MiHomecare Limited

MiHomecare - Thornton Heath

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 10, 12, 14, 23 February 2017 and was announced.
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. MiHomecare – Thornton Heath provides personal care for over 340 people in the London boroughs of Lambeth and Croydon. It provides a service to older adults, and younger adults with disabilities.

At the last inspection of the agency in February 2015 the service met all the regulations we inspected.

At this inspection, there was no 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. A new experienced manager was in charge and present during the inspection. A registered manager's application had been completed and sent to the Care Quality Commission (CQC).

The agency had policies and procedures in place to help protect people from abuse, and staff had a clear understanding of what to do if safeguarding concerns were identified. Contacts and a whistle blowing hotline were available for all staff to enable them share information confidentially and make the working environment transparent. Staff retention was good and helped promote continuity of service. Staff had been recruited, using a robust recruitment process, to check they were suitable and safe to visit or work in people's homes.

People were safe when using the service because staff had been trained and knew how to protect people in their care. Assessments were undertaken to assess any risks to the person using the service and to the staff supporting them, and protect people from harm. Appropriate support plans and guidance were provided for staff to follow and make sure that people were kept as safe as possible.

Procedures were in place for supporting staff to respond appropriately to emergencies. Care staff had guidance to follow and were aware of the on call service available so that they had access to information and management guidance at all times when they were working.

People told us they felt safe with the care provided. One person told us, "Most carers that come here are punctual; staff are very caring and fit the service around our needs." Medicines were managed safely and people received the support they required from staff. Independence was promoted for as long as possible with clarity about support such as prompting people to take their medicines as prescribed. Where people had help with their medicines they told us this had worked well.

Staff understood and protected people's human and civil rights. People were asked for their consent prior to care being undertaken. They were encouraged to make as many choices and decisions for themselves as

they could. People and their relatives told us they were supported by kind and caring staff. One person told us they were happy with the care and support provided by the members of staff who visited, they said, "The carers are great, they go way above and beyond the call of duty, truly great."

Staff were suitably trained, well supported and helped develop the knowledge and skills required to ensure people's health and well-being needs were met. If staff competency and performance were an issue, performance improvement plans were put in place to ensure that staff were competent to carry out their duties. Where it was identified that staff needed training in a particular area, this was provided.

The provider had systems in place for seeking feedback from people using the service which included spot checks, customer reviews and quality monitoring visits. The quality of care provided was continually reviewed by management. Developments or improvements in the service were on-going and made, as appropriate.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Systems were in place that helped to protect people from harm. Any risks to people or staff were identified and appropriate action was taken to make sure they were kept as safe as possible.

The agency used safe recruitment procedures. They had a suitable number of care workers available to deliver the service required. The service was well coordinated and care staff were assigned sufficient time to travel and to care for people safely.

People were supported with retaining autonomy and independence including managing their own medicines for as long as possible. Care staff were trained in the administration of medicines and had their competency assessed.

Is the service effective?

Good

The service was effective. People agreed to their care and support plans and were asked for their consent before personal care was delivered.

Staff engaged in training opportunities and received effective support so that they were able to provide high quality standards of care.

Staff both care workers and field supervisors worked together with other healthcare and well-being professionals, as appropriate, to ensure people were offered the most effective care to meet their identified needs.

Is the service caring?

Good

The service was caring. People received care from a kind and caring staff team who were committed to deliver the service people required.

Staff clearly demonstrated in professional practice their compassion and commitment to providing high quality care to people.

The service made sure that they looked at a person as a whole and included their emotional and social needs in the care planning process.

The service was well coordinated to promote consistency and enable staff to build strong relationships with people and their families.

Is the service responsive?

Good

The service was responsive. People were assessed for a service to determine their care and support needs. Care arrangements were coordinated and planned for accordingly by assigning appropriately qualified regular care workers.

Care plans were developed that helped ensure people received personalised care to meet their needs, wishes and aspirations.

The service showed improvements in that it responded more promptly to people's requests and changing needs.
People had confidence in how their complaints were dealt and aware of who to contact and had received written information on how to make a complaint if they were unhappy with the service provided.

Is the service well-led?

Good

The service was well led. There was a recent management change, the new manager had made an application to register with CQC. The management team had identified areas of the service requiring improvement and work was in progress addressing these areas.

The manager and the staff team made sure that the quality of the care they offered was maintained and improved. The manager was highly regarded by staff and local authority professionals, they promoted a caring and inclusive culture.

