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: 02 October 2013

Date of Publication: October 2013

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Care and welfare of people who use services	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed
Complaints	✓ Met this standard

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

Contents

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'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Direct Health (Sheffield) had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Assessing and monitoring the quality of service provision
- Complaints

This was an unannounced 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 2 October 2013, checked how people were cared for at each stage of their treatment and care and talked with people who use the service. We talked with carers and / or family members, talked with staff, talked with commissioners of services and were accompanied by a specialist advisor.

What people told us and what we found

At our previous inspection visit to Direct Health (Sheffield) on the 15 July 2013 we took enforcement action against the provider and issued a warning notice to protect the health, safety and welfare of people using the service. We carried out a follow up inspection visit on the 2 October 2013 to see if improvements had been made. We found that significant improvements had been made by the provider and the level of concern reduced to minor. The provider still needs to demonstrate compliance and we will continue to monitor their compliance.

We received mixed messages regarding the quality of the care people had received. Some people and relatives made positive comments about the staff that regularly supported them or their family member. We found evidence at the inspection that improvements had been made. However, 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 or at their allocated visit times. The provider was non-compliant with this outcome.

There were no effective quality monitoring systems in place. The provider was non-compliant with this outcome.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately. The provider was 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 asked the provider to send us a report by 25 October 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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 ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

At our previous inspection visit to Direct Health (Sheffield) on the 15 July 2013 we took enforcement action against the provider and issued a warning notice to protect the health, safety and welfare of people using the service. We carried out a follow up inspection visit on the 2 October 2013 to see if improvements had been made. We found that significant improvements had been made by the provider and the level of concern reduced to minor. The provider still needs to demonstrate compliance and we will continue to monitor their compliance.

As part of our inspection visit we spoke 15 people who used the service or their relatives. We visited five people in their homes. We spoke with three care workers, the head of branch operations and the transitional manager. We also reviewed records.

People and family members we spoke with gave mixed reviews about the quality of the care that had been provided by the service.

Some told us that they were very satisfied with the care they had received and made positive comments about the regular staff and the service had improved recently. These included: "Most carers are very good. The carers make me feel safe. Things are improving slowly." "Things are a lot better, it used to be bad. In the last month things have sorted themselves out." "I get the help I need. I am very satisfied, because I have had them a long time. Since the care coordinator has been back they have sorted everything out, and I don't get a lot of agency staff like I used to, it's a lot better." "Seen improvements in the last week and a half. Allocated times are improving" "Smashing, they [care workers] call each day, they're very good." "It's very good, I'm very pleased. No complaints. I wouldn't swap them [care worker] for the world. Can't praise them enough."

In contrast other people we spoke with and family members told us that the care and

support they received from Direct Health was not satisfactory. People told us that staff were late/early at their visits and told us how this impacted on them. Their comments included: "Approximately two and a half weeks ago, there was no carer for the morning visit, and they [care worker] arrived at 13.00. I phoned the office and they said that people were off sick. This morning they came at 8.25 and they are meant to come between 9.00 – 10.00. This was too early. The carers said this was the only way they could do it. We're happy with the time they usually come." "Sundays they are often short staffed. Approximately two weeks ago the 8.45 visit arrived at 11.40 [this happened three weeks in a row], 11.30 and then 12.15. When I called them [the office] they didn't know where the carers were. It was disgusting that. They have come at the normal times after." "A few weeks ago the lunch call was at 14.00 and the carer came at 15.30 [for the tea visit]. Supposed to be four hours between medications. We had to make arrangements for the carer to come back later."

The majority of people we spoke with told us that they were happy with their regular care workers but said it was at weekends when they did not receive continuity of care. Some people we spoke with told us that they did not have regular care workers to support them and how this impacted on them. Their comments included: "There is no real continuity of carers', people don't know her [person that uses the service]. They never read the care plan, they just walk in and deliver care."

We received mixed messages from people we spoke with about the number of care workers that attended to support them and the length of time the care workers stayed. Some people we spoke with were positive and told us, "I always get two [care workers], they give me the help I need. I am very satisfied. They [care workers] more or less stay that time." "Both carers attend." One person told us that it depended if it was regular or agency staff providing care, "Sometimes they [the regular care workers] stay as long as they should, these [agency workers] seem to be in a rush." One relative told us that approximately five weeks ago they had to help the care worker to move their relative as no second care worker arrived. Another person told us, "Sometimes they don't stop that long, 10 minutes on a Sunday and it's supposed to be 30 minutes."

