively about the staff who supported them. They said they felt safe around staff. People also told us that they were treated in a kind way, and their dignity and privacy was promoted by staff. Although, people felt at times they were not always listened to by staff due to staff communication difficulties. This was a language divide which the registered manager had not identified as an issue and had not taken steps to address.

The people we spoke with confirmed staff supported them appropriately with their food and drinks. People felt confident that staff would respond to a change in their health needs.

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always protected from experiencing abuse and harm.

The service had not taken steps to ensure people were always safe around staff.

People did not have safe risk assessments in place.

Care visits were not effectively organised and monitored.

People's medicines were not always being managed in a safe way.

Real improvements were not made when things went wrong.

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not receive robust training and support to do their jobs. Staff training and competency was not being monitored by the leadership of the service.

People's consent to share information was not always being captured.

People were being supported with their eating and drinking needs.

People were confident staff would respond to a change in their health needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always feel listened to. There was often a communication barrier between people and the staff who supported them.

People said staff were kind and thoughtful.

People said staff respected their privacy and promoted their dignity when they supported them.

Is the service responsive?

Inadequate

The service was not responsive to people's needs.

People did not have detailed assessments. People were not matched to the staff who supported them.

Some people had late and missed calls.

Complaints were not fully investigated with action taken to prevent issues from happening again.

People did not have end of life plans in place.

Is the service well-led?

Inadequate

The service was not well led.

There was no clear vision of the service.

The leadership of the service had not demonstrated honesty and transparency when dealing with a safeguarding concern.

There were insufficient or non-existent audits and governance systems to monitor the quality of the service.

People and staff had not been involved to develop the service.

There was no partnership working with other organisations.

Direct Source Healthcare Ltd

Detailed findings

Background to this inspection

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

This was the services first comprehensive inspection. The inspection was announced. We gave the service 48 hours' notice of the inspection. This was because we wanted people's permission to talk to them before we telephoned them. The inspection started on 17 April 2018 and ended on 27 April 2018, taking 2.5 days in total.

The inspection team consisted of one 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. In this instance the Expert-by-Experience had experience of someone they cared for using this type of service.

Before the inspection we had made contact with the local authorities' contracts team and safeguarding team. We asked them for their views on the service. They had concerns about the care people received and if people were safe. We looked at the notifications that the registered manager had sent us over the last year. Notifications are about important events that the provider must send us by law.

We had not asked for a Provider Information Record (PIR) as the inspection was arranged at short notice.

During the inspection we spoke with seven people who used this service, and five relatives. Five members of staff and the registered manager. We looked at the care records of three people, the medicines records and daily notes of two people. The recruitment records for seven members of staff. During our visit we also reviewed the systems and documents available to monitor the quality of the service.

Our findings - Is the service safe? = Inadequate

We found that the service was not supporting people to be safe. The provider did not have robust systems in place to safeguard people from experiencing potential abuse or harm.

Earlier this year a person whose relative used the service had contacted the registered manager and made an allegation of theft. The registered manager did not encourage this person to go to the police. They did not seek advice from the relevant authorities with the legal powers and understanding of how to manage a situation such as this. Instead they paid the person the estimated cost of the loss of property. These actions and the actions later taken by the registered manager did not promote people's safety. It raised serious concerns regarding their understanding of their responsibility to prevent, identify and report abuse. When we spoke with the registered manager they admitted that they had not followed the appropriate and safe processes to protect this person from experiencing harm. This lack of action could have made other people who received care visits from Direct Source staff more vulnerable to theft and experiencing harm.

We spoke with five members of staff about their understanding of safeguarding. Staff knew how to identify potential safeguarding concerns and to report these to the registered manager. However, not all the staff we spoke with were aware of the outside agencies they could also report their concerns to, such as the local authority safeguarding team. Two members of staff were aware of an outside organisation they could contact to share their concerns if they needed to. However, they did not know the name of this organisation and they did not have their contact details. One member of staff said they would tell a person's family if they had concerns. This is not safe practice as this could interfere with a potential safeguarding investigation. This member of staff also said they would ask a colleague to visit a person who they had potential concerns about. This again is not safe practice and goes outside of locally agreed multi agency safeguarding protocols.

We asked staff about their understanding of how they protected people from experiencing discrimination. Most staff were not able to explain clearly what this meant in terms of the people they were supporting. Staff were also unable to tell us how the people they supported could be more vulnerable to experiencing discrimination.