MiHomecare - Thornton Heath

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 used the standard CQC assessment and ratings framework for community adult social care services, but included testing some new and improved methods for inspecting adult social care community services. The new and improved methods are designed to involve people more in the inspection, and to better reflect their experiences of the service. We shadowed two care staff to enable the inspection team to gather more robust evidence from people who receive services in their own homes. Before the inspection visit we reviewed the information we held about the service, including the Provider Information Return (PIR) which the provider 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 other information we received. This included notifications of incidents that the provider had sent us and how they had been managed.

The inspection team consisted of two inspectors 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. This inspection took place over four days within a one week period. We announced the inspection two weeks in advance so that the provider could assist by informing people and staff and to coordinate staff meetings and help us arrange to shadow care staff. We shadowed two care workers on separate days during day time and when they undertook evening visits. While we did not observe the delivery of personal care when doing so, we were able to observe the service in action and talk to staff and people as well as family members. Shadowing was arranged in co-operation with the provider. The agency delivers services in the London boroughs of Lambeth (230) and Croydon (100). We also wrote to commissioners asking for statistics and feedback on the service.

The methods that were used, for example, talking to people using the service, their relatives and friends or other visitors, interviewing staff, pathway tracking, observation of the support people received, reviews of records. We reviewed the care records for 16 people receiving the service, eight of these were reviewed during the visits to people's homes, the remaining care records (eight) were looked at when we visited the agency's office. We examined recruitment processes, as well as training and supervision records for eight care staff. While we visited the agency office we observed how supervisory staff responded to calls and queries. We talked with 10 people when we visited them in their own homes. We spoke by telephone with 33 people who used the service; they shared with us their experiences of the service.

We talked with the manager, the regional manager, four care coordinators, two field supervisors, and the quality assurance officer. We had discussions with two care workers during the time we shadowed them on their rounds, we also spoke with a second care worker that linked up on calls where two care staff were required. We held discussions with another ten care workers at the staff meeting.

Good

Is the service safe?

Our findings

The majority of people praised care staff for their roles and told us how their roles contributed greatly to their safety. Comments included, "I could not remain here in my home without the support of my carers, they help me with all the things I am not able to do such as use the bathroom," "I cannot get to the door but I feel secure knowing that care staff use the key safe outside and make sure my home is secure when they leave", "My carers always turn up no matter what the weather and help me look after my spouse, sometimes they get delayed with traffic but that is okay, the office usually lets us know." A family member told us, "I could not look after my elderly parent alone and rely totally on the carers to assist me; they always ask how I am which is good and make sure that I am coping okay."

The agency had safeguarding policies and procedures in place to help safeguard people from neglect or abuse. Training records showed that staff members had recent safeguarding training. The manager and coordinating staff were in day to day contact with care staff, they had a good knowledge of the signs of abuse and how to refer on to the local authority safeguarding team and were able to discuss several examples of this. Care staff in discussions displayed a competency in their role and were clear about their responsibility in reporting to the line manager or appropriate professionals when they had concerns or doubts about individuals. We saw examples in care records and reports from the local authority of staff promptly informing relevant people. We saw that action was taken as appropriate when staff recognised there were issues of concern relating to the environment, such as smoking. Staff had reported these concerns promptly to their care coordinator or field supervisor.

The manager was aware of her role and responsibilities in raising and reporting any safeguarding concerns. Records held by the home and CQC showed the service had made appropriate safeguarding referrals when necessary and that staff worked in partnership with the local authority and other agencies to protect people. All safeguarding issues were dealt with effectively, with lessons learned and evidence documented of follow up actions.

Staff had access to an employee assistance line which is a confidential support line for them. All care staff we spoke with understood the importance of security in the home. One care worker said, "We support a large number of elderly people who are vulnerable to exploitation from unwanted visitors, some have mobility issues and cannot get to the door, we find the key safe helps us keep people secure and we do not share the code with any others." Another care worker we shadowed on their evening round used the key safes for the majority of people and was careful to leave the person's home secure and lights on when they departed. We observed that care workers ensured the environment was safe looking out for and removing any trip hazards, also making sure the person had their mobility aid close at hand, and the pendant alarm attached.

People and staff were kept as safe as possible by the service. In the agency office, there were appointed first aiders and fire marshals. Infection control code of practice was in place. Every field care supervisor had attended accredited risk assessment training, provided by the company.

MiHomecare – Thornton Heath had incident/accident recording procedures in place. There was a dedicated accident line for the carers to call when an accident happens. People's homes were assessed for any environmental risks and the service had generic risk assessments for issues such as, pregnancy and lone working. Copies of relevant risk assessments were kept on the computer, in staff and people's files, as appropriate. Staff were provided with generic and specific health and safety training, as required. Examples included basic life support and moving and positioning training, with regard to individuals. Following a referral and before a service was commenced a field supervisor or senior carer visited the person in their own home. Risk assessments were undertaken to assess any risks to the person and to the carers, as well as the environment they lived in. For example environmental risks included the observation of electrical equipment, fire risk and measures in place such as smoke detectors, moving and handling equipment, tripping hazards and pets. Where it was identified that two care workers were required to carry out the task safely we saw that two members of staff were assigned for each visit. Care workers were trained in using any specialist equipment required. The risk assessments were proportionate and centred around the needs of the person.
Senior staff reviewed the risk assessments after six weeks, and these were reviewed as often as required such as when care staff reported any changes to the person's care needs and any necessary adjustments as required. Care coordinators referred to occupational therapy as required. In one person's home the carer told us the person remained in bed full time and did not like the hoist, following professional advice from the occupational therapist they used a sliding sheet to move the person safely, records confirmed this was a recommended method.

There was a recruitment consultant based in the office. We saw the recruitment of staff was robust and thorough. Before a new member of staff started employment they were required to complete an application form with a full employment history, other forms of identification. Application forms were fully completed, there were no gaps in work history and notes from interviews were retained. Recruitment records were detailed and well kept. References were taken up and a satisfactory enhanced Disclosure and Barring Service (DBS) check was sought. The DBS carries out a criminal record and barring check on individuals who are applying to work with vulnerable people to help employers make safer recruitment decisions. The agency renewed these checks every three years. Interviews also included Maths and English tests, the use of value based questions and discussions of "scenarios" with each applicant which involved practical examples of working with service users/clients. It was noted that some interviews had been carried out by one person and in discussions with the manager it was agreed that two people will be involved in future interviews.

We found there were enough skilled and competent staff to ensure they could safely support people and meet their individual needs. The agency employed 180 care staff. Care coordinators considered the needs of people and recorded their preferred times for calls. Resources were used effectively and office based carefully planned the care delivery by assigning staff to work in specific geographical areas. We saw that travelling times were kept to a minimum where possible. One care worker we shadowed attended to people that lived local to each other, the care worker walked from one person's home to the other, another care worker we shadowed used a car to deliver the service. The people she supported we visited, told us no delays were experienced to their calls. People and relatives spoken with told us that where possible the same care workers attended weekdays, a large number spoke of the difficulty of getting regular staff to cover weekends especially on Sunday. The manager acknowledged the difficulty with getting staff to work weekends and operated rosters. They had an on-going recruitment programme to recruit staff specifically for weekends. If the regular care worker was on annual leave or on sick leave another staff member who was usually known to the person would cover the visits. This meant that staff knew the person they were supporting well and this provided consistent care to people. There were examples seen of missed calls due to clarity of communication about discharge times, also about not sharing information with colleagues

about other arrangements. We saw that effective disciplinary measures were taken by management to address performance issues and thus avoid this reoccurring.

The agency had made progress and further developed the electronic call monitoring system since the last inspection; a much greater number of people had agreed to allow this method to be used by staff. In the event of a care worker running late due to unforeseen circumstances such as traffic delays the office staff were alerted electronically that the care worker had not 'logged in' at the person's home. This enabled issues to be dealt with immediately by staff in the office and actions taken to find out why there was a delay. This meant that the safety of staff and the person using the service were maintained. Most people spoken with told us staff usually arrived on time but many people accepted delays were inevitable especially when using public transport or when travelling through busy areas. One person said, "The carer that comes to me now is great, they have never missed a visit in all the time they are coming, but one care worker I had before was not so punctual."

Procedures were in place for staff to respond to emergencies. Care staff received guidance during training and this was in staff handbooks, all staff we talked with were aware of the procedures to follow if no reply was received. There was an on call service available during out of office hours, this was staffed by coordinating staff. Care staff were supported and had access to information and guidance at all times when they were working. Care staff were aware how to access this and those who had used this service told us it had worked well. Any incidents and accidents were recorded and the manager told us she kept an overview of these. The provider monitored any patterns and the quality of the care provided and to provide guidance and support where needed.

People's medicines were administered safely and according to their individual needs. The service had a robust medication policy and safe procedures in place. They described levels of support which could be given by the care worker. The level of support people needed was noted clearly on their care plan and further detail of the individual's need and medicines prescribed was recorded in the medicine administration charts (MAR). Staff had been trained in medicines administration, which was up-dated every year. Additionally, staff's competency to administer medicines was checked annually. We observed on our visits to people' homes how staff supported people with their medicines. One person told us he had some memory issues and would not always remember what tablets he should take but liked to be in control. The care record clearly detailed the person's support needs and how they needed prompting on taking their medicines. We observed the care worker prompt them with taking their medicines at breakfast; they signed the care record to confirm the person had taken the medicine. Another person we visited had their medicine administered by the care worker. Medicine profiles and MAR sheets were initially written up by the field supervisors, the visiting care staff completed these records as necessary. In one local authority officers were working closely with MI Homecare - Thornton Heath to make changes to medicine administration records, this involved the supplying pharmacist developing and supplying the medicine profile and the medicine administration record when they supplied the medicine. The manager informed us that all care staff were being trained to use these new medicine records.

Good

Is the service effective?

Our findings

A relative told us, "The service is okay and getting much better, myself and my siblings are satisfied our parent is getting a reliable service despite many changes." A person using the service said, "Some of the staff at the office listen and get it right, but there are some who do not follow things through and carers can turn up when we have already cancelled the call." People told us that care staff mostly did arrive on time and stayed the required time or longer. They said that the office called and always let them know if they were going to be late or a change care staff. The manager acknowledged that issues pertaining to ineffective staff communication in the office were being addressed via staff supervisions.

Staff were supported with training in order to keep up to date with best practice and extend their skills and knowledge in meeting people's needs. The majority of people said they felt care staff were very capable and had the knowledge and skills required. The agency had made provision to ensure new staff were prepared for the role. Care staff received a suitable induction when they started working at the service. This included essential mandatory training, shadowing other staff and time to get to know people who used the service. The provider used the Care Certificate which is a nationally recognised framework for good practice in the induction of staff. Two new members of staff told us that as new employees they had an induction programme which included familiarisation with company policies, training, code of conduct, shadowing a senior member of staff, familiarisation with use of the Electronic Call Monitoring system and Care Certificate Standards modules and workbooks. We saw four completed induction programmes which included sign off by the employee and their line manager.

There was a comprehensive training and development plan in place specific for the staff role. This helped to make sure that care coordinators and field supervisors as well as care staff developed the skills they needed to carry out their roles effectively. The agency had appointed a new trainer and had their own training room where the majority of the training for staff was delivered. The manager told us the emphasis on training was important to enable staff development, also that staff in a supervisory role needed to able to deliver the support and advice needed by care staff. The provider's training and development programme for care staff included training in safeguarding, moving and handling, medicines, dignity and respect, equality and diversity, fire safety, infection control, food hygiene and first aid. Staff told us they were expected to attend refresher courses in key areas regularly. We saw from records and were told by management that a number of office based staff such as field supervisors attended further training in risk management and assessment to enable them improve their competencies in these areas, the majority of the supervisory staff had achieved National Vocational Qualifications (NVQ) to level 3 in Care.

The manager used an electronic training record to monitor the training staff received and check they were up to date. The record included a red, amber or green rating for attendance; we saw letters sent to staff to remind them they must attend refresher training within a set timescale. Training was reviewed and updated regularly. Training records we read showed us that mandatory areas such as moving and handling, basic first aid, medicine management, dementia and health and safety were repeated annually. There were also opportunities to attend specialist training to further staff development and knowledge. For example we saw that care staff had recently attended training on the management of catheter care and stomas. A staff

member told us, "I feel able to assist people with catheter care now since my training." Another carer reported, "I had a good induction and shadowed a senior experienced care worker which I enjoyed, I was asked for feedback when I completed it." Another care worker told us, "Training is good and provided regularly. If I feel I need any extra training I can ask and it will be provided." We observed that care staff used the guidance and training provided.

People were cared for by a staff team who received effective support to enable them to offer people a good standard of care. Staff said they had one to one supervision sessions and found them useful.
Records of these were seen and topics discussed included safeguarding, time keeping and log-in to the electric call monitoring system, communications, service users' feedback, health and safety, policies and procedures, reflection of practice and record keeping. Staff had their performance randomly 'spot checked' and they received an annual appraisal with senior staff. Spot checks involved senior staff members who visited people in their homes and observed care staff at work to assess their competence and skills and identify if any learning or development was needed. Staff told us they felt well supported by the management team. A care worker said, "I have good support from management, so I can feel I can talk through things if there are challenges in the job, I also feel able to share with the manager if there are any concerns."

