Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Direct Health (Sheffield)

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

Tel: 01142566480

Date of Inspection: 15 July 2013

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We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Care and welfare of people who use services	✖	Enforcement action taken

Details about this location

Registered Provider	Direct Health (UK) Limited
Registered Manager	Mrs. Carol Whittaker
Overview of the service	Direct Health Sheffield is a domiciliary care service. The agency office is based in the Attercliffe area of Sheffield. They are registered to provide personal care to people in their own homes. At the time of our inspection the service was providing personal care for up to 580 people
Type of service	Domiciliary care service
Regulated activity	Personal care

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When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an announced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 15 July 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, reviewed information given to us by the provider and talked with commissioners of services.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

As part of our methodology for inspecting large providers we would send 60 surveys to people that used the service to obtain their views and experiences of Direct Health. We requested information from the provider to enable us to send out the questionnaires. However we did not receive the information from Direct Health to enable us to capture peoples views via this method. We will be following up the questionnaires as part of our next inspection process. We did telephone and speak with 29 people who used the service and five relatives who told us about their experiences, and the quality of service provided. We also visited five people in their own home.

We found evidence at the inspection that people's needs were not assessed and care and treatment was not planned and delivered in line with their individual care plan. The provider was non compliant with this outcome.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have taken enforcement action against Direct Health (Sheffield) to protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Enforcement action taken

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People did not experienced care, treatment and support that met their needs and protected their rights.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We telephoned and spoke with 28 people who used the service and five relatives who told us about their experiences, and the quality of service provided. We visited five people in their own home.

Most of the people we spoke with told us that they were very unhappy with the care and support they received at Direct Health. Some people told us that staff were late/early or didn't turn up at all and expressed how this impacted on them. Their comments included: "I do as much as I can to help my carer but it's such a struggle and when they are late I've had to try and get my own breakfast even though I can't see. Once it was 11.30 when they came, it should have been 8.30, that is too late and I'm starving by then." "Missed (visits) twice, nobody came last Monday. I had a message from the office to say there had been a staff shortage and they will send someone on Tuesday." "They're supposed to come three times a day, but they often miss the lunch time visit out." "It just seems impossible to get them to stick to the agreed times. One came at 2.45 for my 12.00 lunchtime visit." "Last week they were useless; twice they came missed out my lunchtime and once they came at nearly 4.00 for my lunch which was nearly teatime, luckily I managed myself." "One day they came at 11.30 to do my 9.00 in the morning visit. Well I have a visit at 12.00 for my lunch so it was pretty useless them coming really."

During our home visits we also observed that one carer was 30 minutes late for their visit.

Some people we spoke with told us that they did not have regular staff to support them and several people said they never know whose coming and expressed how this had impacted on them. Their comments included: "If carers come that I don't know, they don't explain who they are." "You never know what time they're (care workers) are going to turn

up, they're always erratic. When they are late they always make me feel rushed and I don't like that." We found that some people had experienced a lack of continuity of care to meet their individual needs because people had not received support from regular care staff.

During our home visits we spoke with five people. Three people told us that there had been occasions when only one care worker had arrived instead of two as identified as needed and agreed. Their comments included the following: "On average every fortnight only one carer turns up and they have to wait for the other carer." "Sometimes they are late. They should stay for 30 minutes they usually (stay) for 20-25 minutes. Some seem to be in a hurry to get away." "Should have two carers, only one came yesterday teatime. I felt sorry for her as I needed lifting and she couldn't manage." We also spoke with people by telephone who confirmed that they did not always have two care workers with the right competencies, knowledge and skills and experience to meet their needs. Their comments included the following: "They are supposed to send two (care workers), one (care worker) can't do me because of the hoist, but they often send one and then they can't do me at all and it's hopeless." "Once they sent someone who had never used a hoist, anyway they're supposed to send two for that and they often send one (care worker) which means I can't have a proper wash."

On one occasion one service users relative had to help the carer to move their relative even though they know they're not supposed to, they said 'they had to' as the second carer didn't arrive. We checked the log sheets and this confirmed that no second care worker attended. We requested the 'planned vs actuals report' from the provider which stated the planned provision time the carers should visit and the actual time they did visit. The report stated that two carers did attend, however from the documentation we looked at and what their relative told us this confirmed only one carer had attended the call.

We viewed two peoples care plans which stated that their allocated time was 30 minutes. The person who used the service told us that care workers should stay for 30 minutes and that the care workers only stayed for 15 minutes. We checked the providers report of 'planned vs actuals' and the log sheet and this confirmed that carers were not always staying for the allocated times.

We viewed five care plans on the day of our home visits. We found that four of the care plans were out of date and due for a review. We noted that one out of five people had a risk assessment in place. We also found incomplete documentation in one person's care plan. This demonstrated that plans of care, treatment and support were not regularly reviewed for their effectiveness, changed if found to be ineffective and kept up to date in recognition of the changing needs of the person using the service.

We spoke with three people who told us that care workers did not read the care plans before delivering care. We also observed a care worker deliver care without looking at the care plan during a home visit. This demonstrated that care workers did not read the care documentation before delivering care and meant people were at risk of receiving inappropriate care.

We viewed one person's care plan whose allocated visits were time critical. Due to their health condition they had to take their medication at a prescriptive time. We saw evidence that this person was receiving their medication either late or early to their allocated time. This demonstrated that people who used the service were not receiving their medicines at the time they needed them. This meant care or treatment was not delivered to meet the person's individual needs.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 23 August 2013 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The registered person did not take proper steps to ensure that each service user was protected against the risks of receiving care or treatment that is inappropriate or unsafe.

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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