During the home visits we checked the daily log records. One person required two care workers to assist with moving and handling. On their daily log record, it was recorded that only one care worker had attended at a visit. We requested the providers 'Planned vs Actuals' report. This report outlined the planned times and actual times that care workers visited. The report stated that two care workers attended and stayed for 11 minutes. The care workers did not stay for the allocated time of 30 minutes. The 'Planned vs Actual' report contradicts the daily record and meant that proper steps had not been taken to deliver care to service users that meets their assessed needs and ensure service users welfare.

During the home visits we found that two care plans were out of date and due for review. One of the care plans didn't correlate to the person's current medications. One of the care plans should have been reviewed as priority following our last inspection in July 2013. 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 the head of branch operations and the transitional manager who explained that they planned to review all of the care plans by December 2013. We saw evidence that there was a plan in place to undertake the review.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We included this outcome area to check that Direct Health had appropriate systems in place for gathering, recording and evaluating accurate information about the quality and safety of the support the service provided.

We viewed the provider's policies and procedures file. The policies we viewed were past their date for review. This meant that staff did not have up to date information to follow.

We saw that the provider had started to put a system in place to monitor incidents. There was a system in place for recording missed calls as 'untoward incidents.' On the majority of the forms viewed, details of the incident and action taken were not recorded. Records were not linked and it was difficult to follow the audit trail. The provider also had a 'missed medication/incident report file.' We reviewed two incident forms. There were two incident forms which had not been signed off by a designated staff member. This meant that incidents were not being reviewed by management. There was no incident reporting policy in place. This meant staff did not have an effective system to follow.

We viewed the 'medications issue' book. We saw that the provider had started to put a system in place. We noted that incidents reported in the medication/incident report file were not recorded in the book. We spoke with two care workers on the day of the inspection visit who described two medication concerns which had been identified at home visits and reported to the office. We viewed the medications issue book and found that one issue had been recorded. The other medication incident had not been recorded. We found although there was a system in place for staff to report incidents, this was not effective or monitored.

We spoke with the head of branch operations and the transitional manager. They told us that a trainer attended visits with care workers once a week to undertake 'spot checks' on staff administering/prompting or assisting with medication. If the trainer saw any issues they would undertake on the spot training. There was no evidence of an audit tool being

used to identify the issues raised and confirming that on the spot training had been given. This meant that an effective system designed to identify and manage risk was not in place.

We saw that the provider undertook monthly medication audits. As part of the audit staff checked if the Medication Administration Record [MAR] chart was completed. We looked at three audits, which were not dated. The audit stated there were no gaps in peoples MAR charts. We viewed three MAR chart and found that there were gaps. This meant that appropriate checks were not in place to identify, assess and monitor the quality of care provided.

There was no evidence retained by Direct Health that agency staff had received medications training. This told us that there was a lack of monitoring of agency staff training. This meant that people using the service were not protected against the risk of inappropriate or safe care.

We found that the service did not have appropriate systems for gathering, recording and evaluating accurate information about the quality and safety of the support the service provided.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available.

Reasons for our judgement

During our inspection visit on the 5 June 2013 we found that the provider had gaps in addressing complaints and full and complete records were not maintained. The provider was not responding to complaints in line with their policy.

As part of our follow up to the previous inspection, we reviewed the provider's complaints system. The provider had one complaint which has been on-going since May 2013. We viewed three complaints and they had been appropriately addressed in line with the services policy and procedure. There were no gaps noted in addressing complaints and full and complete records were maintained. We also found that the complaints records were linked to the correct record.

We found that a policy on complaints was in place. The provider may find it useful to note that the policy in place needed reviewing to make it clearer for all stakeholders.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 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 safe.
Regulated activity	Regulation
Personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: Regulation 10 (1) (b) HSCA 2008 (Regulated Activities) Regulations 2010. The provider did not have an effective system in place to identify, assess and manage risks relating to the health, safety and welfare of people using the service and others.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 25 October 2013.

CQC should be informed when compliance actions are complete.

This section is primarily information for the provider

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

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

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk