MiHomecare Limited

MiHomecare Hammersmith and Fulham

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
This service is a domiciliary care agency. It provides personal care to people living in their own homes. At the time of the inspection there were 323 people using the service.

People's experience of using this service
People told us they did not always receive a reliable service. Systems to monitor staff were not always used appropriately by care workers, who in some cases used the system to misrepresent their attendance at visits. Sometimes people living with diabetes received very late calls and therefore did not receive meals on time. People told us this caused problems for them.

The service assessed risks to people from moving and handling procedures and how many staff members were required to provide safe support. However, there were occasions when people did not receive care from two staff members when this was part of their care plan.

People told us they felt safe when care staff visited and were well treated by staff. There were robust plans in place to reduce the risk of COVID-19 transmission and ensue the appropriate use of personal protective equipment, which people told us was being used. The provider ensured that people's medicines support was planned and monitored effectively. Staff were subject to appropriate pre-employment checks to ensure their suitability for their roles.

The provider had introduced a new electronic care management system. This allowed an effective way to plan people's care and ensure that it was delivered and appropriately audited by managers. There were measures in place to allow staff to report concerns and staff told us these were addressed appropriately by managers. People had mixed feedback about receiving monitoring visits. We found that telephone monitoring was taking place, but did not always fully capture people's experiences of care.

The provider worked with stakeholders to ensure continuity of the service during the pandemic period. Working practices were changed to minimise contact between staff and there were appropriate business continuity plans in place. People told us that they had had limited contact with the office about this subject and sometimes found it difficult to contact a manager when they needed to.

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

Rating at last inspection:
The last rating for this service was good (published 31 July 2019).

Why we inspected
We received concerns in relation to the management of call timings and monitoring. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the Safe and Well-led sections of this full report.

Enforcement
We have identified breaches in relation to safe care and good governance at this inspection.
Please see the action we have told the provider to take at the end of this report.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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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 Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes. The service did not have a manager registered with the Care Quality Commission. A registered manager is a person who is legally responsible for how the service is run and for the quality and safety of the care provided. It is a requirement of the provider's registration that they have a registered manager. At the time of the inspection a new branch manager had recently started in post and was in the process of applying to become the registered manager.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was to ensure that key members of staff were available to support the inspection and to ensure our team were aware of the provider's infection control requirements.

What we did before the inspection
We reviewed information we held on the provider, including records of complaints and serious incidents they are required to tell us about. We spoke with monitoring officers from the local authority to gather

relevant information.
We used all of this information to plan our inspection.

During the inspection
We visited this location on 8 September 2020.
Due to the COVID-19 pandemic we conducted most of this inspection remotely. This was to minimise infection control risks to our staff and to the provider's staff. This meant we requested the provider send us certain documents for us to review off site. We conducted a teleconference with the provider on 28 September to give feedback about our findings. We spoke with the branch manager, operations director, head of people and operations manager.

Between 7 and 9 September 2020 we contacted people who used the service by telephone and spoke with 26 people who used the service and 10 relatives. We made calls to six care workers. We reviewed records of care and support, including medicines records, for 21 people. We reviewed records of induction and recruitment for ten care workers and rotas for a further ten care workers.

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 the last inspection this key question was rated as good. At this inspection this key question is now rated 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.

Staffing and recruitment

● People did not always receive care from two staff when this formed part of their care plans. Records showed that six people did not receive care from two staff for more than one in ten visits. The provider acknowledged that double handed care was not always delivered due to staff being delayed and told us that family members sometimes assisted with care when this was the case. However, despite this being a known risk the provider had not assessed this or put mitigation plans in place.

● People did not always receive timely care. More than half of people we spoke with told us they had experienced problems with the timing of visits. Comments included, "It's a big lottery who comes and at what time" and "My morning call should be 8.30-9am but they come as late as 10am or 11am". In particular, we saw examples of visits for people living with diabetes being carried out much later than planned, with people receiving meals late, and some people told us that this made it difficult to manage their conditions. One person told us, "They are often running late and never phone to say they are late. I also haven't eaten anything before they come so I have had times where I have felt a bit unwell" and another said, "They never come before noon, so it makes it hard to plan my insulin".