The above issues constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we were informed of the safeguarding concerns by the local authority we wrote to the registered manager and asked them to send us information to see if they had safe recruitment processes in place. The registered manager had employed staff with past criminal offences. Although the registered manager had ensured that staff completed a Disclosure and Barring Service (DBS) check, and had also completed a risk assessment these risk assessments were not robust. For example, they did not record how the assessors had reached a particular decision. In one case the assessor had based their answer to whether the applicant had a good previous employment record by speaking with a previous colleague of the applicants, not their manager. It did not record what they had said about the applicant. The risk assessment asked if the applicants had a good employment history was with Direct Source. In each case the assessor answered "yes." This implies these checks were taking place after employment had started. The risk assessment asked if the applicant had ever presented at work under the influence of drugs and alcohol. If this had ever

occurred it would have placed people at immediate risk. This question was always answered “No” but again the assessor did not explain how they had reached this answer. The risk assessment did not ask whether the person had been rehabilitated. There was no checking if the applicant had a full employment history. There was also no follow up or monitoring of the staff once they were employed and working independently with people. This meant the registered manager was unable to evidence that these members of staff were working in a safe way.

We looked at seven recruitment files for staff working at the service and identified other short falls. Legally required checks had not been carried out in all cases. For example, we found that staff did not have complete histories of employment. In addition, it was not clear in some members of staff application forms, what relation their referees were to them. In two cases it was unclear if the referrer was a colleague or someone who supervised or managed them. One member of staff had worked for a company for many years but had not given permission for Direct Source to contact them as a reference. During the interview process the registered manager had not asked why this was the case or maintained a record of this.

One member of staff had started working before the service had confirmed their DBS check was completed. This means that an important security check had not been completed before this person had access to confidential information and was supporting vulnerable people. These shortfalls in recruitment checks were also present with staff who had a disclosed criminal background. The registered manager should be taking every step to ensure that safe recruitment processes are in place before a new member of staff starts working with people who used the service. This is because the registered manager needs to be assured that vulnerable people are safe around the staff they recruit.

The above issues constituted a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we visited Direct Source’s office we looked at people’s risk assessments. These documents contained limited information about the risks which people faced. These documents did not consider the impact that these risks had on individuals on a day to day basis. People’s corresponding care plans were also limited. The purpose of these care plans should be to guide and prompt staff about how to meet people’s needs. For example one person was at risk of developing pressure sores. Their care plan and risk assessment did not clearly outline to staff what they needed to be doing to try and prevent a breakdown to their skin.

Some people used equipment to support them to mobilise. For their assessments the registered manager had not consistently considered people’s ability to safely mobilise and transfer in the presence of staff in their own homes. They had not documented this information in their risk assessments.

The service had not risk assessed people’s environments at all to ensure that people were safe and that staff were safe when they were supporting people. For example one person smoked cigarettes and was at risk of falling. This person had no environmental risk assessment to consider the risk of them smoking. We spoke with a member of staff and the registered manager about this. They told us that they were aware of this risk. However, this did not prompt them to assess this potential risk. To consider the person’s safety and the safety of staff. When we spoke with the registered manager about the lack of environmental risk assessments they confirmed these had not been completed. They added that they would now implement these assessments.

A member of staff and the registered manager had told us about one person had left something cooking in their kitchen and forgotten about it. When staff arrived their home was filled with smoke. We were told that action had been taken and contact was made with the organisation funding the care this person received. However, no follow up action was taken to ensure steps were or had been

taken to promote this person's safety. We needed to prompt this at the inspection.

Direct Source were supporting some people with their prescribed medicines. The registered manager told us about one person whose family prepared the medicines for staff to administer to their relative. They did this by putting their tablets into separate containers. The registered manager said that staff were administrating this person's medicines but they did not know what tablets they were giving them. The registered manager also recognised that if an error had occurred it would be a member of staff who would have 'administered' this person their medicines. The registered manager had identified this as unsafe practice, but had not taken any action to rectify this situation. When they told us about this we asked them to take action that day. We observed during the course of the day that they had not taken action about this. At feedback the registered manager confirmed that no action had been taken on this issue.

We looked at people's Medication Administration Records (MARs) which staff are to follow and complete when administering people their medicines. When we looked at these records there were gaps when staff had not signed to say they had given people their medicines. It was also unclear if or when some people's medicines had been stopped by the GP. This meant there was a risk that people were not receiving their medicines as prescribed.

