MiHomecare Limited

MiHomecare Kensington and Chelsea

Inspection report

Unit 2 , 2nd and 3rd Floors
Cambridge Court, 210 Shepherds Bush Road
London
W6 7NJ

Tel: 03331212401
Website: www.mihomecare.com

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31 August 2022
16 September 2022

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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

About the service:
MiHomecare Kensington and Chelsea is a domiciliary care agency which provides personal care and support to people living in their own homes. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of our inspection 106 people were receiving personal care support.

People's experience of using this service
People were not always safe. The service had experienced issues with late and missed care visits which meant people were exposed to harm by not getting their visits as planned. Medicines were not always managed safely. We found conflicting information in people's care plans about the level of support they required.

Due to the poor timekeeping and the inconsistent staff people did not feel safe. We received comments such as, "I'm not really happy with the care. Sometimes they don't even turn up and don't ring. They just turn up when they feel like it and I don't have a regular carer."

People who received care and staff were not confident in the management of the organisation. Staff told us they did not always feel supported by their manager and they did not have enough travel time to enable them to attend to people on time. The provider's quality assurance processed were not effective as they had not identified all the issues we found with care plans and risk assessments. The provider did not work in partnership with other professionals. The provider did not use feedback effectively to improve standards of care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
At the last inspection, the service was rated as Good (Report published 4 September 2019).

Why we inspected
We received concerns in relation to missed and late care visits. As a result, we undertook a focused inspection to review the key questions of safe and well led only.

For those key questions not inspected, we used the ratings awarded at the last comprehensive inspection to calculate the overall rating. The overall rating for the service has changed from Good to Requires Improvement based on the findings of this inspection.
We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.
You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for MiHomecare Kensington and Chelsea on our website at www.cqc.org.uk.

Enforcement:
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safety, staffing and good governance processes at this inspection. Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up:
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our Safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

MiHomecare Kensington and Chelsea

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection Team
The inspection was carried out by one inspector 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.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats and specialist housing.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.
Inspection activity started on 30 August 2022. We visited the location's office on 31 August 2022. Inspection

activity ended on 16 September when we gave final formal feedback.

What we did before the inspection
We looked at information we held about the service. This included details about incidents the provider must notify us about, such as allegations of abuse and serious accidents and incidents. We also reviewed all other information sent to us from other stakeholders, for example the local authority and members of the public. We used all this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We reviewed 10 people's care and medicine records. We analysed electronic call monitoring (ECM) data for all people. We looked at seven staff files in relation to recruitment and supervision. We also looked at policies and procedures and records related to the management of the service. We spoke with 20 people receiving care and two relatives. During the visit to the office we spoke with the registered manager, the ECM manager, the Regional Manager and the Regional Head of Quality. We sent feedback questionnaires to 41 care workers and we received 5 responses. We also spoke with three care workers to get their feedback about the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Risks to people were not always adequately assessed and there was limited information in place for staff to ensure some risks were mitigated. People and their relatives did not feel the service was keeping them safe. We received comments such as, "I feel that [family member] isn't safe, and they don't feel safe either" and "The staff don't always clean spillages up and I'm worried about my [family member] slipping on it".

● Not all known risks were being managed safely. One person's care notes showed they were routinely being escorted by care staff in the local community. This activity had not been risk assessed and there was no guidance in place for staff to ensure this was being managed safely.

● Another person's care notes showed that care staff recently reported they found the person on the floor after a fall in their home. The falls assessment in their care plan had not been updated to reflect this and stated there was no history of falls.

● There was a lack of evidence that moving and handling equipment being used by staff was safe and was being regularly maintained. Care plans did not contain information on the model or maintenance history of moving and handling equipment or any details of who was responsible for maintaining these.

