

MiHomecare Limited

# MiHomecare - Carterton

## Inspection report

7/9 Ramilles House  
Black Bourton Road  
Carterton  
Oxfordshire  
OX18 3DW  
Tel: 01993 846099  
Website: [www.enara.co.uk](http://www.enara.co.uk)

Date of inspection visit: 10 April 2015  
Date of publication: 10/06/2015

### Ratings

#### Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Requires improvement



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



### Overall summary

We inspected MiHomecare on 13 April 2015. This was an unannounced inspection. We inspected this service in February 2014 and it was meeting all the standards required.

There was a registered manager in post at the service. The registered manager was in the process of working their notice period before moving into another role within the organisation. 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.

People were not always safe because risks associated with their care needs were not always documented. Where the risks were documented there was not always clear guidance for how staff should deliver care to manage these risks.

# Summary of findings

The service had enough staff but they were not always suitably skilled or deployed in a way that met people's needs. People we spoke with felt most staff were caring, however a lack of consistency in staff who provided their care meant positive relationships were not always easy to maintain. People we spoke with felt they did not always receive information such as rotas that they felt was important for their piece of mind or clear explanations when this was requested.

Staff received training and felt supported. However staff we spoke with felt that supervision was not as effective since moving from individual supervision to group supervision. Staff did not benefit from clear development plans.

People did not benefit from a culture that understood or embedded the key principles of the Mental Capacity Act (MCA) (2005). The MCA provides a legal framework to assess people's capacity to make certain decisions, at a certain time. People's needs were assessed and these

assessments were used to develop support plans. Staff we spoke with raised concerns that these were not always up to date and reviewed needs were not always communicated to them.

There was a system in place to monitor the quality and safety of the service but it was not always effective. It was not clear how the findings of these audits were implemented to improve the quality of the service provided. Audits we reviewed had not identified the areas of concern highlighted at this inspection.

Staff we spoke with felt there was not always a fair culture in terms of what was expected of them. Many staff felt the flexibility of the contracts they were on was not being respected and this was impacting on their ability to do the job to the best of their ability.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we took and 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?

The service was not safe.

Support needs were not always supported by risk assessments and clear guidelines for staff.

There were enough staff but because staff did not provide care to a consistent set of people this negatively impacted on their ability to meet people's needs.

People's medicines were mainly administered and recorded adequately, but there were occasions where medicines had been missed or not signed for.

**Requires improvement**



### Is the service effective?

The service was not always effective.

People were not always supported by staff who had the skills and understanding to meet their needs.

People did not benefit from a culture that fully embedded the principles of the Mental Capacity Act regarding their choices.

Staff felt supported but their formal supervision and appraisals did not always detail the support they needed to improve practice or develop professionally.

Staff received training, but some staff felt it wasn't always adequate to fully meet the needs of people they supported.

**Requires improvement**



### Is the service caring?

The service was not always caring.

People did not always benefit from positive relationships due to changing staff teams and carers that often appeared rushed.

People did not always receive information regarding their care that they felt would make them feel more comfortable such as staff rotas.

Many people we spoke felt that most staff were caring and were respectful of their homes and belongings.

**Requires improvement**



### Is the service responsive?

The service was not always responsive.

People needs were assessed and used to develop support plans for staff to meet their needs.

The service was responsive to people's needs when changing needs were identified. However people, relatives and staff felt this was dependant on when regular carers were working.

**Requires improvement**



# Summary of findings

Complaints and feedback were recorded but it was not always clear what action had been taken to resolve the complaint or what lesson had been learned and applied across the whole service.

## Is the service well-led?

The service was not always well led.

Systems in place to monitor the quality and safety of the service were in place but were not always effective.

Staff did not always feel they worked within a fair culture which was impacting on the quality of the service delivered.

Staff felt confident they could raise concerns with management and were aware of the service whistleblowing policy.

**Requires improvement**



# MiHomecare - Carterton

## Detailed findings

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was 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 took place on the 13 April 2015 it was unannounced. The inspection team consisted of two inspectors and an expert by experience (ExE). An ExE is a person who has personal experience of using, or caring for someone who uses this type of care service.

We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law.