People's health and well-being needs were well detailed in care plans. While speaking with a person and their relatives we found the care records accurately reflected their individual needs. Care staff told of calling the office, doctor or other health professional, whenever necessary. One care worker said, "I do not take chances, if someone is unwell I feel it is important to get the relevant professional help." Care staff told us they had received basic life support training and would call emergency services as appropriate. A number of examples were seen in care records of people being unwell staff had recorded the action taken as a result of the concerns. For example one person's record noted that they had breathing problems, the care worker gave the person their inhaler and called the GP and contacted relatives. We saw from care records how information was shared with other visiting care staff the need to monitor and observe the individual and to seek further medical advice if there was no improvement. The instructions had been followed and appropriate action taken. A relative said, "The outcome for the person was good as a result of prompt action by the carer and ensuring medicine prescribed by the doctor was sought in good time." Care staff worked closely with community health professionals such as district nurses to ensure they gave a safe and effective service to individuals, as appropriate. We saw examples of good joint working with nurses and how communication was excellent, especially when one person had complications from using a catheter.

If people needed support with food, this was assessed and noted clearly on their care plans. People were supported to remain in their homes for as long as they wished, the service was consistent and reliable. Staff told us that they were allocated to support people in a geographical area which provided them with the opportunity to get to know the people and their preferences and provide continuity. People were supported to eat a balanced diet. Some people were supported to prepare individual meals and to shop for the food items they needed. Staff received the relevant training and kept appropriate food and fluid charts, if required. Staff understood the importance of monitoring the temperature of people's homes when they visited, thus ensuring their comfort and ensuring people were not left at risk of hypothermia or overheated environments. Care staff told of being trained in nutrition and hydration and could explain how they encouraged people to stay hydrated even if not specifically noted on plans of care. We observed care staff placed within reach jugs and containers of drinks of choice for people who were unable to get to the kitchen independently. We observed the thought the carer put into preparing snacks for later in the day, they asked the person their choice of filling and left sandwiches well presented. One person who was recovering from a hospital stay said, "She is a diamond, my carer, I am fussy with food and a poor eater, she makes sure I have a nice breakfast and knows exactly how I like my sandwich left for later." We observed during visits to a

person's home how the carer checked with the person their plans for later in the day. They recognised the person could become isolated and lonely; they encouraged them to take a short walk to local shops. Another person as part of their package of care had their care worker accompany them to the bank to complete their business.

People told us care staff listened to them and respected their wishes and choices. Throughout our home visits care staff offered people choices and supported their decisions about what they wanted to do. People using the service and relatives, where appropriate, had signed an agreement in records about their care. Staff knew their responsibilities and what to do if a person could not make decisions about their care and treatment. This included involving people close to the person as well as other professionals such as an advocate or GP.

The Mental Capacity Act 2005 (MCA) provides a 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 mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. Staff told us that the people they supported had capacity to make decisions for themselves. They confirmed that they sought consent from the people when offering support to ensure they were happy with the care they received. One care worker said, "I respect people can make their own decisions about their care." Another care worker said, "I help people in the way that they want. We know we do not make people do things against their will."

Records showed that the provider had taken steps to comply with the requirements of the MCA. We found example of person whose mental capacity had been assessed with regard to a specific decision making area as required by the MCA. However, we noted that their support had also been discussed with a family member to ensure the care provided was in their best interests and there was no evidence that this had impacted on their rights. The manager told us that no people using the service were currently deprived of their liberty. The manager was aware of the process of making applications through the Court of Protection should a person need to be deprived of their liberty in their best interests.

Good

Is the service caring?

Our findings

People reported positively on the calibre of staff that provided the care, comments included, ''I am satisfied with the service and have confidence in the care team." Another person described staff as," Very kind and polite," and one person we visited said, "I'd gladly recommend them to anyone I have no qualms with the carers who come in to me". One family member told us of occasions when the regular carers were on holidays they found it difficult to adjust to the replacement carers. They said, "My regular carers know where everything is in my parent's home and know exactly their pattern of getting them up and going to bed, however staff unfamiliar with coming to our home are okay but have to be guided, this cannot be helped."