● Another person's care notes showed they were being supported by staff to empty their catheter. There was no risk assessment in place for this and guidelines for this task did not contain sufficient information to ensure staff understood how to identify concerns or any guidance on who to contact if there were issues.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● People's medicines were not always managed safely. Care plans contained conflicting information about the level of support people required to take their medicines. One person's medicine assessment stated they required level 1 medicine support and later in the same document it stated they required level 2 medicine support. This same person's nutrition and skin integrity assessment stated, "the district nurse is administering PRN medication for constipation" but the medicine assessment stated, "I do not get support with medicines from any other professionals."

● Another person's medicine administration record (MAR) stated on 21 August 2022 their medicines were left out for the person to take later. However, their care plan did not state this was the planned support for this person, and they were at risk of forgetting to take their medicines. This person had also not received their medicines for two consecutive days in August as they had run out of their medicine.

● Another person's MAR showed numerous occasions in August when their medicines had not been

administered as planned. On one occasion medicine was not given as the carer stated it was given by another carer. However, there was no record of the prior administration. On other occasions care notes showed the person was sometimes refusing their medicines as they did not want to accept support from an unfamiliar agency worker.
● Staff received training in the administration of medicines, however, their competency had not been assessed in line with best practice guidance. We saw several competency assessments that had been carried out during care visits of people who did not require medicines support.
● The provider carried out audits of people's MARs and reviewed medicine risk assessments. However, the provider's audits and reviews had not identified the issue we found.

The failure to ensure safe management of medicines and follow best practice guidance was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were persistent complaints made to the local authority about late and missed visits and not getting support from regular staff. People also complained that they could not get through to the office when they needed to as the office phones were not answered.
● As part of the inspection the provider submitted a late visits report that showed there were 8,379 late visits between March and August 2022. Analysis of the ECM data showed people's planned visit times were changed often. Many people told us they did not get their care visits at consistent times. Comments included, "Sometimes they can be an hour late. This is also a concern if [family member] has medical appointments" and "I've no idea what time they are meant to arrive."
● Most staff told us they did not have sufficient time between care visits which meant they could not get to people at the agreed time. We received comments such as, "Often without prior asking they add long distance visits to clients whom I have never seen before. I don't know really where I am going and what problem I am going to face" and "Sometimes the travel time given between clients is five minutes while the distance between the clients can be 20 minutes or more on foot."
● The provider's systems for recording attendance times was not effective as different systems were recording different times for planned and actual visit times. The ECM system was recording different times to the times recorded on care notes and MARs so we could not be certain which system was correct.
● The provider told us they had been experiencing ongoing staffing shortages but they utilised staff from other offices to ensure enough staff were in place to answer the telephone. However, during the inspection we also made several calls to the office but did not get an answer which showed there continued to be insufficient staff in the office to answer the volume of calls received.

The provider had failed to ensure sufficient staff were deployed to meet people's needs. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service followed safer recruitment processes. There was a system in place to ensure that all pre employment checks were completed before staff started work. Checks included people's right to work in the UK, employment history, references from previous employers and Disclosure and Barring Service (DBS)checks. The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions.

Learning Lessons when things go wrong
● There were systems in place to record, analyse and learn from accidents and incidents. Staff understood their responsibility to report these to the registered manager. The registered manager analysed accidents

and incidents and shared lessons learnt with other staff to help avoid similar events from happening again.

Systems and processes to safeguard people from the risk of abuse

● Staff had a good understanding of safeguarding procedures. They knew who to inform if they had any concerns about abuse or safety and how to escalate their concerns if they were not satisfied their concerns were being taken seriously.

● The registered manager was aware of their responsibility to report safeguarding concerns to relevant organisations including the local authority and CQC.

Preventing and controlling infection

● The provider ensured procedures were in place to prevent and control the risk of infections. People told us they were satisfied that staff followed safe hygiene and wore appropriate personal protective equipment (PPE). One person told us "The staff wear a mask and gloves and always clean up afterwards."

