MiHomecare Limited

MiHomecare - Thornton Heath

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This service provides a domiciliary care agency. It provides personal care to people living in their own houses and flats and specialist housing. It provides a service to older adults and younger disabled adults. At the time of our inspection there were around 200 adults using the service.

We gave the service eight working days' notice of the inspection visit because we needed to be sure the provider was available over the festive season.
This inspection took place on 2, 19 and 22 January 2018.

At our last comprehensive inspection of the service in February 2017 we found it was meeting the fundamental standards and we rated the service Good overall. At this inspection we found the service had deteriorated and the rating was Requires Improvement overall.

There was no registered manager in post at the time of our inspection. 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. There had been instability in management since our last inspection and the most recent manager resigned shortly after we announced our inspection. A new manager had permanently transferred to the role from another branch within the organisation a few days before our inspection. The manager in post had promptly made an application to register with us before we inspected the service. We found they understood their role and they told us they were committed to improving the service in light of our findings.

We arranged this focused inspection because of the high number of safeguarding alerts we received relating to missed visits. Since our previous inspection there had been over ten allegations of neglect due to missed calls or people not receiving their care at the agreed time. We found people still experienced problems with missed calls and also lateness. In addition the provider did not always inform people in advance who would be caring for them which made people feel unsafe. When people felt uncomfortable with a staff member the provider did not always respond to their request to no longer send that member of staff. The provider had not taken sufficient action to assess, monitor and improve in relation to these concerns.

People's medicines were not always managed safely by the provider. Three people told us staff lateness and missed visits meant they did not always receive the right support to take their medicines, some of which were time critical. The provider had not audited people's medicines in recent months and this had not been identified until the day of our inspection. The provider was unable to show us recent medicines records for people and instead showed us medicines records for one person for July and August 2017 which had several omissions the provider had not identified and was unable to explain. The provider told us they would improve medicines management immediately in response to our findings.

The provider took action to improve systems to safeguard people following safeguarding incidents,

including cooperating with the safeguarding investigations by the local authority, carrying out their own internal investigations and reporting back to the safeguarding team. However, the provider had not always thoroughly investigated why missed visits occurred as part of improving the service.

The provider identified, assessed and managed risks relating to people's care. The provider held a monthly quality forum where all safeguarding investigations, complaints, compliments and accidents and incidents were discussed in depth as part of reducing the risk of recurrence.

The provider carried out recruitment checks on staff to ensure they were suitable to support people. We received mixed feedback from people and relatives regarding whether there were enough staff deployed to care for people.

The provider's governance systems had failed to improve people's experience of lateness, missed visits and inconsistency of care workers. Although the provider carried out quality monitoring audits, satisfaction surveys and spot checks of carers these had not identified and improved the issues we found. The provider's systems had failed to recognise people's experience of poor communication from office staff. In addition the provider had failed to recognise the issues relating to medicines management, including that audits of medicines had not been carried out as expected.

The provider worked openly in partnership with key organisations. For example, the provider met with the local authority regularly to review service delivery including any accidents and incidents and worked with the safeguarding team in relation to any allegations of abuse.

The provider submitted statutory notifications to CQC as required by law, such as in relation to allegations of abuse.

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's medicines were not always managed safely.

Some people felt unsafe due to issues with missed calls, lateness, lack of information about staff who would be caring for them and inconsistency of care workers.

The provider took action to improve systems to safeguard people following safeguarding incidents. However, the provider did not always carry out robust investigations as part of identifying improvements.

The provider identified, assessed and managed risks relating to people's care and shared learning across the organisation.

The provider carried out recruitment checks on staff to ensure they were suitable to support people. We received mixed feedback from people and relatives regarding whether there were enough staff deployed to care for people.

Is the service well-led?

Requires Improvement

The service was not always well-led. The provider's governance systems had failed to identify and improve medicines management, people's experience of lateness, missed visits and inconsistency of care workers and poor communication from office staff.

There was no registered manager in post although a new manager had applied to register with us. The instability of management contributed to the failings we found.

The provider worked openly in partnership with key organisations.

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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 inspection was prompted due to a high number of safeguarding allegations.