People's care needs were met mostly by care staff who had over time established a good relationship with them. To ensure, as far as possible, continuity of care people were allocated a team of care staff as 'main carers'. The staff team got to know people so that when the main carer(s) were not available someone who knew them would be. Most people told us the care was consistent with the 'main carers' completing the visits whenever possible, there was less consistency at weekends when the regular carers had days off. Care staff told us that they had regular "clients" which provided continuity and they knew them well. People's support plans provided guidance for staff in promoting people's independence, outlining areas where people were independent and the activities where they required staff support. During our visit to one person's home the person told us that some days they could manage the shower themselves safely with the carer present and they liked that the carer encouraged them to do things for themselves.

We found on our observational visits that care staff were highly motivated and delivered kind and compassionate care. Interactions between care staff and people were positive and caring. Care plans in people's homes recorded people's emotional, cultural and spiritual needs, as appropriate and relevant to the service offered. On visiting a person's homes a care worker explained prior to our arrival there that a person's cultural needs required that those visiting remove their shoes or wear shoe covers. The care worker carried shoe covers along with other protective clothing. They placed the covers over the shoes before entering the person's home. When we entered the person's home the person told us care staff showed respect for their cultural needs.

People told us staff respected them and their privacy and dignity was maintained at all times. Care workers described the everyday practices used when visiting people's homes that were important to preserve people's dignity such as pulling curtains and closing doors, not intruding on other family members. Additionally they said they allowed people time to complete as much of their personal care independently, as possible. They talked about respecting people's opinions and following person–centred care plans. Throughout our visits to individual's homes care staff supported people with kindness and compassion. Their approach to people was respectful and patient. Despite set times and time constraints for visits we did not see people being rushed. What we observed was care staff speaking clearly and kindly with people and taking time to chat about everyday things as they prepared a meal or drinks. Many of the care staff had worked with the agency for several years and knew people well. Care staff were careful to promote people's privacy. For example, a number of people we visited were unable to walk to the door and had key safes for security, we observed the carers knocked first to announce their presence before they opened the door.

Some staff had worked in other organisations and felt this agency really cared about people they provided service to; they also felt they cared for their staff. One long serving care worker we accompanied to people's homes showed total commitment and dedication to their role, they spoke lovingly about the people they supported. They had a regular group of people they visited and were able to explain people's individual likes and preferences in relation to the way they were supported. This information corresponded with what people told us and their care records. The relative of a person we visited spoke glowingly of the care staff and singled out one care worker for their dedication. They said, "I come in most days to visit my mother. The care worker shows such passion and commitment in her role. My mother is well looked after."

Supervisors and management undertook checks by doing home visits. During spot checks and outcome monitoring visits a discussion was held with the person receiving the service about the care and if the carer maintained their privacy, dignity and respected their choices. Records of these spot checks were maintained and any follow up actions required were addressed in supervision and team meetings.

What people expressed demonstrated that they felt valued as members of staff. We heard from staff that a long serving member of the care team had recently died suddenly. The manager and staff spoke with compassion about the treasured member of the team they had lost. A person using the service told us they rated the agency for the concern it shows for people using the service. One person we visited told us their spouse was frequently unwell and spent a lot of time in hospital. They found the carers showed real empathy and compassion which helped them deal with the situation. Office staff were able to provide a "hands on approach" when needed. Staff told us of occasions such as bank holidays or weekends where the field supervisors or care coordinators had covered their calls because of short term emergencies.

Staff told us they had usually enough time to provide the care needed to meet people's needs, but a number of staff told us the quality of care could be greatly enhanced by allowing more time. They told of being able to provide additional care in emergency situations and were supported by management staff to do this. The manager liaised with the local authority if additional time was needed; they said they had not accepted any calls for less than thirty minutes.

Good

Is the service responsive?

Our findings

People told us they were listened to and the service usually responded well to their needs and concerns. People's regular care workers were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a personalised service. We looked at the progress made by people who were highly dependent and received four calls a day when they were first discharged from hospital. We saw that they were now eating and drinking well, regaining some of their independence and doing more chores themselves. They acknowledged the improvement in their wellbeing was due to the diligence and encouragement from "great carers who always turned up whatever the weather." One person told us they had now requested to reduce the number of calls required as they could manage, a field supervisor was due to visit and review their needs.

People's needs were assessed prior to them being offered a service. In the case of emergencies, senior care staff made the first visit and completed an assessment at that time. Care was planned with people and other professionals, as appropriate, to meet the needs of the individual. The care plans were person-centred and contained all the relevant information to enable staff deliver the agreed amount of care in the way that people preferred. Care plans showed that people were involved in the assessment process and in developing care plans and suitable care arrangements. Care records contained details including the person's name, address, family contacts, GP and name of social worker (if applicable). People's diverse needs were understood and supported and they were asked about their preferences as part of the assessment process. Care plans included details about people's needs in relation to age, disability, gender, race, religion and belief. People told us how important their faith was to them. One person we spoke with said, "The care worker shows great respect for my beliefs, there are certain foods I do not have, the carer is careful to only purchase the food I eat."