The above issues constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have an effective and robust emergency contingency plan in place. The plan that was in place lacked details and practical information to enable people's needs to be met in an emergency. For example there was no plan when there was severe weather or if there was a sudden loss or reduction of staff to complete people's care visits. We spoke with the registered manager about this who agreed the short comings of this plan and told us they would rectify these issues.

It was unclear if there were enough staff to support people's needs. We were told by some people and the registered manager that some people had late visits, and two people had had missed care visits. They registered manager confirmed that there had been no investigation into these situations to see why these had taken place. Was it due to system errors or a lack of available staff. We concluded due to the issues with the governance of the service, the issues of late and missed care visits were the result of how staff were being organised and the lack of systems in place to identify missed and late care visits.

When we spoke with staff they told us how they promoted good hygiene and infection control. However, not all the staff had received training in infection control and safe food preparation practices. This meant that there could be short falls in staff knowledge and understanding in this area of their work.

The registered manager was not reviewing and reflecting when things went wrong. They did not investigate and consider what actions were needed to make improvements and learn from previous mistakes.

The people we spoke with said they felt safe around the staff who supported them. One person said, "I do (feel safe) they [staff] always make sure I am using my standing frame safely." Another person said, "I am completely satisfied with them [staff] and always feel safe with them [staff]." A person's relative told us, "Yes we are very happy with them. They [staff] look after [relative's name] very well."

Our findings - Is the service effective? = Requires Improvement

When we visited Direct Source's office we identified that there were insufficient and inadequate processes and systems in place to ensure staff had the right skills and knowledge to deliver effective care and support to people.

We asked people if they felt staff were well trained. We received a mixed response. One person said, "I think they are trained well enough, but the language is a problem and rushing in and out." Another person said, "Yes, they are well trained carers, and the regular ones know me very well." A person's relative told us that, "Yes they are well trained. I wish some of them [staff] would wash up after [relative's name] has eaten."

When we spoke with the registered manager they had not identified if staff had communication issues when English was not their first language. The registered manager had not considered if staff needed training to improve their English or communication skills. Even though a complaint had been raised about staff speaking in a language unknown to the person they were supporting. The registered manager did not complete further checks to see if staff needed support or training in this area.

We spoke with five members of staff about their inductions to working at Direct Source. Staff told us that they had moving and handling training when they visited people in their homes. However one member of staff said there was no follow up to check they were putting this training into practice or to offer more support. Staff told us that they had not received any other formal training before they started working independently. Some staff said they had some 'shadow shifts' when they would work alongside a more experienced member of staff. Two members of staff said they had had eight hours in total shadow time with a member of staff before they started working independently. These members of staff felt this was not enough. They said they would have benefitted from training sessions before they went into people's homes to provide them with care and support. One member of staff said, "You are put into the deep end." Another member of staff said, "The induction did not feel organised."

During our inspection we spoke with the registered manager about this. They told us that they sometimes used new staff's previous training certificates as evidence of up to date training, which they had gained from their previous employer. The registered manager could not explain to us how they were assured this training was effective and if this member of staff was putting it into practice. We looked at two members of staff's training records which they had obtained from a previous employer. This training had expired, but when we told the registered manager about this, they were not aware of this.

We asked staff what their most recent training was. No one could tell us what this was; some said it would have been provided by their last employer. One member of staff told us it was "Catheter care." When we asked when they completed this training they said, "Three years ago." They also confirmed they did not support a person who had a catheter in place. So this training was not currently useful to them. Also professional advice about catheter care may have changed during this timeframe.

The registered manager told us about a training day they had recently organised. They said that they were unable to tell us which members of staff had attended and who had not. They said that an additional training day was to be arranged but they had not arranged this. This meant that some staff were supporting people without this training. When we asked the registered manager to explain to us what this 'training day' consisted of they told us, that it included training on safeguarding. However when we looked at the training certificates for this day that a member of staff had obtained it only listed infection control, pressure care, and medication. We spoke with the registered manager about this. They could not explain this. The registered manager could also not produce any evidence to confirm that staff had had moving and handling training. Staff we spoke with confirmed this was a key part of the day to day care provided to people using the service.

The registered manager had not devised a training programme to meet people's needs or a system to monitor that staff training in these subjects were up to date. Staff told us they were supporting people with specific long term conditions such as Parkinson's disease, dementia and Multiple Sclerosis. They confirmed they had not received training in these specific areas to ensure they were knowledgeable or understood how these conditions affected the people they supported.

