Midlands Home Care Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was announced and took place on 10 and 11 August 2017. This was the first inspection since the provider registered with us on 24 July 2017. Midlands Home Care Limited provides a domiciliary care service for people living in the own homes in the Nottingham area. At the time of our inspection, 98 people were receiving personal care support from the service. We brought this inspection forward as we had received information of concern from the local authority. People who used the service had also made us aware of concerns they had.

There was a registered manager in post. 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.

People did not always receive their agreed levels of support, and did not always know who would be visiting them. Risks to people were not consistently managed, and improvements were needed to ensure that people received their medicines as prescribed.

Staff gained people's consent before supporting them. However, when people were not able to make decisions about their care, the provider had not assessed their capacity. They were also not able to show how decisions made on their behalf were in their best interests. People were supported to have their meals when needed, but some people did not have easy access to drinks.

The registered manager understood their responsibilities, but had not notified us of incident they should have done. The audits that were completed were not used to identify issues and were not effective at driving improvements. People's care records were not always kept up to date.

Staff were recruited safely and they received an induction and further training to develop their skills. Staff knew how to recognise and report potential abuse.

People were supported in a kind and caring manner, and they had developed positive relationships with the staff that visited them. People were involved in making decisions about their day-to-day care, and staff promoted their independence. People's privacy was respected and their dignity promoted. They were supported to access health care services.

People and their relatives were involved with the assessment, planning and review of their care. The provider sought feedback from people to understand their experiences. People knew how to raise issues and make a complaint. These were responded to in line with the policy in place.

Staff felt supported and people knew who managed the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People did not always receive their agreed levels of support, and did not always know who would be visiting them. Risks to people were not consistently managed, and improvements were needed to ensure that people received their medicines as prescribed. New staff were recruited safely. Staff knew how to recognise and report potential abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff gained people's consent before supporting them. However, when people were not able to make decisions about their care, the provider had not assessed their capacity. They were also not able to show how decisions made on their behalf were in their best interests. People were supported to have their meals when needed, but some people did not have easy access to drinks. Staff received an induction and training to develop their skills, and people were supported to access health care services.

Is the service caring?

Good

The service was caring.

Staff supported people in a kind and caring manner, and people had developed positive relationships with the staff that visited them. People were involved in making decisions about their day-to-day care, and staff promoted their independence. People's privacy was respected and their dignity promoted.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved with the assessment, planning and review of their care. The provider sought feedback from people to understand their experiences. People knew how to raise issues and make a complaint. These were responded to in line with the policy in place.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager understood their responsibilities, but had not notified us of incident they should have done. The audits that were completed were not used to identify issues and were not effective at driving improvements. People's care records were not always kept up to date. Staff felt supported and people knew who managed the service.

Midlands Home Care Limited

Detailed findings

Background to this inspection

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

This inspection visit took place on 10 and 11 August 2017 and was announced. We gave the provider 48 hours' notice because the location provides domiciliary support to people living in their own homes, and we had to make arrangements to contact people who used the service. The inspection team consisted of two inspectors and two experts 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.

We checked the information we held about the service and the provider. This included notifications that the provider had sent to us about incidents at the service and information we had received from the public. We also spoke with the local authority who provided us with current monitoring information. We used this information to formulate our inspection plan.

On this occasion, we had not asked the provider to send us a provider Information return (PIR). A PIR is a form that asks the provider to give some key information about the service. This includes what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt was relevant.

We used a range of different methods to help us understand people's experiences of using the service. We made telephone calls to 22 people who used the service and eight relatives. We also spoke with six members of care staff and the registered manager. We reviewed the feedback received from another four members of care staff, five community professionals and the local authority.

We looked at the care plans of six people to see if they were accurate and up to date. We reviewed five staff files to see how staff were recruited and checked the training records to see how staff were trained and supported to deliver care appropriate to meet each person's needs. We also looked at records that related to the management of the service. This included the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement.

Requires Improvement

Is the service safe?

Our findings

We were not assured that there were enough staff available to meet people's needs and keep them safe. People did not always receive support at the agreed times. One person told us, "I have had missed calls. I had to ring the office and the reason they gave was different from the reason the carer gave later. And then they come an hour late." One relative said, "The times are erratic and this can upset my relation. We have had no missed calls though. But as far as phoning, only once did this happen when they were very late." Another relative commented, "The times do vary. They have phoned in the past to say they will be late, but this hasn't happened for some time now." A third relative told us, "There are issues with them not turning up and not telling me. Then my relation is left on their own." One community professional reported a situation where the person who used the service did not use their pendant alarm as they were expecting the care staff to arrive. The feedback we received from community professionals also raised concerns that people had experienced missed calls..