There was a health assessment which included medical conditions and any vital medicine required as well as any known allergies. One person told us, "Office staff came out and talked to me and my family about what I needed." Another person told us that a supervisor came and assessed their needs, for themselves and their spouse and the activities they could do themselves, as well as the facilities available. The service delivered was personalised and care staff confirmed that, where possible, people were directly involved in their care planning and in the review of their care needs. The care and support plans had improved and contained clear instructions about the care and support needs of the individual and the outcomes that people hoped to be achieved with the support provided. A care worker told us, "I go according to the care plan but will always ask if the person needs additional help. If there is any extra needed I will do this and relay it to office staff. "Another care worker reported that a person needed more time for the morning call, they did not want to rush the person as they were stiff and slow to mobilise, extra time was approved by the social worker . A person spoken with said, "They are ever so good the carers and nothing is too much trouble, my girls put their heart into the work."

There was also information regarding support with personal hygiene, the gender of carers preferred, hearing, visual ability, speech, language, comprehension and use of personal equipment if required. Staff

recorded information in the person's daily log at each visit stating the support given, there were also notes made of the person's state of wellbeing and mood. We saw numerous examples in daily records of care staff taking prompt and appropriate actions, for example when people were unwell we saw that staff had summoned the GP and relatives where relevant. We saw other examples of staff calling emergency services such as the ambulance to take people to hospital. We referenced this with office records and saw that the out of hours service had been informed of changes arising to the person's needs and welfare.

Care staff told us they were kept up-to-date with any changes to people's plans of care, but some staff highlighted some weakness among office staff in communicating with others. We shared this with the manager who was addressing this issue with retraining and supervision. Staff were advised of any changes or new needs by telephone or e mail from office staff. People told us staff met their current needs and responded to any changes to the care plan they requested.

Staff told us the schedules were planned in advance and visits which required co-ordination such as two members of staff working together was arranged and worked well. There were improvements seen in how care workers were assigned to people on a regular basis. Most people were assigned regular care staff. As we shadowed care workers we found that planning of schedules was good, people told us the same carers generally came unless on leave or days off. Where people needed two care staff we saw that schedules arranged this well so that double up calls did not have care staff arriving at different time. Care workers said staff were normally linked to work in a specific geographical area in order to prevent any time delays. Staff said the rotas were planned in advance and flexible enough to provide person centred care. A care coordinator told us of methods used to ensure weekends and bank holidays went smooth. On Fridays they double checked to make sure the most vulnerable people had the correct carer assigned to them.

The manager told us office staff monitored the service schedules on an on-going basis. We saw that the electronic system highlighted an alert if a support worker/carer was running late by fifteen minutes. This also was monitored at weekends and bank holidays and reduced the likelihood of missed calls. If a delay was identified the member of staff was contacted and then the person using the service. They were provided with an update regarding the approximate time of arrival.

Good

Is the service well-led?

Our findings

The service had an operations manager in post that people found offered stability and continuity in the service. The previous registered manager left her role in June 2016. The manager was not yet registered but had applied to register with the CQC. Staff were familiar with the manager as she was an experienced manager who had previously been involved in inducting the former registered manager for this branch.

The manager was supported by a team of field care supervisors and care coordinators. Care staff told us they were well supported at work. Care staff told us their supervisors were approachable, knew the service well and would act on any issues raised with them. One care worker told us, "If you want support it's there. I feel able to drop into the office anytime and I am listened to." Another staff member told us, "It is more organised now. We are working together well. We all help each other out." People felt supported and staff had confidence in her ability. They told us they felt included and listened to. The comments we received from people were that they had experienced some improvements in the consistency of the service. Care staff told us they found that communication was getting a lot better with care coordinators and field supervisors. One care worker said, "I feel they have learned to listen more now to what we have to say and share relevant information more effectively, less wasted calls experienced."

The manager told us the coordinating and administration staff regularly liaised with people using the service throughout the day as required and provided updates regarding traffic problems and any issues which may result in a carer being late for a visit. They told of having more regular care staff and of having more monitoring visits and telephone checks. We were told by care staff that there was an open culture at the service with clear lines of communication. Feedback from people and care staff was that they felt comfortable raising issues and providing comments on the care provided in the service. One person's relative commented negatively on the response of a care coordinator and felt their relative's outcome was not as good as it should have been due to their inappropriate response to a telephone call. Feedback from a social care professional told us of having confidence in the present management of the service, the communication with them and the staff at the agency was good, with guidance and changes requested to people's care and support needs being followed through.