At the time of the inspection there were 65 people being supported by the service. We spoke with the 19 people who were using the service and six people's relatives. We spoke with 20 care staff, two service coordinators, and the registered manager. We reviewed six people's care files, records relating to staff supervision, training, and the general management of the home.

# Is the service safe?

## Our findings

Support plans identified risks but were not always supported by risk assessments or clear guidelines with how to manage these risks. For example, one person had epilepsy; there was no epilepsy risk assessment in place. One member of staff told us how one day they were 'Completely panicked' when this person had a seizure as, 'I didn't know what was going on, fortunately the carer I was with knew about it, not everyone does though'. We raised this with the registered manager who took action to ensure an assessment was undertaken and guidelines for staff put in place.

Another person presented behaviours that could be challenging, this was identified in the persons support plan, however there was no risk assessment or guidelines for staff to support this person. Four care staff we spoke with said they had turned up to support this person without knowing of this risk. Comments included, "It was dangerous as I didn't know they were like that" and "It's not ok that we aren't told this before we arrive, it's spoilt their relationship with many carers, you can't prepare yourself properly". We discussed this issue with the registered manager who acknowledged that risk assessments needed to provide clearer guidelines for care staff. Following the inspection we were informed the registered manager was taking action to ensure all people's support plans and risk assessment were reviewed.

Accidents and incidents were recorded but it was not always clear what action was taken to prevent future incidents. For example, medicine errors were recorded, but it was not clear what action was taken to prevent future occurrences. There was also an incident regarding a staff fall but no action was taken to prevent further incidents.

These issues were breaches of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were receiving care from adequate numbers of care staff, but staff were not always deployed consistently in a way that met people's needs. 18 people we spoke with were not happy with the inconsistency of their carers. Most of people told us that the practice of 'moving staff around all the time' made people feel less safe. Comments included; "I never know who's coming from day to day, it's a bit unsettling if I'm honest with you", "I have very bad

eyesight now, I'm lucky to have the same person twice, they move things around and then I can't find them. If I had regular carers, they'd know wouldn't they?" and "A constant stream of new girls (carers) means they don't know things, and can sometimes cause my mum pain, she doesn't feel safe with some of the carers". One relative we spoke with told us, "I long for consistency of care to feel more confident about my mum's safety".

Staff also expressed similar concerns about not providing care regularly to the same people. Comments included, "We are deliberately not given a regular round of people to visit, I'm sure there is a reason but surely consistency and safety should be more important" and "I've stopped asking for a regular round, but I'm sure my anxiety of constantly changing must effect how safe people feel with me". We discussed these issues with the area manager who had identified the concern and was planning to take action to ensure there would be more consistency. We were told, "We are looking to set up more regular templates. We have had staff issues up until recently that has made this difficult".

These concerns were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and staff benefited from environmental risk assessments that identified environmental hazards and recorded where action was taken to mitigate risks. There were also emergency plans in place in the event of incidents that may impact on the service's ability to deliver people's planned care.

Staff had knowledge of types of abuse and signs of possible abuse. Staff we spoke with could tell us what action they would take if they suspected abuse. Staff also knew arrangements for alerting external agencies such as local authority safeguarding and the Care Quality Commission (CQC). We reviewed the safeguarding alerts that had been raised and they had been managed appropriately and in line with the service safeguarding policy.

People we spoke with confirmed that their care workers made sure the dosage of tablets was correct, gave them water to take them with and then filled in the paperwork to confirm that the medication had been taken.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the service. These included employment

## Is the service safe?

references and Disclosure and Barring Service checks. These checks identified if prospective staff have a criminal record or were barred from working with children or vulnerable people

# Is the service effective?

## Our findings

Some people we spoke with felt some care staff were sufficiently well-trained, and able to care for them with the right levels of competence and professionalism. Comments included, "Some staff are very good, lovely girls". However, most people we spoke with did not feel care staff always had sufficient knowledge and skills to meet their needs. Comments included, "I had one girl come to do me some lunch, and she didn't know how to boil an egg and another one didn't know how to slice some cooked chicken for me", "I have to have microwave meals in my freezer at all times, which I don't like and wouldn't choose because some girls only know how to do them" and "I think some (staff) are better trained than the others. Some always seem to rush round and try to get out quickly. The more experienced ones give you more time". A relative said "It doesn't help mum's condition and state of mind if they don't have the skills to understand that she always wants her breakfast and medication before her personal care, and she's not always able to explain that."