Staff did not always stay with people for the agreed amount of time. One person told us, "If they have finished, they do leave early. They were in such a rush once they left my commode full and had to return later to empty it." One relative said, "Sometimes it feels like they are in and out in five minutes; it's not that the jobs don't get done, but it's all so quick." The records we looked at confirmed that some people did not receive their care as required. For example, on three occasions in a week, one person's care call times were 50 minutes, 35 minutes and 30 minutes shorter over the day than agreed. This meant we could not be confident people were always receiving the agreed level of support they needed.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were sent a weekly rota that stated which staff members would visit. However, people did not always receive support from regular care staff. Comments included, "I never know who is going to turn up or when;" "I have different ones every time;" and "They swap and change, a lot have left; I don't know who is going to come." Other people told us that their support was provided by a regular team of care staff. One relative commented, "My relation has mostly the same carers, but they do change for holidays and sickness which is acceptable." This demonstrated that people were not always supported by a consistent team of care staff.

Risks to individuals were not consistently managed. Some people were at risk of developing sore skin, and one person told us, "They left me sitting on the sore area; when the nurse came they said that they could not have left me in a worse position." One community professional reported a situation where care staff had taken the instructions from the district nurse literally, and this had resulted in skin damage to the person who used the service. The community professional had investigated this issue and confirmed that no documentation or written care plan was in place to give staff the guidance needed to ensure the support was carried out in the correct way. The registered manager told us they had taken action against the staff members involved.

Some people needed to use equipment to enable them to move or transfer safely. We received mixed

feedback about this from people who used the service and their relatives. One person told us, "I feel safe with most of them, but there have been a lot of new carers, then not so much." Another person commented, "I haven't felt safe of late; I don't know what's going on with them as they have been putting my sling on incorrectly and twisting me." One relative said, "There have been a couple of incidents with my relations hoist where they have caught their foot and leg when moving. The senior came out and had to show them what to do." Other people told us they felt safe when being transferred and that the staff knew how to do this correctly. This demonstrated that people did not feel consistently safe when receiving care.

We saw that risks had been considered within people's care plans, however, the information was often general and some issues had not been considered. For example, people's home environments had not been assessed to ensure that these were safe for staff to work in. Other risk assessments were more specific. For example, we saw guidance that gave staff clear information about how to reduce a person's risk of falling.

Some people needed support to take their medicines as prescribed. Some of the people we spoke with were happy with the way staff did this, however others had concerns. One relative told us, "There have been a couple of times when the smaller tablets have been left in the blister pack by the carers. Fortunately I am here to rectify these things." We looked at the guidance that was available for the care staff to follow. We saw that this was not always clear. For example, one person's records stated that they needed the staff to prompt them to take their medicines. However, no further details were provided. The information available showed that the person was not actually able to open the bottles, and so staff would have to dispense the medicines. Another person's records stated that staff needed to apply cream to certain areas. There were no directions for staff to follow to ensure this was applied on the correct parts of their skin. The records we looked at did not have clear information about the times or dosages of the medicines people were prescribed. This meant we could not be assured that people received their medicines as prescribed.

We saw the provider had checked new staffs suitability to support people with their personal care before their employment commenced. This included references, confirmation of their identity and DBS checks. The disclosure and barring service (DBS) is a national agency that helps employers make safer recruitment decisions, and prevent unsuitable staff from working with people. The recruitment files we looked at showed that pre-employment checks had been carried out.

Staff we spoke with showed an understanding about their responsibilities to protect people from potential abuse. They were able to recognise possible signs of abuse, and had been given information about what to do if they had any concerns. One staff member told us, "If I had any concerns or saw something that was wrong, I would record it and report it straight away to the office." They added, "We have charts we can fill in if people have any marks on them. I would take my concerns further, to CQC if needed." Staff were given handbooks they could refer to that contained information about safeguarding people from harm. One staff member commented, "All the information is in there, which is helpful." We saw that staff completed questionnaires to test their understanding about safeguarding, and that this was discussed with them as part of their induction.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides the 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 capacity to make particular decisions, any made on their behalf must be in their best interests and least restrictive as possible. We checked whether the provider was working within the principles of the MCA.