This service provides a domiciliary care agency. It provides personal care to people living in their own houses and flats and specialist housing. It provides a service to older adults and younger disabled adults. There were 220 people using the service at the time of our inspection.

Not everyone using MiHomecare – Thornton Heath receives regulated activity; 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.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

We gave the service eight working days' notice of the inspection visit to ensure the provider would be available to meet with us over the festive season.

Before the inspection we looked at all the information we had about the service. This information included information about safeguarding allegations investigated by the local authority and the statutory notifications that the provider had sent to CQC. A notification is information about significant events which the service is required to send us by law. We also used information the provider sent us in the Provider

Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also received feedback from the local authority commissioning team.

The inspection was carried out by 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.

Our inspector visited the office location to see the new manager, the quality and performance manager, the chief executive office and a care coordinator; and to review care records and policies and procedures. Our inspector also spoke with three care workers during our inspection.

After our inspection our expert by experience spoke with 16 people using the service and eight relatives. Our inspector also received concerns from two relatives of people using the service shortly after our inspection and we used this information to inform our inspection findings.

Requires Improvement

Is the service safe?

Our findings

People's medicines were not always managed safely by the provider. Most people told us staff administered medicines safely to them. However, two people told us their medicines were time-critical and they had experienced staff lateness which caused them difficulties. A third person told us they experienced bad headaches if they did not receive their medicines and as such they had experienced these due to missed calls.

The provider informed us many people's medicines records had not been audited in recent months and this had not been identified until the day of our inspection. The provider passed us medicines records for two people. We identified these medicines records were not recent, covering June and July 2017 for one person and August 2017 for the second person. We found these medicines records had many omissions which the provider could not explain, even though they had been reviewed by the provider. The provider told us they were unable to provide any more recent medicines records for any people using the service. This meant the way the provider managed people's medicines had deteriorated since our last inspection and it was no longer safe. The chief executive officer told us they would immediately put systems in place to improve in light of our findings.

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

We arranged this focused inspection because of the high number of safeguarding alerts we received relating to missed visits. Since our previous inspection there had been over ten allegations of neglect due to missed calls or people not receiving their care at the agreed time. Some people told us they had experienced missed calls and this was a concern for them. One person told us they experienced a missed call within the last seven days. A second person told us, "Staff once missed a call. The carer had told the office staff but they had not passed it on." A second person told us, "[Missed calls] happened twice and they didn't ring [to inform me]. I rang [the office] and they didn't know the carer wasn't coming." A third person told us, "If the regular carer doesn't come they say another carer will come and they don't. I have missed carers as sometimes I don't get anybody [to care for me]." The manager told us they had agreed with office staff they would cover any visits to people whenever necessary to help cover calls which were proving difficult.

Some people also felt unsafe due to staff lateness. One person and three relatives told us there had been occasions when only one care worker hoisted them, or their family member, when two were required to hoist safely, mainly due to the second care worker being delayed. This meant people may have been at risk due to unsafe moving and handling practices.

Some people felt unsafe because they were not informed in advance who would be caring for them, if there were changes to the staff assigned to care for them, or if staff were going to be late. However most, but not all, people and relatives told us staff stayed for the agreed amount of time. One person told us, "I am not happy because they don't let me know who is coming or the time they are coming."

People told us they felt safe with the regular staff who cared for them. However, several people told us they felt unsafe because they did not have regular care workers, or because too many different staff were allocated to care for them when their regular care worker was away. One person told us, "When I get the regular carers they are fabulous my regular carer is on holiday next week this is where is it all goes wrong. A couple of months ago I had twelve carers in one week. I have a key fob and also a key safe the carers get to use. I don't feel very secure when there are so many carers who know how to get in." A second person told us, "I feel safe 98% of the time. Things go wrong when I don't get regular carers." A third person told us, "Every time it's a different carer, even though I call and beg them to send the same carers. I raised this but they kept telling me they would try but it never happened. I always got different people."

Some people told us they had felt uncomfortable with certain staff and had requested the provider did not send them again. Most people told us the provider had responded positively to them and had not sent the staff again. However, one person told us, "On one date in December they sent a carer. I told the office not to send her again. They sent her three times including Christmas night, I sent her away."