Whilst people and their relatives were happy that changing needs were identified, many told us it was dependant on seeing a regular carer. One relative told us, "They are flexible to my relatives needs and respond well to that, but I am having to remind all the new faces about the changes". For example one person's relative told us how their mum had a degenerative disease (Degenerative disease is the result of a continuous process where health will increasingly deteriorate over time) and that they were "regularly having to tell staff about their relative's needs."

People we spoke with felt new carers should have the opportunity to 'shadow' more experienced staff for longer periods of time. One person told us, "When they're training, I think new girls should be more pro-active and be encouraged to do more rather than just watch the experienced girls, that way mistakes would be spotted sooner." One person's relative told us they made private arrangements to have extra care in as they, "did not feel confident that they'd be cared for properly". One person told us of an incident when a carer who had not been to her before tried to wheel her wheelchair without swinging the footplates into position. She told us, "I cut my foot on the sharp edges, it was because she hadn't been to me before, they don't all seem competent enough."

Staff also expressed similar concerns. Comments included, "New staff should be paired with more experienced carers for longer periods of time and be able to continue on two-handed visits until they felt competent to go out on their own" and "Some staff may need more time observing and being observed before going solo". Another member of care staff told us that in their induction, they were surprised by the lack of first aid training, and how pressured they felt to go out alone. They also told us, "people don't shadow the visits of people they end up working with, it's pointless". We raised this with the regional manager who told us, "All staff receive a supervision/ shadowing meeting to sign them off before they go out on their own. No-one is expected to cover single calls until they are confident". However this didn't reflect the views of most staff we spoke with.

Staff we spoke with felt supported. Some gave examples of times they had needed additional emotional support from the registered manager and this was always available. Other staff commented on the support they could get from the office staff if they needed it. Staff told us they received regular supervision but didn't feel it was effective as they were supervised as a group rather than on a one to one basis. One staff member told us, "I can't always speak openly in a group, so it ends up being more about people than my own support needs". Other staff we spoke with raised the same concern. We raised this with the manager who informed us that all staff are also offered one to one supervision in addition to group support.

There was no clear link between supervision, appraisal and the support staff received. Staff did not have clear objectives set or development plans as a result of their supervision or appraisal. However, staff did tell us they had access to qualifications, but "would have to chase it up".

Staff received training, but a number of staff raised concerns that this was not always adequate. One person told us, "there needs to be more hands on, we get some and it works for experienced carers but new people to care need more".

These issues were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with felt that staff were respectful in asking for their consent before providing them with care. Staff we spoke with also spoke clearly about the



## Is the service effective?

importance of making sure people were consenting. Comments included, “I always ask first even if I think I know the answer” and, “I don’t assume people are going to be ok with what I need to do, so would always ask first”.

However, despite staff showing a good understanding of the need for people choices to be respected, staff did not have an understanding of the Mental Capacity Act 2005. The MCA provides a legal framework to assess people’s capacity to make certain decisions, at a certain time. Staff had not received training and staff we spoke with were not able to speak with us about the key principles of this Act. We discussed this with the registered manager and their coordinator who agreed to take appropriate action to ensure their staff had enough understanding to enable them to adhere to the principles of this Act. Staff we spoke with told us there were times that they felt relatives were on occasions making decisions for people and this ‘didn’t feel right’. The absence of an understanding of the Act meant people were at risk of not making decision for themselves in relation to the legal framework. There were

generic Mental Capacity forms in people’s files that did not make it clear the specific time or decision that capacity was being assessed for. This meant people’s capacity was not appropriately assessed.