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

● Staff were safely recruited. The provider carried out suitable pre-employment checks on potential new staff. This included checks of identification and obtaining references from previous employers. The provider carried out appropriate checks with the Disclosure and Barring Service (DBS). The DBS provides information on people's backgrounds, including convictions, to help employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● People were safeguarded from abuse. The provider had appropriate systems for reporting and responding to allegations of abuse. When abuse had been alleged, the provider reported these concerns and took appropriate action. Staff told us they felt managers responded promptly and listened when they had concerns about people's wellbeing.

● People told us they felt safe when their care workers came to visit them. Comments included, "The regular carer is like a son to us", "I have generally felt safe" and "They are all kind."

Assessing risk, safety monitoring and management

● The provider had detailed risk management plans in certain key areas. This included assessing people's living environments, falls risks, and fluid and nutritional risks. Where people were at risk from long term

conditions there were appropriate risk assessments which highlighted signs staff should look for and the action they should take.

● There were suitable moving and handling plans in place. This included assessing the equipment people required to make transfers and ensuring it was safe to use. Plans highlighted how many care staff were required to carry out certain moving and handling tasks, but aspects of the plans were generic, and did not always details people's specific wishes for how they were transferred.

● Staff received training in moving and handling, and managers carried out competency assessments on new staff to check they carried out these tasks safely. However, three people we spoke with told us they had experienced issues with new staff members being unsure how to use their lifting equipment.

Using medicines safely

● Medicines were safely managed. The provider carried out detailed assessments of people's medicines needs, including the level of support they required. Medicines plans contained a comprehensive list of people's medicines, including why they took them and possible side effects.

● Medicines were monitored safely. People told us they received appropriate support with their medicines. The provider used electronic recording systems for staff to account for medicines using their mobile phones, and included details of which medicines should be administered at which time. This meant that managers were able to monitor this information in real time, and respond promptly to discrepancies.

Preventing and controlling infection

● The provider had an infection control procedure to mitigate risks from the COVID-19 pandemic. Staff were issued with appropriate personal protective equipment (PPE) and people told us their care workers used this appropriately and washed their hands when arriving at their homes. Comments included, "They do wash their hands and they wear masks." Staff told us they had no issues accessing PPE. Comments from staff included, "There was always someone available to help us with this" and "We always had enough and lots of PPE."

● The provider used appropriate communication to help staff prevent the spread of infection. This included using staff mobile phones to keep them updated on the latest guidance for care workers. Staff used electronic recording to verify that infection measures were taken on each visit.

● The provider had assessed the risk of coronavirus spreading in their office and had taken steps to mitigate this. This included promoting home working wherever possible, introducing social distancing within the office and requiring visitors to complete a declaration and agree to temperatures checks.

Learning lessons when things go wrong

● There were suitable systems for responding to incidents. The provider had an incident reporting policy which required information on incidents to be recorded and investigated by managers, with actions taken to prevent a recurrence.

● The provider had introduced new systems for improving how concerns were reported. Care workers used the electronic recording system to verify on each visit whether they had concerns and to describe the nature of these. This system generated an alert for managers to respond to concerns promptly.

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 the last inspection this key question was rated as good. At this inspection this key question is now rated 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, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At the time of our inspection there was no registered manager in post, as the registered manager had recently left the service. The provider had recruited a new branch manager who started in post soon afterwards, and the branch manager had started the process of becoming the registered manager.