We concluded that staff were working without a robust induction and training to enable them to be effective in their work. The registered manager had no real assurances that staff were sufficiently trained to care for the people they supported.

We asked the registered manager what assurances they had that staff were skilled and competent to support people's needs. The registered manager said they believed that staff were competent because they spoke with staff. However, these were ad hoc conversations. The registered manager was not completing spot checks to see and observe staff practice. They were not regularly checking staff practice against a set of standards of practice and evidencing how staff were competent. There was no evidence that robust staff checks were taking place. This meant that the registered manager could have no real assurances of the effective competency of staff.

The staff we spoke with told us that they did not have observed competency checks with feedback afterwards. These members of staff also confirmed they did not have supervisions. The registered manager could also not produce any evidence to contradict this.

The above issues constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

During this inspection we asked staff if they had had training about the mental capacity act. Staff said they had not had this training. However, when we asked staff about how they promoted choice they were able to tell us about how they did this as part of their day to day practice. One person confirmed that staff did ask their permission when supporting them. They said, "They [staff] always ask permission before they do anything for me."

When we looked at people's care records we could see that people had signed a consent form to agree to receive care. However, some people's consent forms did not request people's consent to share information or concerns to other organisations or professional bodies. For example the local authority. We noted that one person had a consent form which did include this and other organisations. The registered manager advised us that they had changed the form to make it more

“User friendly,” but some of this important information had been removed. This is important as staff and the registered manager maybe sharing personal information without a person’s expressed consent.

The registered manager was considering if people had the mental capacity to consent to care and accept the support provided by staff. However, we noted that one person’s record stated that they had capacity, but their relative had signed their consent form. This was not explained or addressed in this person’s care records. There was no evidence to say that this relative had the powers to consent for their relative to receive this support.

We concluded that further work was required to evidence Direct Source was compliant with the MCA.

Some people were being supported with their eating and drinking needs. The people we spoke with confirmed that staff supported them in this way. One person said, “They [staff] get my lunch ready and leave me a sandwich or something for my tea.” People’s relatives also confirmed that staff supported their relatives appropriately in this way. One person’s relative said, “Yes they [staff] get [person’s name] breakfast and usually something like soup for lunch.”

When we looked at people’s daily notes we could see that staff had stated they had prepared people a meal and drinks. Some records evidenced more clearly what they had made the person to eat. However, there were records that did not confirm if people had eaten their food. This could be important to show people’s needs were consistently being met in this way.

The service had not considered how technology could support people to enhance people’s care experience and promote their independence. There was no evidence to say that people’s needs were assessed and delivered in line with current standards, guidance, and legislation.

People’s relatives told us that they were confident that if their relative needed medical support or input from their GP that staff would respond to this. One person’s relative said, “They [staff] would if need be. But they usually ring me if there is a problem.” When we looked at a person’s daily notes we could see that when a person presented as unwell they spoke with this person’s relative and suggested the GP was called. We later saw recorded that this is what happened and what the GP recommended. This told us that staff were aware of what actions they must take in these situations.

Our findings - Is the service caring? = Requires Improvement

When we spoke with people and their relatives we asked them how the service made sure that they matter as a person, we had a mixed response.

One person said, “They [staff] are never rushed and always ask if there is anything else they can do.” A person’s relative said, “They [staff] don’t rush around in fact sometimes they will sit and chat for a few minutes.”

However, one person’s relative said, “They [staff] are in and out, they are rushed quite a lot.” Another person’s relative told us how when staff came to support their relative on one occasion they completed the care visit in 15 minutes, when normally it would take much longer. During this care visit they heard their relative cry out in pain. They felt this was because their relative was being rushed. This relative also said that sometimes more staff would visit than was required and they would leave soon after arriving.

We asked people and their relatives if staff talked to them appropriately and in a way that they could understand. One person said, “I can’t understand some staff.” Another person said, “I think they [staff] are caring people. It’s a shame they [staff] don’t speak better English.” A person’s relative told us that, “Sometimes the language difference can cause problems.”

We concluded that this communication barrier could be a challenge for staff to give and explain information to people. It could also be a barrier for people to feel listened to and involved in their care. The registered manager had not considered if staff required further support and training in this area.