Where people’s support needs required preparing meals these needs were recorded. We saw that there was also a system in place to ensure people were drinking enough water. However, there was no indication on these forms as to what the safe level was for each person. This meant there was a risk people may not receive adequate fluid. We discussed this with the manager who agreed to amend the forms to ensure sufficient water intake levels are clearly indicated. People were supported to access appropriate health services when required and were supported to maintain good health. For example one person’s relative told us, “The staff let me know if they think my mum needs to see the dentist”. Staff we spoke with told us they were observant to people’s changing health needs. Comments included, “you know when giving personal care what to look out for and if we have a concern we tell the office who get referrals done”.

# Is the service caring?

## Our findings

Many staff were described as caring and kind in their dealing with those they visited. We were told that staff were very respectful of people, their homes and possessions. One person told us, “The girls encourage me to be as independent as I can be, but they can tell if I’m not well, and will give me extra assistance on those days it make me feel better with a greater sense of self-worth.”

However, the issue of people not always having regular carers was having an impact on the levels of relationship possible. Some staff told us that they sometimes do not know anything about the person they were visiting until they arrived. For example, they would not know if the person was hearing or sight impaired, or had dementia. One member of staff told us, “I will always ask the office about the person I am visiting as I feel it’s very important, but I know that other girls will go into a home with no information at all” One person told us, “New girls don’t know anything about me. They don’t know I’m almost blind now, and will stand over me expecting me to know they’re there. I have to keep explaining that I don’t know who they are, or where they are.”

Most people told us they would really appreciate having a weekly rota, detailing who would be visiting them, and at what time. Comments included, “We never know who’s coming, and it would be nice to know in advance.”, “I have asked for a rota, but never received one. I get anxious when I don’t know who’s coming.” Most people felt they were listened to, but again the issue of not having regular carers seemed to impact on levels of choice available to people.

People told us that they got fed-up with explaining their preferences to different carers every day, and some now just accepted that every day their care would be slightly different.

Three members of staff told us, “Management say they don’t want us to get too close to our clients’, ‘They don’t want attachments to be made’, and ‘They’ve said they don’t want us to get too involved’. One member of staff in particular told us, “This practice is potentially very damaging to people, both in a social and emotional sense as you can’t have a proper relationship”. We discussed these concerns with the area manager who told us, “It’s not that we don’t want these relationships, it is just we haven’t had enough regular staff to keep teams stable, but we are hoping to change that now”.

Some people told us that punctuality was not always as efficient as they would like. Nobody we spoke with had experienced any missed calls, but a number of people told us carers could be late and did not always inform them. We were told of a number of occasions where the lack of punctuality meant care was given irregularly. For example one relative told us, “If they are not on time my mother’s incontinence pads are sometimes changed too regularly, or not regularly enough I find it completely undignified”.

These issues were a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with were involved in their care. Comments included, “Yes, they come and talk to me and we talk about what support I need” and “I feel they care about what it is I need”. Relatives we spoke with told us, “I feel my views are important, and the regular staff that come always ask my opinion”.

# Is the service responsive?

## Our findings

People received phone calls to see how they felt about the care they were receiving. However, the feedback we reviewed was not always detailed and did not always show what action had been taken to act upon this feedback.

According to the services annual satisfaction monitoring overall satisfaction of care had reduced. There was no plan in place to identify why this had reduced or how to improve it. We spoke to the registered manager about this who shared the action plan they had, which did not include areas of improvement in relation to this feedback.

These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us they always reported people's changing needs, but also shared a concern about being able to do this consistently. One staff member told us, "They (office staff) send us so many different places, we wouldn't always be able to see if people are going downhill physically, because most of them we've never met before". Another member of staff told us, "I've noticed that care plans are not always kept up to date – things are not updated as conditions deteriorate perhaps." They went on

to explain that, "because we are often visiting somebody for the first time, I will read the care plan to find what is required, but then notice that the recent carers have been providing more, or different support than is noted, I find it confusing, and can sometimes lead to insufficient care being provided." Another staff member told us, "I'm always surprised by how little we know about a client before we visit them."

Despite these issues a number of people and their relatives felt the service was responsive. Comments included, "The carers have been good at recognising when things have changed, they always act upon it", "my needs have fluctuated and care has been reduced as I get better".

People's needs were assessed and these assessments were used to create support plans. We saw that these support plans were reviewed and staff informed the office when they identified changes. One staff member told us that they felt one person needed two-handed support, so they told the office staff who arranged for the lady to be re-assessed, and she now has two carers at all visits.