● Staff told us they had access to appropriate PPE to prevent the spread of infection and the registered manager often spoke with them about their infection prevention and control (IPC) responsibilities and they had enough PPE to carry out their role.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our we rated this key question Good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, safe care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Quality assurance systems were not effective as they had not identified all the issues we found with care plans, risk assessments, medicines support and the anomalies with care visit times.
- The service improvement plan had not been effective and did not contain sufficient detail about how the provider intended to resolve the issues with staffing and timekeeping they had been experiencing for some time.
- The provider was not always learning from significant events. The provider's investigation into the missed visits did not show what the root cause of this incident was so we could not be assured that the provider was able to learn lessons from this to prevent a similar event happening again.

The failure to assess, monitor and improve the quality and safety of the service was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Their were systems in place to engage with people using the service but these were not always effective. The system for seeking feedback from people receiving care was not effective and did not drive improvements to standards of care. Overall satisfaction levels recorded did not correspond with the negative feedback we received from people receiving care and their representatives. We found many examples where quality assurance surveys recorded overall satisfaction as satisfied or very satisfied despite negative answers to key questions.
- When surveys did record people as being very dissatisfied there were no follow-up actions to show what the provider was doing to resolve the issues people were experiencing. Despite the quality assurance surveys some people told us they had not been consulted about their experience of care. Comments included, "I've never been contacted by the manager to check how things are going" and "I've never really spoken to the manager."
- The registered manager arranged regular staff meetings to discuss the quality of the service, plan improvements and keep all staff up to date with relevant information. However, minutes of meetings did not show which staff attended so we were not able to see if meetings were an effective way of communicating with staff and gave them the opportunity to raise concerns. One member of staff told us, "Sometimes we identify problems and we don't receive feedback or clarification."

The failure to assess, monitor and improve the quality and safety of the service was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People did not always get person-centred, high quality care. Many people receiving care and their relatives told us they were not happy with care provided. The late and missed visits and the lack of consistent staff were having an impact on many people's experience of care. We saw examples of people refusing support from unfamiliar staff. Comments from people included, "I do not trust the carers to give me personal care" and "I have complained about not having a regular carer but the management haven't done anything about it."

● Staff feedback about the service was mainly negative. Many members of staff told us that they did not feel there was a culture of openness and they did not feel well supported by managers or office staff. We received comments such as, "I don't feel supported and I don't think the service is well-led" and "The culture of the organisation is unapproachable, rude and dismissive."

● Staff also told us that the staffing shortages and rotas were having a negative impact on the quality of service provided. Comments included, "I feel like the management is trying their all to provide a good service but can't with how understaffed they are" and "I like the company but there are things like the rotas that need to be improved." We have addressed these issues in the Safe section of this report.

● Despite the majority of feedback being negative some people were happy with the care they received from regular staff. Positive comments included, "The staff are very caring with a good personality and I can talk to them and feel relaxed" and "I think they have a polite personality. They are polite and nice and helpful."

● People's religious and cultural needs were well documented in their care plans. The provider also recorded people's personal history to help carers have a broad understanding of the people they were caring for.

Working in partnership with others

● The service did not work well with other professionals. Apart from the local authority homecare team the provider was not able to provide details of any other professionals they worked with to plan and deliver care and support.

● Local authority commissioners were not satisfied with how the service was being managed and had raised concerns about the lack of improvement being made. One professional told us, "Unfortunately we continue to receive complaints from people about late and missed calls. So far we have not seen sufficient improvements."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager understood their duty of candour and the regulatory responsibilities around reporting to the CQC.

● People receiving care and/or their representatives were informed when events such as missed visits had occurred.

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 provider did not do all that was practicable to ensure that care and treatment was provided in a safe way as risks to people were not always identified and mitigated. The provider did not ensure people's medicine needs were safely managed Regulation 12(1)(2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure sufficient staff were deployed to meet people's needs. Regulation 18(1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and improve the quality and safety of the service effectively. The provider had failed to ensure people received a consistently safe service. Regulation 17 (1) (2)

The enforcement action we took:

Warning notice