Staff training needs and competency issues were identified and supported appropriately. The manager was working hard and developing performance improvement plans for staff to ensure they had the competencies required to carry out their duties effectively, also to support appropriately care staff they line managed. We saw that where it was identified that staff needed further training in a particular area such as coordinating services efficiently this was provided and this helped ensure the management of the care package was done by qualified competent staff. The manager had identified areas for improvement, firstly that office based care coordinators needed to go out and visit people in their homes to get a better understanding of their needs. They planned too for monthly coordinator visits to be implemented so that they could discuss issues and encourage better communications, as well as contribute to making services more person-centred. The manager planned to establish forums for care workers to come and share their opinion, experiences and contribute to the improvements in the community.

The manager told us the coordinating staff regularly liaised with people using the service throughout the day as required and provided updates regarding traffic problems and any issues which may result in a carer being late for a visit. We were told there was a manager's on call rota in place from 17.00hrs to 09.00hrs each evening and at weekends. Care co-coordinators told us that the weekend workload and staffing arrangements were planned up to 11.00hrs on Monday morning and a written handover is provided to colleagues at the end of each shift. Staff were encouraged to inform the manager on call if they were unable to work due to sickness in order that a replacement could be found as soon as possible to ensure that people did not experience a delay to their visit or any disruption to their service. The manager said that the majority of staff worked on a full time basis and there was good retention of staff which supported continuity of care for people.

The provider had systems in place for seeking feedback from people using the service which included spot checks, customer reviews and quality monitoring visits and we saw examples of these. These activities included a discussion with the client/service user regarding their carer and any areas of improvement and timescales for action were identified. The manager told us that the local authorities carried out monitoring visits and a monthly meeting was arranged between one local authority and the management. At this meeting the local authority officers discussed progress and pertinent issues such as safeguarding concerns and those relating to quality of the service delivered by MI Homecare – Thornton Heath.

Management staff worked alongside the commissioning and brokerage team to ensure they planned, delivered, and evaluated services in reference to the case for opportunities for improvement to delivering high quality care. The manager had monthly meetings with one commissioner to discuss service deliveries and the outcome of monitoring operations. Robust systems were operated that included incident/accident recording procedures, monitoring was embedded in practice to ensure staff focused on no service omissions, and for risks to be managed appropriately and in a responsive, measurable and controlled manner.

Senior staff had submitted notifications to us, in a timely manner, about any events or incidents they were required by law to tell us about. There was a policy and procedure on people's responsibility under the Duty of Candour. This is where providers are required to ensure the there is an open and honest culture within the service, with people and other 'relevant persons' (people acting lawfully on behalf of people) when things go wrong with care and treatment. The manager received regularly statistical information from the local authority to keep them up-to-date with the service delivery. This enabled them to monitor or analyse information over time to determine trends, create learning and to make changes to the way the service was run.

MI Homecare - Thornton Heath was part of a scheme, which recognised and rewarded the individuals and teams that go above and beyond for clients and/or colleagues, this was reflected in certificates and in monetary terms. The manager told us they used it as an opportunity to give something back for a job extremely well done. Weekly briefings, fortnightly targets for care coordinators/field care supervisors. Mentoring was in place for the team leader for further personal development/training to enhance their skills so that they were able to execute management duties. Monthly staff meetings were held to ensure that staff were learning from each other and sharing best practice.

The quality and performance manager shared with us the most recent quality audit report. She said she carried out annual internal audits at the service and a detailed report was produced and an action plan agreed with the service manager.

The feedback from staff and people using the service was that management had worked hard to make

improvements; people and staff told us these improvements were tangible. During a meeting with nine support workers they told us that communication was improving and they had the opportunity to attend staff meetings and discuss their rotas. They said that team leaders and field care supervisors carried out spot checks and monitored their practice and they had one to one supervision meetings. Staff said that when issues or problems were identified they were passed on to the relevant coordinator who would follow it up and take any relevant actions required.

The regional manager said they visited the service a few times each week and worked closely with the manager. The operations manager and regional manager described some of the challenges of running the service such as requests from commissioners for fifteen minute visits and recruiting staff to work in specific areas where public transport links were not good.