The registered manager told us that some people who used the service were not able to make decisions about their care. Care staff we spoke with confirmed this, and one commented, "One person keeps telling us they want to go home; we explain that they are at home. They find it hard to understand." Another member of staff said, "The district nurse or GP will let us know if people can't consent to their care and this is recorded in the care plan." We saw that this had happened. However, when people were not able to agree to their support, their capacity had not been assessed to make specific decisions. For example, some people did not understand that they needed support at home, and other people had been involved with this decision. The provider had also not evidenced why it would be in their best interest to receive the support. There was a policy in place describing how the principles of the MCA should be adhered to; however, this had not been followed.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When people were able to consent to their care, we saw they had signed their care plans and service agreements. People told us that staff would ask for their permission prior to assisting them. One person said, "They will always listen to anything I have to say and will respect my opinion." Staff understood the importance of gaining people's consent, and one staff member commented, "We ask if they would like us to do this or that. Some people will refuse, and then we have to log it. We will then report this to the office. I know we can't force things onto people. We have to respect their decisions."

Some people received support to ensure they had sufficient to eat and drink. One person told us, "They will get my lunch for me; I buy the frozen meals and they then microwave them." Another person said, "I chose what I want to eat and the carers will get that for me." However, we received feedback that indicated people were not always enabled to have access to drinks when needed. One relative commented, "I have asked the carers to ensure my relation is left with a drink when they go, but this doesn't always happen, some do and some don't." Another relative told us, "My relation is at risk of getting urinary tract infections; but the staff don't leave enough drinks out for them." We saw that when people needed to have specific diets, for example if they were diabetic, guidance was not in their care plans for staff to follow. This meant that people were at risk of not having their nutritional needs met.

Staff received an induction to prepare them for their roles. One person commented, "The new carers will just shadow the more experienced ones. They introduce themselves and watch what needs to happen." One staff member told us, "To begin with I had some training in the office and then went out to do a week of

shadowing. That time I spent with other staff helped more as I was actually doing the care and seeing what I needed to do." Another staff member said, "The length of time that new staff spend shadowing others varies; each individual person is different, and some may need longer than others. Staff also received ongoing training to develop their skills. One staff member told us, "I've done lots of training. The moving and handling one was a practical session where we were shown how to use the equipment people have properly." We saw that staff had completed training sessions on a variety of areas, and most training courses were supported by quizzes to check staffs understanding of the topic. We saw that staffs care practices were observed during 'spot checks' that were carried out. One staff member said, "The manager will come out and check we are doing things right every three to four months. They will also check the notes we keep from our visits."

Staff supported people to access healthcare services. One person told us, "They called the doctor once for me and I was grateful for that." One relative said, "The carers recently sent for the doctor as they were concerned; they waited for the ambulance to arrive and called me to let me know what had happened." One staff member told us, "There is a main number we can use to make all the referrals to health and social care. If the occupational therapist is visiting to assess, then they meet us at the person's home so we can understand what needs to happen in the future." They added, "If there are changes the care staff need to be aware of, they are sent a text message to tell them what the changes are. They then have to then text back to confirm they have read the information and understood." Staff we spoke with confirmed that they would receive updated information about people's care needs.

Good

Is the service caring?

Our findings

People had developed positive relationships with the staff that supported them. One person told us, "The carers are lovely; they have become my friends now." Another person said, "They are all friendly and caring in their approach." One relative commented, "They are all very nice; we get on very well with them." Another relative told us, "The carers will always chat to my relation when they are supporting them." Staff we spoke with knew people well, and understood them. One staff member told us, "Some of the people can get upset at times; we'll hold their hand and try to give reassurance until they feel better."

People were involved in making decisions about their day-to-day care. One person told us, "I tell them if any changes are required." Another person said, "I live in my own home and they understand that. If I don't want something to happen, they will listen to me." People were encouraged to be independent. One person told us, "I do as much as I can for myself." Another person explained how they would do their own shopping. They added, "I try to do what I can, the carers will only help me with what I need the help with. That's important to me."

People's privacy was respected. One person told us, "The carers are good and will go out of the room when I'm in the shower." Another person said, "They all certainly respect my dignity; when I am having a wash, they will always ensure I'm not left with nothing on at all." One relative commented, "They will always close the door and make sure the curtains are closed." Another relative told us, "They are all very respectful, and are aware if we have visitors; then they will make sure my relation is [supported with their personal care needs] in private." We saw that during one team meeting, staff had been asked to reflect on dignity in care. This had been an interactive session, and staff had been encouraged to share examples of how they did this. This demonstrated that people's dignity was promoted.

