

MiHomecare Limited

MiHomecare - Reading

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 13 January 2016 and was announced. MiHomecare - Reading is a domiciliary care service and at the time of the inspection was providing personal care to 180 people living in their own homes in the Reading and Newbury areas of Berkshire.

At the last inspection on 26 February and 4 March 2015 we asked the provider to take action to make improvements in meeting people's individual needs safely, managing medicines, responding to complaints, deployment of staff and monitoring the quality of the service. The provider sent us an action plan and told us they would meet the relevant requirements by 30 October 2015 and these actions have been completed.

At the time of the 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. The provider had appointed a branch manager in December 2015 who was waiting for a Disclosure and Barring Service (DBS) check in order to be able to register with CQC.

There were sufficient numbers of staff deployed by the service. A targeted recruitment drive had enabled the service to stop using agency staff. People mostly received their care from a consistent team of care staff. Recruitment processes were robust and helped to ensure suitable staff were employed.

Work had been undertaken to improve the scheduling of visits. Time was allocated to care workers to travel between visits helping to ensure people received more timely visits. However people and professionals told us timeliness of visits could be an issue with some visits being made late. Further work to train the care co-ordinators in the efficient use of the computerised scheduling system was taking place in order to overcome these issues.

The provider had reviewed their medicines policy which was robust and gave staff clear guidance to follow in order to support people with their medicines safely. People told us they received their medicines when they needed them. Audits of medicine administration records were conducted frequently. Issues or errors were noted, addressed with staff and action taken.

People told us they felt safe using the service. Risk assessments had been completed to identify risks to individual people and to staff. Guidance was available for staff to use in order to minimise those risks.

Following a period of feeling unsupported staff had begun to feel they could go to the new manager and they would be listened to. They benefited from regular meetings with their line manager and had an opportunity to discuss their work and future development at an annual appraisal.

People felt staff were knowledgeable. Staff were inducted into the service using the care certificate

standards and then received regular refresher training. Their practical skills were assessed at unannounced spot checks carried out by senior staff.

Staff understood their responsibilities in relation to gaining consent before providing support and care. People's right to make decisions was protected. Staff sought advice from health and social care professionals when appropriate in order to maintain people's well-being.

People told us they were treated with kindness and their privacy and dignity was respected by the staff who visited them. They told us they mostly received their care from a consistent team of care staff but on occasion were visited by care staff unfamiliar to them.

Staff knew people well and described how they cared for them. People told us they were supported to be as independent as they wished to be. They told us they had been involved in the planning and review of their care.

People's personal and confidential information was protected by staff who were knowledgeable about what information could be shared and with whom. People knew how to make a complaint and who they could speak to about any concerns they had. Complaints made to the service had been recorded, investigated and responded to in a timely manner. Appropriate actions had been taken in response to complaints made.

Staff responded to people's changing needs and communicated information promptly to the wider care team. Where it was part of the agreed care plan people were supported to take part in activities in the community.

Quality assurance audits were conducted and had identified areas for improvement. Action had been taken to improve and develop the service using this information. Staff felt the culture of the service had improved recently and described it as "open and informative." They described the new manager as "approachable." Due to the diverse locations staff worked in they did not always feel they were part of a wider team. The new manager was addressing this and had organised staff meetings to bring the team together.

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 safe

Improvements had been made in scheduling visits and ensuring staff had time to travel between visits. Further work was being carried out to ensure improvements could be built on. At the time of the inspection we could not be assured the improvements would be sustained.

People felt safe when being supported by the staff. Staff understood their responsibilities and how to keep people safe.

Risks were assessed and guidance provided to reduce risks identified.

Medicines were managed safely.

Is the service effective?

Requires Improvement ●

The service was effective

Staff had previously felt confused about who to turn to for support. They told us that since the appointment of the new manager they felt more supported and had someone to go to. At the time of the inspection we could not be assured these improvements would be sustained.

Staff understood the need to gain consent before providing care and people's right to make decisions was protected.

People were supported by staff who received relevant training which was refreshed regularly. Meetings were planned for staff to meet regularly with their line manager for support and to discuss any concerns.

Staff sought advice with regard to people's health and well-being when appropriate.

Is the service caring?

Good ●

The service was caring

People were treated with kindness. They told us staff respected

their privacy and dignity when supporting them.

People were encouraged and supported to maintain their independence.

People were involved in making decisions about their care.

Is the service responsive?

Good ●

The service was responsive

People's needs were assessed and they were involved in planning their care.

People were asked to give feedback on the service and knew how to make a complaint or raise a concern if necessary.

Complaints were investigated and responded to in a timely manner.

Is the service well-led?

Requires Improvement ●

The service was not always well- led

The service had not had a registered manager since May 2015. A manager had been appointed and was about to start the registration process with CQC.

