MiHomecare Limited

MiHomecare - Okehampton

Inspection report

Unit 2 Jacobspool House
11 West Street
Okehampton
Devon
EX20 1HQ
Tel: 01837 541670
Website: www.mihomecare.com

Date of inspection visit: 20 & 25 August 2015
Date of publication: 05/10/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We undertook an announced inspection of MiHomecare - Okehampton on 20 and 25 August 2015. We told the provider two days before our visits that we would be coming to ensure the information we needed would be available. Mihomecare - Okehampton is a domiciliary care agency which provides personal care to people in their own homes in the Okehampton, Tavistock and Crediton areas. MiHomecare Limited has 40 domiciliary care services across the country with 29 in the South of England. At the time of our inspection between 50 and 60 people were receiving a personal care service from Mihomecare – Okehampton.

We last inspected the agency in April 2014 and found no breaches in the regulations we looked at. However, the April 2014 inspection did not include us checking the outstanding breach of the registered manager not

Summary of findings

notifying us of serious incidents. This was because of the brief timescale between the breach and that inspection. However, we were notified of serious incidents, as required, from that date.

The service is required to have a registered manager. 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. At the time of this inspection the manager of MiHomecare – Okehampton was completing their registration.

The arrangements and instruction for care workers about handling medicines for people were not clear and had led to medicine being administered which should not have been.

The organisation had auditing systems in place but they were not fully effective. For example, some people's care plans, which should provide care workers with accurate information about people's needs and wishes, were not up to date.

The visit arrangements had been reviewed and updated since an internal investigation into staff travel times. Most people felt the staffing arrangements had improved and were satisfactory. One person said, "Time keeping is getting better and most carers arrive on time now. Carers now stay for the full time".

Care workers were clear how to protect people from abuse and there was clear information for staff on how to alert concerns.

Risks were assessed and kept under regular review. These included hazards within people's home and the risk from falling.

Care was delivered with people's consent. Care workers explained to people about risks to their welfare and involved family members in decisions where this was in the person's best interest.

Care workers were complimentary about their induction and training. They were supported and supervised in their work. A district nurse said, "They're on the ball; don't panic, do things appropriately and follow advice." Recruitment arrangements ensured staff had been checked before they worked in people's homes.

Care workers showed a concern for the people they provided care and support to. People said they were treated with respect, dignity and their privacy was upheld. People's views were sought and listened to.

People's health, welfare and independence were maintained and promoted. People told us they could stay in their own home because of the help they received. One person said, "Because they see to my feet and legs I can still get around and go out using my walker."

There was a current review of office arrangements by the recently appointed manager. Their emphasis was on listening to what people and staff had to say so the service could be improved. Staff said there was always somebody they could call for advice and support.

There were two breaches of regulation. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
Aspects of the service were not safe.

The arrangements for the management of people's medicines were not clear for staff to follow and this posed a risk.

People were protected from abuse and harm.

People mostly received their visits on time because the staffing arrangements were working.

Risk was understood and mitigated wherever possible.

Requires Improvement

Is the service effective?
The service was effective.

Care workers received a thorough induction, training and support.

People were fully involved in decisions about their care and the staff understood legal requirements to make sure people's rights were protected.

Where people's diet was a concern the agency staff took steps to keep the person safe. Where external advice was required to promote people's health it was sought on their behalf.

Good

Is the service caring?
The service was caring.

Care workers provided a kind and caring service to people. People's views were sought and taken into account. Their privacy and dignity were upheld and they were treated with respect.

Good

Is the service responsive?
Aspects of the service were not responsive.

People's care plans did not always reflect their current needs but people did receive care centred on their personal preferences and needs. People were consulted and involved in decisions about their care.

Care workers were very responsive to people's needs and promoted their health and wellbeing.

Complaints were investigated and responded to toward improving the service for people.

Requires Improvement

Is the service well-led?
Aspects of the service were not well-led.

Requires Improvement

Summary of findings

The quality of the service was monitored at location and organisational level but not always effectively because areas for improvement were not always identified and followed up.

The manager was reviewing office arrangements and listening to staff and people's views so they could make improvements. Those improvements were making a difference but needed to be embedded into practice.

MiHomecare - Okehampton

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.