The provider had not always investigated the role of the on-call staff in incidents of safeguarding due to missed calls. The provider used an electronic system to monitor the times staff arrived to care for people in real time. The care coordinator showed us how this system worked and explained if staff were ten minutes late for a visit they would receive an alert from the system. The care coordinator explained during 'out of hours' a staff member was 'on-call' and they were responsible for watching the electronic system to check people received their visits at the right time. However, when reading the providers safeguarding investigation reports we found the provider had not investigated whether the on-call staff had been actively monitoring the electronic system as required. It was possible therefore that the on-call staff missed alerts raised by the system but this did not form part of the provider's investigations. When we queried these issues with the provider they were unable to tell us whether the on-call staff had acted appropriately in identifying and responding to an alert. In addition, in one safeguarding incident a relative and care worker reported they were unable to contact the on-call person to report concerns, yet the lack of contact was not investigated by the provider. The provider took on board our feedback and told us they would consider the performance of the on-call staff in any future safeguarding investigations.

These issues contributed to the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback from people and relatives regarding whether there were enough staff deployed to care for people safely. Of the ten people and relatives we asked, seven told us they believed there were not enough staff. One person told us, "They don't have enough staff because when the regular carer is on holiday, they don't come at the right time." A second person said, "I don't think they had enough staff, [care workers] leave as they get fed up." A third person said, "I don't think [there are enough staff]. I get carers complaining constantly about the way they are treated by MiHomecare, it is getting worse." The provider told us they continued on-going to recruit to fill vacancies. The manager told us they encouraged staff to discuss any concerns with them as part of increasing staff retention and they had received a strong response from care workers who wanted to discuss issues with them. The manager told us they were meeting care workers individually to listen to them and resolve concerns.

The provider took some action to improve systems to safeguard people following safeguarding incidents. We found for each allegation the provider followed their procedures in reporting to the local authority safeguarding team and they also informed the CQC via statutory notifications, as required by law. In this way the provider acted in an open and transparent way in relation to safeguarding allegations. The provider cooperated with the safeguarding investigations by the local authority, carrying out their own internal

investigations and reporting back to the safeguarding team. The provider took action to support staff involved in the safeguarding incidents, providing further training and closer supervision and monitoring. Where staff performance was below the expected standard the provider followed their disciplinary policy and procedure. The provider also issued people and their relatives with a written apology when the service was found to be at fault. In addition, the provider trained staff in safeguarding adults at risk each year to keep their knowledge current. Our discussions with staff showed they understood their responsibilities in relation to safeguarding.

Risks relating to people's care were reduced because the provider managed risks, despite the issues discussed above relating to moving and handling. The provider identified and assessed risks relating to people's care, such as those relating to infection control and the environment. The provider then put management plans in place for staff to follow in managing risk. Risk assessments were sufficiently detailed and were reliable for staff to follow as they were reviewed when people's needs changed. Our discussions with staff showed they had a good understanding of the risks relating to people's care and how to support them in relation to these.

The provider held a monthly quality forum where all safeguarding investigations, complaints, compliments and accidents and incidents were discussed in depth. The provider shared this information with the registered managers across the organisation. In addition the in-house trainer added some examples of things that had gone wrong to their staff training courses to open up discussions about how staff should respond in similar situations. Staff understood their responsibilities to report concerns and were aware of the provider's whistleblowing line which they could use to raise concerns anonymously.

People were supported by staff who the provider checked were suitable to support people. The provider had a dedicated recruiter who interviewed all candidates and checked their literacy and numeracy levels were acceptable. The provider checked candidates work history, obtained references from former employers and character references, criminal records checks, and reviewed identification, the right to work in the UK and any health conditions. Once appointed, the provider reviewed the suitability of staff to care for people during their probationary period.

Requires Improvement

Is the service well-led?

Our findings

The provider's governance systems had failed to improve people's experience of lateness, missed visits and inconsistency of care workers. Although the provider carried out quality monitoring audits, satisfaction surveys and spot checks of carers these had not identified and improved the issues we found. The provider's systems had failed to recognise people's experience of poor communication from office staff. In addition the provider had failed to recognise the issues relating to medicines management, including that audits of medicines had not been carried out as expected.