Staff now felt the culture was open but until recently had felt it was chaotic and were unsure who to look to for support.

Quality assurance systems were in place and used to improve and develop the service.

MiHomecare - Reading

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 took place on 13 January 2016 and was announced. The provider was given 48 hours notice because the location provides a domiciliary care service and we needed to be sure that senior staff would be available in the office to assist with the inspection.

The inspection was carried out by two inspectors.

Before the inspection we reviewed the information we held about the service which included notifications they had sent us. Notifications are sent to the Care Quality Commission (CQC) to inform us of events relating to the service.

We also reviewed the Provider Information Return (PIR). This 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 looked at the results of a survey carried out by CQC to gain the views of people who use the service, staff and community professionals. 15 people, 7 staff members and 2 community professionals had responded to the survey.

During the inspection we spoke with ten people and/or their relatives. We spoke with seven members of staff including the manager, regional manager a care co-ordinator and six care workers. We also received feedback from two community healthcare professionals and the quality and performance monitoring team from two local authorities. We looked at records relating to the management of the service including seven people's care plans, eight people's medicine records and daily notes, six staff recruitment files, training and supervision records, the complaints log and policies.

Is the service safe?

Our findings

At a previous inspection on 26 February and 4 March 2015 the provider was not meeting the requirements of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. The registered person did not deploy sufficient numbers of staff. The provider sent us an action plan on 19 June 2015 describing how they were going to make improvements to meet the requirement by 30 September 2015. At this inspection the provider had met the requirement of the regulation.

There were sufficient numbers of staff. At the time of the inspection the service employed ninety staff, a mixture of full and part time workers. There had recently been an intensive recruitment drive and the service was recruiting staff as quickly as possible. We were told twelve new members of staff were beginning their induction training the following week and efforts to recruit more staff continued.

Agency staff were no longer used to cover visits in the event of staff absence due to illness or leave. Cover was now provided by the care team or by senior staff such as field care supervisors or care co-ordinators on a rota basis. We were told targeted recruitment had made a difference, for example staff were now employed for specific times of the day such as early mornings or evenings making scheduling more manageable.

We reviewed the scheduling of visits and saw travelling time was now allocated between visits. This helped to ensure staff were not rushed when travelling and arrived more punctually at people's homes. However some people told us, although they felt there had been improvement in the timeliness of their visits, care workers sometimes still arrived late. A health and social care professional also commented on lateness of visits.

During the inspection some of the office staff were receiving additional training on the computer system in order to make the scheduling process more efficient. The regional manager informed us further work and training was taking place so that more accurate travel time could be allocated and timing of visits could be managed more effectively. At our previous inspection, scheduling had been completed on a daily basis, this had been difficult to manage and had resulted in visits being missed. At this inspection schedules were completed at least two to three days ahead of time with only unexpected changes made to the current day's schedule, for example, if a care worker went off sick or a person using the service went into hospital or cancelled a visit. Appropriate time intervals were planned between each visit to a person where the care they required relied on precise timing. For example, if a person was assisted with medicines there was sufficient time allowed between visits to make certain doses were spaced out in accordance with guidelines.

The service had introduced electronic monitoring of visits. This was a system by which a care worker used a mobile telephone to record when they started and finished a visit. This information was relayed back to the office and helped to ensure that people received visits at the time they were planned. It also highlighted to office staff if a visit had not been made. This system had brought about a significant reduction in the number of visits missed, helping to ensure people received the care they required. People told us that care workers

stayed with them for the correct amount of time. One person commented, "The new phones have made a difference, they always stay the full time and do some extra bits for me like folding the washing." At the time of the inspection we could not be assured these improvements would be sustained as both the manager and regional manager were new in post.

At our previous inspection on 26 February and 4 March 2015 the provider was not meeting the requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. The registered person had not protected people against the risks associated with medicines because appropriate arrangements had not been made for the safe and proper management of medicines. The provider sent us an action plan on 19 June 2015 describing how they were going to make improvements to meet the requirement by 30 October 2015. At this inspection the provider had met the requirement of the regulation.

The provider had reviewed and updated their medicines policy. This provided clear guidance for staff on all aspects of supporting people with their medicines. Medicines care plans clearly stated the responsibilities the service undertook when supporting people with their medicines. They also provided information and guidance to staff on supporting people with medicines to be taken as necessary (PRN). However, we found an example of one medicines care plan not matching the overall care plan. One part of the care plan stated the person was able to self-medicate whereas the medicines care plan gave instructions to staff on how to administer the medicines to the individual. This may have led to staff being confused about their responsibility. The manager and regional manager undertook to review this immediately.