The inspection of MiHomecare - Okehampton took place on 20 and 26 August 2015 and was announced. We told the provider two days before our visit that we would be coming. We did this because the manager is sometimes out of the office supporting staff, visiting people who use the service or managing the MiHomecare – Exeter office. One inspector undertook the inspection.

Before the inspection visit we reviewed the information we held about the service, including the Provider Information Return (PIR) which the previous registered manager completed before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we received since the service was registered with CQC. This included notifications that the provider had sent us which showed they had been managed appropriately.

During our inspection we went to the MiHomecare – Okehampton office and spoke to the manager and office staff, reviewed the care records of seven people that used the service, reviewed the records for three staff and records relating to the management of the service. Prior to the office visit we undertook telephone calls to 13 people using the service and 10 staff members. We also visited five people in their own homes, with their permission. We spoke to four health care professionals involved in the care provided to people who use the service.

Requires Improvement

Is the service safe?

Our findings

Medicine management was not always safe.

All care workers received training in the safe handling of medicines and there were policies and procedures available for their reference. However, the information in those policies did not correspond to the information prompts in people's care plans, or their medication risk assessments. The policy described three levels of medicine management: self-medication, prompting with medicines or administering medicines for the person. However, information in one person's care file described them 'self-medicating' but also that the care worker should 'assist with medication'. It was therefore difficult to understand what the care worker was supposed to do. That person's care plan then informed the care worker they were to remove the medicine from the box and put the tablets in the person's hand. According to the policy, this would be considered level three, administering the medicine to the person. The manager said the medicines administration forms were currently being reviewed.

Records showed that one person had been administered a pain relieving patch by a care worker although administering the patch was not part of the person's risk assessment or care plan. This increased the risk of a mistake in its use and the monitoring of its effectiveness.

Each person whose medicine management was part of their care plan had in place a record of their medicines administration. Those records were completed by care workers using codes if a medicine was not taken for some reason. The code mostly used was '0', which was described as 'other'. The reader then had to refer to the care plan or risk assessment to interpret what that meant, which, as outlined above, was not always clear. Each medicine administration record had the information about the medicine hand written by a care worker. The care worker did not sign to say they had written the information and so there was no record of which care worker wrote it. Neither had the entry been checked for accuracy. This had the potential for mistakes. One person told us this had happened but it only related to an emollient cream, so they were not concerned about it and the mistake was amended.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that where a person had stopped taking their medicines the agency contacted their GP promptly to inform them, and for advice. There was one medicine error on record at the agency and the support worker had identified this and reported it themselves.

People said they felt safe when care workers were providing care and they described how their home was kept secure when support workers visited them. Where care workers handled money for people, they were satisfied with the arrangements. One person said, "They do a weekly shop for me and there has never been a problem, the receipts are brought back with the change." We found there were receipts in place for another person where shopping was undertaken for them. One person expressed disappointment that the care worker was not allowed to receive gifts from them; the care worker was very clear that receiving gifts was not permitted.

Care workers demonstrated a good understanding of what might constitute abuse and knew where they should go to report any concerns they might have. For example, they knew to report concerns to the manager and externally such as the local authority, police and the Care Quality Commission (CQC). Staff said they had received safeguarding training and records confirmed this.

The manager provided detail about how to protect people from abuse. For example, ensuring staff awareness through training, including video examples of where abuse might occur, new staff shadowing experienced support workers and the recording and reporting of any concerns, such as bruising. They were less confident than care workers in describing how and when to report concerns externally. They said as they were a newly appointed manager this was not something they had yet needed to do and they would make sure they sourced appropriate training.

The whistle blowing policy provided information for care workers on how to alert concerns which might be abuse and included the contact details for the local authority safeguarding team to assist them to do this if required. There was also information about how to respond to concerns of abuse posted around the agency office. Staff had actively contacted social services with any concerns about people's welfare.

The agency had a recent recruitment drive. Suitable recruitment procedures and required checks were undertaken before care workers began to work for the

Is the service safe?

agency. Applications were sent to the provider's head office which filtered applications considered suitable to go forward for interview at the local office. Checks included the Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Head office would analyse recruitment records and make the final decision to offer employment. Newly appointed care workers confirmed they were not allowed to work with people until all the recruitment checks were completed.