Ten out of fifteen people and relatives felt the service was not well-led. The main reasons for this were poor communication from office staff to people, relatives and staff and also poor timekeeping. In response to our question as to whether the service was well led one person responded, "No it's not well managed. It's the timing and not letting us know if they are going to be late or if they are sending a carer." A second person told us, "I don't think it is well managed. Sometimes the carers don't know what they need to do when they get here and they ask what I need doing. It is bad organisation from the start." A third person told us, "Over the Christmas period I filled a form to say I just wanted a breakfast call and night call but two carers came at lunch and tea time. I feel sorry for the carers [as I didn't need their support]. This is just an example they don't listen." A fourth person said, "Office staff don't seem to understand the job. I called them once when one [of two staff required for a double-handed visit] carer didn't turn up and I wasn't impressed by their management skills. They say they will try and contact the second carer. They don't seem to coordinate the carers." A relative told us, "The timing is the main problem as we're not sure when carers are coming." A second relative said, "It's not unorganised but it isn't consistent. Three years ago we could set the clock by carers but now, there is rough pattern." A third relative told us, "The administration is inadequate." A fourth relative told us, "[Office staff] came to do a review. It wasn't convenient so she made arrangements to come back before Christmas. She didn't come back on that day and I haven't heard from her since."

Ten people and relatives raised concerns about difficulties contacting office staff to discuss issues. One person told us, "You ring and ring. You don't get them straight away, you have to leave a message." A second person told us, "Sometimes you can't get through to the office. Once the hospital staff tried to ring to let them know I was going home but they couldn't get through to the office!" A third person told us, "I don't want to talk to them it stresses me out. Before Christmas no one could be bothered to answer the phone. I left a message but nothing happened. They don't ring me back." A fourth person told us, "If you ring the office it takes a long time to answer. They are laughing and really not listening to what I am saying. I say, 'Did you get that?' they say, 'What did you say?'. They do not do what you ask." A relative told us, "I think it is an organisation in crisis I phoned four times the other night and the phone is engaged." When we raised our concerns with the manager they responded by implementing a new system to ensure all voicemail was delivered directly to the manager. The manager told us this helped them recognise when there were difficulties in office staff answering calls and also helped ensure people's calls were returned.

These issues contributed to the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager in post and several managers had been in post for short periods since our last inspection. Shortly after we announced our inspection the manager in post resigned. The lack of stability of management meant the service experiencing difficulties in providing high quality care. When we inspected the service a manager had promptly transferred from a different service within the organisation and had already applied to register with us. The new manager had been in post only a few days at the start of our inspection so the issues pre-date their leadership. The manager was experienced in leading large care agencies and had a qualification in health and social care. The new manager told us they intended to stay at the branch long-term and rectify the issues we identified.

When we raised concerns with the manager in relation to our inspection findings we found they understood the issues and took prompt action where possible to monitor and improve the issues. For example, in response to concerns people reported to us about the poor attitude of some office staff the manager spoke with staff and arranged customer service training. People told us they had received letters without postage from the agency. We spoke with the manager about this who told us they reviewed their postage systems to reduce the risk of this occurring again and would issue people full refunds. In response to lateness and missed calls the manager told us they were upgrading the electronic alert system which monitored calls to better identify and respond to this. A person told us they were concerned a staff member who had a fear of a particular animal was inappropriately sent to a person with this animal on several occasions. The manager told us they had spoken with office staff to ensure detailed information about staff preferences were recorded on their electronic system to prevent this happening again.

The provider had submitted notifications to us about any events or incidents they were required by law to tell us about such as allegations of abuse.

The provider worked openly in partnership with key organisations. For example, the provider met with the local authority regularly to review service delivery including any accidents and incidents. A representative from the local authority told us they provider communicated well with them. The provider worked closely with the local authority safeguarding team regarding any allegations of abuse.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always ensure care was provided to people in a safe way by ensuring the proper and safe management of medicines. Regulation 12(1)(2)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not established systems or processes which operated effectively to enable them to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); act on feedback from people and relatives as part of continually evaluating and improving such services; evaluate and improve their practice in respect of the processing of the information referred to above. Regulation 17(1)(2)(a)(e)(f)