At this inspection we considered if people’s private information was being kept securely. We saw that people’s records were stored in a secure way. However, we asked the registered manager to copy some documents for us as part of our evidence about the service. The registered manager initially said they would ask the office’s receptionist to copy these documents. The receptionist was not employed directly by the service and was situated in the reception of a large office building used by other local companies. We spoke with the registered manager about this. They then told us that they had changed their mind and they would complete the photo copying them self. We reminded the registered manager of their responsibilities to protect people’s personal information.

Most people we spoke with were complimentary about the staff who supported them. One person said, “I think they are caring people.” Another person said, “Yes they are lovely ladies.” A further person said, “They [staff] are brilliant.” A person’s relative told us that, “They [staff] are kind and caring. They [staff] always give me a hug when they leave.” A further person’s relative said, “They [staff] do an excellent job. They [staff] sit and chat and hold [relatives’ name] hand.”

When we spoke with staff we asked them if they had got to know the people they were supporting. Some staff were able to tell us about the people they visited. They were able to tell us about what was important to them and their interests. However, some staff did not have this level of knowledge or understanding of the people they supported. Some people told us that they did not see a regular

group of staff. We concluded that this could be a factor in staff not getting to know the people they supported. The registered manager had not considered this when arranging the staff rotas.

During the inspection people told us that staff treated them with dignity and respect. One person said, “The carers are very respectful and always think about my dignity, especially when helping me with personal care. They [staff] always close the blinds and I feel very comfortable with them.” Another person told us that they were always treated with dignity, they said, “Yes all the time. They [staff] make sure the door is closed for privacy.”

When we spoke with staff they were clear about what dignity looked like. They told us how they promoted people’s privacy when they were supporting them. People also told us that when they requested that they did not want to be supported by a male member of staff this was adhered to.

Our findings - Is the service responsive? = Inadequate

We found that the service was not always meeting and responding to people's needs.

When we looked at people's care records there was no evidence to show that people were being involved in the planning of their care. When we asked people about whether they had been involved in creating their care plan and reviewing it, they made reference to their care plans with the local authority, not with Direct Source.

We looked at a sample of three people's care records. These records lacked detailed information about people's needs, preferences, and backgrounds. There was no real information about how people wanted to be supported to live their lives. There was also no information about people's interests and hobbies. The registered manager told us that they matched people to staff who would be supporting them. However, they were unable to tell us how they did this without gaining some of this information, in order to match staff and people together.

The service was completing telephone reviews about people's needs. People were being asked if they were happy with the staff and if the staff treated them with respect. However it did not ask if staff visited them on time and if people saw a regular group of people who knew them well.

We asked people if they had missed or late calls. People told us that they did. One person said, "I do have a few issues with time keeping, it can be appalling. My [relative] has to help me out with toileting, when they are late I am desperate for the loo." Another person said, "They [staff] can be two hours late and I have incidences where they have not turned up for three, four or five days." A person's relative told us that, "They [staff] are not reliable at all. They ring to say we can't make it at all sometimes."

During the inspection we spoke with the registered manager about late care visits. They told us that they do not have a system of monitoring care visits being late at present. Staff were often telephoning the person themselves if they were running late. Recently a person complained about the number of telephone calls they were receiving from staff saying they were going to be late. The registered manager told us that staff are to contact them directly now. The registered manager had not considered an appropriate system to manage the very real potential of care visits being late. The registered manager later told us about plans for staff to be using an electronic system, so they can monitor how timely care visits are. However, this was not in place at the time of the inspection and there was no confirmed date of when this would be in place.

We also spoke with the registered manager about missed care visits. The registered manager told us about one person who had had no care visits for three days. This was because they had been accidently not placed on the staff rota. They only found out about this when their relative called Direct Source to advise them of this. This person we were told did not come to any harm. During the inspection we also identified another person who said they had missed care visits. The registered manager had insufficient systems in place to prevent this from happening again. This had the potential of causing significant harm to some people who relied on the support of staff and who could not access assistance independently. The registered manager had not considered putting remedial

measures in place following these instances of missed care visits.

When we asked people if they saw a regular group of staff, we had a mixed response. One person said, “No I have so many. They [staff] come for a while then disappear.” Another person said, “I had some I was really happy with but they have left now. I can never rely on the same ones coming back. I never know from one day to the next who is coming to see me.” One person’s relative said, “We have the same ones [members of staff] for a while, then they disappear for weeks on end and then come back again. It is confusing for [relative’s name].”