People were mostly positive about the current staffing arrangements. Previous to, and during the inspection, information from staff that had previously worked for the agency had indicated the staffing arrangements did not ensure a safe service for people. One said, "Travelling times between clients is just not realistic." The provider undertook an internal investigation of staffing travelling times in May 2015 and made recommendations for improvement. We found improvement had been made. Currently employed care workers said the majority of the time they could travel between visits in the time allotted and the arrangements for staffing had improved.

During the inspection people's comments about the staffing arrangements included:

- "Time keeping is getting better and most carers arrive on time now. Carers now stay for the full time"
- "Pretty good on punctuality, ten minutes early this morning",
- "Usually arrive on time and phone if they are going to be delayed"
- "The time keeping of the morning visit is excellent but the evening one is not so good"

Our visits to three people were at a time when their care worker was due to visit. We found those care workers arrived in time for the visits. Some people said they were informed when a support worker was going to be late and some said this did not always happen. Care workers confirmed that if they found a person had an accident, collapsed or ill when they visited, they always stayed with them until help arrived. The office then informed any other people on their visit list they would be late. We were given a recent example.

The manager told us how they had undertaken a complete review of care worker visit arrangements, including feedback from them about the effectiveness of the visit planning. They said they were aiming for care workers to have set times and people to visit, so people had continuity of care. The care workers felt their views about the travelling were heard and responded to. They had also made arrangements for agency staff to cover any staffing shortfalls, such as for sickness or when care workers left the agency. The need for those agency staff was now reduced due to recruitment of new care workers. A health care professional felt there was a significant improvement at the agency over the last six months saying, in relation to staffing, "Mainly they are honest about the work they can take on and the times they can do."

People had individual, current risk assessments in place for their protection. For example, with regard to the home environment, potential falls, adequate diet and prevention of pressure damage. Where a person had a heightened risk of falls the agency had ensured health care professionals were involved to reduce the risk. Where a person had a heightened risk with regard to moving them safely agency staff had worked with an occupational therapist to find the best solution.

Good

Is the service effective?

Our findings

People received an effective service because staff received the training they needed to ensure they were competent in their work. People said care workers appeared knowledgeable and skilled in their work.

Care workers were complimentary about the induction and training they received saying, “Pretty fair”; “I enjoyed the training”, “Absolutely fine” and “Absolutely amazing, and in-depth training. Really, really thorough.” New staff were able to shadow experienced support workers in addition to a three day office based induction.

The agency had a training matrix so essential training was planned and up to date. That training included infection control, moving people safely, fire safety, first aid and safeguarding adults from abuse. Staff also received training in subjects relevant to people’s health care needs, such as diabetes and when a person’s needs, such as moving safely, were complex.

Supervision provides an opportunity for staff to discuss work and training issues with their manager. Records showed that staff received regular supervision of their work through face to face meetings with senior care staff, called Field Care Supervisors. Those supervisors also undertook visits to observe care workers when they provided people with their care and support. This meant the standard of their work was kept under review and care workers could ask if they needed advice or support.

Before people received any care they were asked for their consent and staff acted in accordance with their wishes. People’s comments about consent included, “They always ask me”; “They always ask me before they start”, “They always check with me” and “Yes, we have a conversation but it’s the same routine anyway.” We observed care workers asking people how they wanted their care and support to be delivered.

Records showed that staff received training in the Mental Capacity Act (2005) (MCA). Senior staff demonstrated an understanding of the MCA which provides the legal framework to assess people’s capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. One senior staff gave an example of how they had explained the possible consequences of a person’s decision to refuse their personal care. They then involved the person’s family so decisions about the level of care provided would include the people who knew the person best. The agency kept good records of actions taken to ensure people were protected and their rights upheld, including contacts with professional agencies.

DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person’s own best interests. However, this only applies where a person is in hospital or resident in a care home. The MiHomecare policy included extensive information about DoLS, which was therefore confusing. The Director of Quality Care for MiHomecare said the policies on MCA and DoLS were due to be reviewed.