The service kept a record of complaints. Complaints were managed in line with the service's policy with clear investigation and actions recorded.

# Is the service well-led?

## Our findings

Overall the staff we spoke with were positive about the service, and several told us that they felt the management team was committed to the service. One staff member told us, “The managers want to provide a good service to people, and want to support us in that”. However, all staff we spoke with did not always feel they worked in a fair culture. All staff were recruited on bank (zero hours) contracts (these are contracts where there is no obligation for the service to give any hours, and no obligation for staff to have to work regular hours). Most staff we spoke with told us that they could not take time off when they wanted to or feared they would lose hours if they did. Comments included, “I work very long hours, and I have repeatedly asked to do less hours, but when the rotas came out I have been put on for early starts which affects my childcare”, “We are given too many late nights in a row, and we get exhausted, but you don’t feel like you can say no in case they don’t give you any the following week” and “I often end up working late or unsociable hours and then have to be up early, how’s this fair”. Five staff we spoke with had made leave request with “plenty of notice”, but were not given the requested time off when the relevant rotas were documented.

The issues relating to staff contracts and working hours was impacting of the quality of care provided by the service. Several service-users expressed concern for some of the staff who ‘work far too hard and always seem tired’. One person told us, “They tell me sometimes they start early in the morning and don’t get home until late at night with just a short break during the day. I think that’s why there’s always girls leaving or don’t always seem happy.” We spoke with the registered manager about these issues who informed us contracted hours were being trialled across the organisation as “the issue had been acknowledged”.

We also found that not all staff in senior positions had the level of qualifications deemed essential by the services own job specification for the role. We spoke with the regional manager about this who acknowledged that there

were areas that required improving. This was to ensure accountability and job roles were clearer and decisions regarding care were being made by staff with the appropriate levels of experience and competence.

There was a system in place to monitor the quality and safety of the service. Senior managers conducted quarterly audits which involved checking through people’s care files to ensure paperwork was detailed and up to date. These audit identified actions to improve the quality of the service. However this system had not identified the issues we identified through the inspection and it was not always clear whether the identified actions had been followed up and completed. Field care supervisors conducted regular spot checks and telephone monitoring to assess the quality of service provided. However it was not clear how this information was being used to improve the quality of the service.

These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had been taken over by a new provider (MiHomecare) in February 2013, but there were still many areas that were still being used from the previous provider such as paperwork and systems. This made it difficult for the manager and staff we spoke with to discuss a clear vision with us. Comments included, “I’m not sure why things changed, they were working and now things are just confusing”, “Things changed without looking at what was working first, it’s just left repetition and duplication which has made improvement difficult”. We spoke with the regional manager about this who told us they would take immediate action to ensure paperwork within the service was consistent and the team were clear of the vision of the service.

All staff we spoke with felt that they could go to the management, or speak to any of the office staff if they had any concerns about service-users, other member of staff, or had any personal issues they needed to discuss. All staff also felt clear on the services whistleblowing policy and would feel confident to use it if needed.

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Regulation 17 (1) (2) (a) (b) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>Systems were not always effective in assessing, monitoring and improving the quality and safety of the services provided including the quality of the experience of service users in receiving those services; or assessing, monitoring and mitigating the risks relating to the health, safety and welfare of service users and others who may be at risk.</p> <p>The service did not always evaluate and improve their practice in respect of the feedback they received from service users and staff.</p>
Regulated activity	Regulation
Personal care	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation (12) (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment</p> <p>Care and treatment is not always provided in a safe way for service users.</p> <p>The service were not always assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. Including staff not always having the skills to meet these needs safely.</p>
Regulated activity	Regulation
Personal care	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p>

This section is primarily information for the provider

## Action we have told the provider to take

Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing

Suitably qualified, competent, skilled and experienced persons were not always deployed in a way that met people's needs.

Staff were not always qualified to be in the roles for which they were employed.

Staff had not received adequate training regarding the Mental Capacity Act (2005).

### Regulated activity

Personal care

### Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Dignity and Respect

Service users must be treated with dignity and respect.