Good

Is the service responsive?

Our findings

People were involved with the planning of their care. One person said, "I was involved with the initial assessment they did." One relative told us, "They came out and did an assessment in the beginning, and there is a care plan which we are all involved in." We saw that people's care had been reviewed and they had been involved with this. Some of the reviews took place at people's homes; others were conducted over the telephone. When people had been visited, they had signed the review form and were able to add comments about their care. One person told us, "I wanted the call earlier than had been originally agreed, and they did this. I'm very happy thank you." One relative told us, "My relation now needs more calls each day and they have put this in place." This demonstrated people's needs and wishes were responded to.

People told us they were asked if they had any preferences about the gender of the staff that supported them with their personal care needs. One person said, "They did check with me and I said that I didn't mind. I'm happy with the carers I have; they respect my views and wishes." Staff we spoke with knew the people they supported. They were able to describe some of the individual ways that people had, and demonstrated how they responded to this.

We saw that people who used the service and their relatives were sent anonymous questionnaires to offer their feedback. One person said, "I have had a survey in the post, and someone calls me every three months to see how things are going." The registered manager told us, "We get about 50% returned; people are pretty good at sending these back. We look to see if there are any common themes. Last time we found there was an issue about effective communication. One of the things we did was go out to visit people so they knew who they were talking to when they phoned up. There is still more that we can do, but we will get there."

People who used the service knew how to raise any concerns or complaints. One person said, "I have had to raise things with the office, and on the whole they have listened. Things do get better for a while, but then they slip; mainly about the call times." One relative told us, "In the early days I had to make a complaint; I was not happy with the care my relation was receiving. I phoned them up and they sorted it out straight away." We looked at the written complaints the provider had received. We saw that the registered manager had responded to these in line with their policy. They had also taken actions following the complaints, demonstrating they learnt from this feedback.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was aware of their responsibilities to inform us about specific incidents that had occurred. They showed us the policy in place that outlined the various notifications that should have been submitted. However, they had not followed this policy. This included when safeguarding concerns had been made, and when people sustained certain injuries.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People gave mixed feedback about the effectiveness of the management in place. One person told us, "I don't know why they can't get the call times right. It really is an important thing. I need to be confident that the carers will arrive when they should and stay for the right amount of time." We saw that the timesheets and care records were audited, however there was no evidence of any action taken when the care calls fell short of the agreed times. The registered manager stated that they would implement a tracker sheet to identify when call times were not as scheduled. They felt this would give them a clearer picture to then take actions. The registered manager told us how people that used the service should sign the timesheets to confirm they received the care calls on the staff rotas. However, we saw that this did not always happen. They had not followed this up with people. This meant they could not ensure that people had received their care as agreed. It also demonstrated that the audits in place were not effectively used to drive improvements.

We saw that some records had not been amended to reflect the actual care people were receiving. For example, when people's request for a change in their call times had been responded to, this had not been recorded. This meant that it could have been confusing for the care staff visiting. Some care records did not include information that was important about the person. For example, regarding people's health conditions or how staff should provide support to people when they became upset or distressed. We found many of the records kept had either not been dated, or did not have a specific date recorded. The registered manager agreed that they would start to check people's care plans when they visited people to carry out reviews.

Staff we spoke with told us they felt supported in their roles. One staff member commented, "The manager is approachable, I know I could go to them at any time." Another staff member said, "The manager listens to me. If we need to speak to someone out of hours, we can ring and they have always answered." Staff told us they would receive supervision sessions, and explained they used these to discuss any concerns or highlight any learning they needed. The registered manager told us how they had altered the format of the staff meetings. They said, "It used to be about us talking and the staff listening. But it wasn't working. So now the sessions are a lot more interactive. We also use the time to reflect on what has been happening." Staff were aware of the whistle blowing policy, and understood how and when to use it. This policy is in place to support staff when they need to raise concerns, anonymously if preferred, about the care people received.

We saw there was an on call system in place to enable staff and people who used the service to make contact out of hours. We were shown how the person covering the on call system would be equipped with

the information needed to provide a response when issues arose. People told us they were able to make contact with the office when needed, and were aware of who the management team were.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider did not notify the Commission without delay of the incidents that occurred in the service that affected the health, safety and welfare of people who used the service. Regulation 18(2) and (5)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that when people lacked capacity to make an informed decision, or give consent, they acted in accordance with the requirements of the of the Mental Capacity Act 2005 and associated code of practice. Regulation 11(1)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times. Regulation 18(1)