People at risk from poor nutrition and hydration were protected through the care workers concern for their welfare and the agency’s arrangements. The records of two people at risk of not eating or drinking enough showed this concern was identified and care workers understood how to protect them. For example, one person’s family were involved in how best to provide meals the person would accept and health care professionals had been consulted. One person had a food and fluid chart in place so care workers could monitor their diet. Some people described how support workers helped them with their diet, such as preparing meals for them where they could not manage themselves.

Care workers communicated any concerns about people’s health and they, with the support of the office staff, made arrangements for health care professionals to support people to have access to health care services. Records showed that those services included emergency calls, such as the 111 or 999 services and contacting people’s GP or district nurse. Where people’s needs were complex there was regular communication between the agency, health care professionals and people’s family members.

Good

Is the service caring?

Our findings

People were complimentary about the attitude of care workers currently visiting them. Their comments included, “All as good as gold and I must have had more than 20 different ones over the past three years”; “Yes and they are all very pleasant”, “Yes, very kind, caring and respectful. I can’t fault them”, and “They’ve all been marvellous.” Care workers were observed discussing people’s needs with them, asking how they felt and giving them information. For example, checking what level of personal care they required and did the bird need feeding? Particular support workers were praised by people and observed providing a friendly service.

People confirmed staff promoted their dignity and ensured their privacy. One person said, “If anyone comes in and I am undressed they will wrap me in towels”. Another person confirmed the support worker made sure they had their dressing gown on when they moved from the bathroom to the bedroom in case the postman arrived. A third person said, “The carers are very professional and make sure the curtains and doors are closed.” People said they were not expected to have male care workers provide their personal care if they did not want this.

People’s views were sought on a regular basis through telephone interviews and monitoring visits. People were asked about staff attitude, including: respect, helpfulness and professionalism during the telephone interviews. People’s responses were positive stating, excellent, very good or good. Care workers also liaised with people during the visits to deliver their care, listening and responding to what the person wanted. One person said they always told the care workers what to do and another said, “They ask me and do what they do perfectly well.”

Care workers demonstrated a concern for people’s well-being. A health care professional said how a “team lead” from the agency had visited a person before their package of care started, “instilling confidence” and introducing the care worker who would be their main carer. They added, “They are doing a very good job.”

Good

Is the service responsive?

Our findings

Care plans are a tool used to inform and direct staff about people's health and social care needs.

Those plans should be developed following an assessment of the person's needs and wishes. Where people received care funded through the local authority an assessment was in place prior to the agency developing the necessary care plan, in preparation for the care and support to be delivered. The agency also conducted their own assessment of people's needs, in particular, where they were privately funded.

Two of the five care plans we reviewed in people's homes accurately described the people's needs and what care workers were required to do. They provided clear, in-depth and person centred detail for care workers to follow. For example, one person's care plan described their anxieties and how they could be helped to manage this. We saw them becoming anxious about a letter they had received but the care worker reassured them and gave sensible suggestions about how to deal with it, which made the person calmer. The person told us their life had been transformed by the regular visits from the care workers, who they liked and trusted.

Three of the five care plans did not provide correct information about those people's physical care needs for the care workers to follow. For example, one had no care plan completed by MiHomecare for the care workers to follow, only an 'NHS' plan, dated April 2013. One recorded the person was to be helped to use the commode, but the person told us, and the care workers confirmed this had stopped some time before. Another person's plan informed care workers the person should have a "full strip wash" but the person said they had a daily shower instead. Where care plans were not describing people's current physical needs those people were able to direct their care and so felt their needs were none-the-less being met. People said care workers were observant and responsive to their needs, one saying, "They see what needs doing and they do it." A district nurse described care workers as "on the ball". They said the workers did not panic; they followed advice and did their work appropriately.

We discussed the care plan review arrangements with the senior care member who was responsible for reviewing people's care. We were shown records of two people's reviews, which we were told were recent but were not dated or signed. They said that, following the review, the information would be transferred to a computerised copy and then would replace the previous copy in the person's home file. However, this had taken some weeks. The senior care member said this was in part due to their annual leave. Care workers who visited people regularly knew people's preferred and current needs. However, the use of agency staff increased the risk of people not getting their current care needs met, as they did not always have accurate information to follow.

People described how the care they received helped them to remain independent. Their comments included, "Without them I could not remain in my own home" and "Because they see to my feet and legs I can still get around and go out using my walker."