● Call recording systems were sometimes misused to give a false impression of when people had received care. Staff scanned codes to log into calls and the system recorded where these log ins had taken place. We identified 13 staff during the month of July who had logged in or out from locations more than 1km from people' s homes. This meant we couldn't be sure that these visits had taken place as recorded. In some cases, these visits corresponded with people who told us their visits were not delivered as planned.
This constituted a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was aware of this issue and were taking steps to mitigate this. They had spoken to a further 8 staff where they had concerns about how people had been using the system, but this was not addressed until September. Some staff had admitted to taking pictures of the codes to be able to log into calls. The provider told us they had ordered replacement tags which could not be easily duplicated and would be monitoring this going forwards. We saw examples of communications to staff about not misusing the system.
● The provider had employed systems to ensure that staff had enough time to travel between calls. This used journey planners to prevent calls being allocated where there was not enough travel time. We reviewed 10 staff rotas and found that these were realistic.

Continuous learning and improving care
● The provider had invested in a new electronic care recording system. This meant that staff could access care plans, risk assessments and notes of care on their mobile devices, and these documents could be more easily reviewed. Staff told us they found this useful and that the provider continued to improve this system. The provider showed us examples of additional capabilities they intended to add to allow people's wellbeing to be monitored over a period of time.
● The recording system was used to improve the recording and monitoring of people's care. There was clear information on what care workers needed to do each visit, with care workers confirming tasks were completed and giving more details. Managers were able to review notes in real time, whereas previously they would have needed to wait for logs to be returned to the office. This allowed management oversight of

these records to be prompter and more responsive.
● The service had a business continuity plan to help ensure services were maintained during the pandemic. This included ensuring that recruitment continued despite restrictions on movement and assessing which visits should be prioritised in the event of staffing shortages.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff told us they felt well supported by managers. Comments included, "We feel supported, if I had any issues I would contact the co-ordinator", "The team were very dedicated during the COVID period, we worked well together to keep people safe."
● The provider had used mobile systems to ensure better communication with staff during the pandemic, despite changes to their ways of working. This included mobile messaging apps and sending short messages to staff alerting them to key information.

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; Working in partnership with others
● The provider worked in partnership with the local authority to ensure the service was delivered appropriately during the height of the pandemic. This included attending regular meetings with contracts officers and ensuring supplies of personal protective equipment (PPE) were maintained.
● The provider engaged well with other stakeholders to help monitor local services during the pandemic. This included regular contact with the local authority and CQC. There was regular reporting of key indicators such as staff absences, service capacity and access to PPE.
● The provider was not consistent with being open and honest when adverse events had occurred. Serious incidents were reported promptly to CQC, with evidence of what the provider had done in response. However, despite a known serious issue with the use of monitoring systems, this was not disclosed to the local authority or CQC.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had systems to monitor people's experience of care, but aspects of this were not responsive. Some people's telephone monitoring had not taken place since May and two-thirds of people we spoke with could not recall the provider contacting them. Comments ranged from, "A young man comes out to check I'm OK, he's very friendly" to "They never contact me from the office." We found records of these monitoring calls and visits were often generic and did not contain personalised information on people's feedback and the response the provider had taken as a result.
● Most people we spoke with had no recollection of the service contacting them to explain how their service may be affected by the pandemic. Comments included, "There has been nothing from the agency about the pandemic but the carers do wear PPE." The provider however wrote to people in March to outline how their service could be affected and maintained telephone contact with people who had chosen not to receive a service due to the pandemic.
● The provider acknowledged that changes to the service forced by the pandemic could make it harder to contact the office due to staff needing to work remotely. Around half of people we spoke with had a negative experience of contacting managers when they needed to. Comments included, "You can get hold of the office alright" and "The phone just rings out and It stops ringing". The provider told us they were aware of this risk and had introduced a reactive reporting facility as part of their new electronic recording system to help mitigate this.

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 always assess the risks to the health and safety of service users of receiving care or do all that was reasonably practical to mitigate any such risks 12(2)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to monitor and improve the quality and safety of the services provided in the carrying on the regulated activity or maintain an accurate, complete and contemporaneous record in respect of each service user 17(2)(a)(c)