Alternatively one person said, “Yes I have the same ones [staff]. Unless they are off sick or anything.” One person’s relative said, “Yes as far as I know, there seems to be regular staff.” A further person’s relative said, “Generally we do, some come and go, they are all lovely people.”

When we spoke with staff some told us that they saw a regular group of people and others said they did not. One member of staff could not remember any of the people’s names they had seen the same week that we spoke with them.

People did not have end of life care plans in place who were receiving support from Direct Source. The purpose of these plans were to ensure people’s wishes and needs were being met by staff when they reached the end of their lives. The service was not capturing this information or initiating these conversations. The service was supporting some people where a health professional had confirmed that they were at the end of their lives. These plans were not being made with these people. This meant that there was a risk that these people’s particular wishes and preferences would not be known and fulfilled by the staff who were supporting them.

The above issues constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did have a complaints process in place but it was not clear if this had been shared with people who used the service. The registered manager told us about a complaint which a person had made. It highlighted concerns about staff practice in terms of how they communicated with a person who had a sensory impairment. The registered manager said they spoke with the staff in question. However, there was no investigation or follow up to check staff practice was now appropriate or if the person was satisfied with the actions taken. Therefore we could not be confident that this situation could not happen again.

The above issues constituted a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our findings - Is the service well-led? = Inadequate

The service was not well led. The leadership and governance of the service did not deliver high quality care and support. In addition it did not promote a positive culture that was person centred and achieved good outcomes for people.

The registered manager did not have an understanding of what the key values were for the service.

The registered manager demonstrated that they had a lack of knowledge in key areas of providing a registered service. For example, the registered manager had not dealt with a safeguarding concern appropriately. Their knowledge of how to protect people from experiencing harm and abuse was insufficient. Following this event there was no real consideration given to try and learn from it. In order to prevent it from happening again.

The service did not show honesty and transparency following an error and incident. This event did not alert the registered manager to consider a review of how they recruited staff and monitored staff practice. We found that the registered manager had not met the legal requirements in how they appointed staff. This was contrary to creating an open culture at the service. Their risk assessments and systems in relation to staff who had disclosed criminal backgrounds were not adequate. When we were told about this event by the local authority we asked the registered manager how they would be preventing this from happening again. The registered manager said they would ensure that staff and themselves had safeguarding training. However, this had not taken place when we inspected the service. No firm plans had been made to rectify the mistakes made. There was no consideration of other actions required to prevent this error from happening again.

There were no systems to observe and monitor staff practice after they started working for the service. There was no system to monitor or provide training to staff. Staff had limited inductions which relied on staff having had previous training or experience at other care services. Staff did not receive a full and comprehensive induction to their work. One member of staff told us that, “It felt like it was thrown together.” There were no systems to test in a transparent way the competency of staff.

The registered manager was not auditing and testing the quality of people’s care assessments and care plans. These documents did not assist staff in meeting people’s needs and enable staff to respond to the risks which people faced. The registered manager had appointed staff with known criminal offences. They had not considered if people needed to be made aware of this. In order to make an informed decision themselves. They had not sought advice on this matter in an open way.

When quality checks were taking place they were either non-effective or not evidenced. We looked at people’s Medication Administration Records. The registered manager said that these had been audited by themselves, but there were issues with these records. We therefore could not be confident that people always received their medicines as the GP prescribed.

The registered manager had no systems to monitor if people had late or missed care visits. When they were made aware that late care visits and missed care visits had taken place the registered manager did not investigate these. They did not explore why these had occurred and if the service had enough staff and if additional action was required.

The registered manager was also the provider (owner) of the service. As a provider they had not considered if an independent audit of the service was required to address issues and make plans to improve the service.

We concluded that the service was not operating in a transparent and open way. The leadership of Direct Source had not responded in an honest and transparent way. The leadership of the service had not tried to robustly test the service to learn from mistakes and make improvements.

The above issues constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in place. When we asked the registered manager about the important events they must notify us about by law, they did not understand their responsibilities in meeting the legal requirements of Health and Social Care Act 2008. They had also not informed us at the CQC about a potential safeguarding event which could have had significant consequences to people's safety.

The above issues constituted a breach of Registration 18 Regulations 2009 (Part 4).

There were no systems to involve the staff and people who used the service in developing the service. Consideration was not given to looking at new and improved ways of working. There were no strong links with the local communities and with the health and social care professionals who worked with the people the service was supporting.