The majority of people said they knew how to make a complaint. We saw that information about making a complaint was prominent in people's care files. People also received calls from the agency to check if people were happy with the service, so concerns could be raised before reaching the level of formal complaint.

There was a theme of people telling us they had complained about particular care workers but following the complaint the worker never came to them again, which they were happy about. One person said, "They stopped two carers from coming as they argued with me." Some people were unhappy when changes in the list of care workers visiting them were not communicated to them in advance.

Paper records of complaints did not correspond to the computerised records of complaints. However, the manager was clear about how any concerns or complaints were now to be dealt with. He had visited one person to personally discuss their concern about agency staff visiting. That person confirmed they were happy with the result of their complaint and the problem seemed to have been resolved.

Requires Improvement

Is the service well-led?

Our findings

The manager was newly in post at the time of this inspection. MiHomecare is a national company and all systems and documents stem from the head office.

The quality of the service was monitored, but not always effectively. Internal audits were held, the last recorded being 4 August 2014. These included checking information was available to people, and the efficiency of the office. Where a concern was identified it was followed up, such as a care worker accepting a gift, which was against the organisation's policy.

There were monthly visits by the regional lead for the organisation. Their audit included checking staff induction, a review of complaints and some people's file. The manager told us, "The audit tool that we use on a monthly basis only audits 3 (people), 1, new (person) and 2 that have been with us for a longer period. If a review is out of date it is shown on the audit, and action taken by the manager." The audit carried out on 29 June had identified that the two people's files had been reviewed in April 2015. The audit carried out on 31 July 2015, identified one person whose file had been reviewed on 14 July 2015 and the other person was reviewed on 22 January 2015. This was just out of date. We had found that three of the five files we looked at were out of date and did not describe how care workers were to meet people's current physical needs. Also, the audit arrangements had not identified that medicine management had the potential to put people at risk as the information was unclear for staff and not always followed.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's views were sought through a well organised programme of telephone and visit monitoring by senior staff. These gave people using the service their opportunity to raise any issues, such as visit times. People's views had been surveyed in 2013 and 2014. The manager said there was no survey yet in 2015 but this was planned.

Most people using the service, their family representatives and health and social care professionals said they were satisfied with the way the agency was managed. People's comments included: "Much better run lately"; "I don't think anything could be improved" and "Yes, all very efficient as far as I am concerned." Negative comments included, "I don't think they value their staff" and "They sometimes struggle in the office – it is stressful." The manager had recognised these shortfalls, which were already being addressed.

Staff members told us, "(The new manager) seems as if he will follow through and is genuine" and "Whatever is asked is put in place if possible." Some staff members had negative comments about the organisation, including, "I don't think they value their staff." An employee of the month scheme was in place but staff never mentioned this.

A social care professional said, "I have found a significant improvement at MiHomecare over the last six months." A district nurse said there had been no recent need to speak with the office about any issues which needed to be addressed.

The registration of the manager with the Care Quality Commission was confirmed at the time this inspection was completed. He understood the importance of communicating with people and put a lot of emphasis on his 'open door policy', saying that if staff did not speak to him about any problems he could not resolve them. He had prioritised improvement of the service and already taken steps toward that improvement, including the review of staff travelling and visits to make them more achievable. The manager sometimes visited people to provide their care. He said these visits helped him understand the work and difficulties care workers might have.

Staff views, for example, about their travelling times, were sought through staff meetings. There were to be regular meetings some having already taken place, though the attendance of care workers was not high.

Since April 2015 the provider organisation was required to have policies and procedures in place to ensure openness and transparency with regard to notifiable safety incidents, known as their duty of candour. The provider's Director of Care Quality told us these were being written, and would be in place by 8 September 2015 and rolled out to staff from that date.

At a previous inspection in January 2014 we found that the agency did not notify the Care Quality Commission of events as required. A notification is information about important events which the service is required to send us by law. Since that date those notifications have been received. This enabled us to ensure we were addressing any potential areas of concern.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 arrangements for the management of medicines had the potential to put people at risk. Regulation 12 (2) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Audit arrangements did not always identified where improvement was needed. Regulation 17 (2) (a) (b) &(c)