People told us they received their medicines when they required them. Staff were able to describe the procedure for supporting people with their medicines. They told us they had received medicines administration training, annual refresher training and competency tests, usually completed during 'spot checks' by senior staff. A 'spot check' is an unannounced check on the practical work of a member of staff during a visit to a person who uses the service. One staff member gave an example of reporting a medicine storage safety issue to the office. Senior staff responded immediately and action was taken to ensure the safety of the person and the staff member.

An audit of medicines records was completed by senior staff. Errors were noted and action taken to address any issues. The frequency of audits was regular with most being carried out on a monthly basis when records were returned to the office.

At our previous inspection on 26 February and 4 March 2015 the provider was not meeting the requirements of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care. The registered person had not taken proper steps to ensure people received care to meet their individual needs and to ensure their welfare and safety. The provider sent us an action plan on 19 June 2015 describing how they were going to make improvements to meet the requirement by 30 September 2015. At this inspection the provider had met the requirement of the regulation.

The service had reviewed the care plans and associated risk assessments. Risks to people who use the service and staff were identified. For example, individual risks relating to people such as, falls, skin integrity and moving and handling had been assessed. These had been cross referenced to individual care plans and gave staff information on how to minimise the identified risks. This provided protection for both the person and the care staff. In addition people's home environments had been assessed for risks, for example such things as pets in the home, flooring and lighting were considered and guidance for staff to follow was available. Risks were reviewed at least annually but more frequently if a change in circumstance was noted.

People and their relatives told us they felt safe using the service. Comments included, "Oh yes, I feel very safe," "I do feel safe, they're very good" and "Safe, yes no worries about safety." The provider's recruitment procedure ensured staff had been recruited as safely as possible. The provider completed the necessary safety checks on applicants. These included Disclosure and Barring Service (DBS) checks to confirm that prospective employees did not have a criminal conviction that prevented them from working with vulnerable adults. Completed application forms included full employment history. However, in four records small gaps in employment history had not been explored. The manager and regional manager told us they would address this immediately and following the inspection confirmed this had been done. Records of interviews were held on file and appropriate references were taken up and verified prior to employment being offered.

Staff were able to describe how they kept people safe and how they identified any changes to their well-being. They told us they had received safeguarding training and were able to talk about and identify types of abuse such as financial, physical and emotional. They were familiar with the provider's policy and the reporting systems relating to safeguarding people. One staff member said, "[I would] definitely report it, no hesitation, something must be done." Staff were aware of other organisations they could contact with concerns such as the Care Quality Commission (CQC), the police and the local authority if necessary. The provider had a whistleblowing policy which staff were aware of and a copy was included in their employment folder.

The provider had plans in place to deal with foreseeable emergencies. People had individual contingency plans. These described action staff should take in the event of emergency situations such as adverse weather conditions.

A system for recording accidents and incidents was in place. None had been recorded since the last inspection.

Is the service effective?

Our findings

Staff told us they felt supported. However, some told us this had not been the case until recently. They said there had been a number of changes in the management of the service which had left them feeling unsupported but they were beginning to see improvements. They told us they could go to the current managers for advice and support and felt they would be listened to. One staff member said, "The new manager is very approachable and knowledgeable. She came out to meet one of my clients and introduce herself. She asked me if I was OK and if I needed anything."

We spoke with the manager and regional manager about support for staff. The manager who was new to the service told us they had recognised this as a priority and she was working hard to build a rapport with staff in order to offer the support they needed. The regional manager said lack of support had been identified as an issue through exit interviews held with staff leaving the service. Information gathered at these interviews had helped the service put a new starter's support programme in place. Other measures to support and value staff such as offering guaranteed hours contracts had been adopted. However, the majority of staff remained on a zero hours contract which, we were told was their choice. At the time of the inspection we could not be assured these improvements would be sustained as both the manager and regional manager were new in post.

A programme of planned meetings was arranged for each member of staff to meet with their line manager. Staff confirmed they met and discussed their work on a regular basis and one said, "I can use these sessions to discuss any concerns." They went on to describe a concern they had discussed and the actions that had resulted.

Staff told us they had an annual appraisal once they had worked at the service for over a year. Spot check visits were also carried out to check on the practical work of staff and their competency. When concerns were identified with any aspect of a staff member's work they were addressed and discussed with them. For example, the timing of visits had been discussed with one member of staff and the appropriate wearing of gloves with another.

People and their relatives told us they thought staff were skilled and knowledgeable about the work they do. One relative said, "They know what they're doing" while a person who uses the service said, "I think they are on the whole very well trained."

Staff received regular training. Induction training for new staff was now to the Care Certificate standards. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. In addition to this training, staff completed shadow shifts, watching and working with more experienced staff. This allowed them to build confidence and develop their skills. At the end of the shadowing period, their work was assessed and signed off by a senior member of staff. Staff told us their induction had prepared them to carry out their duties. They said they had not been asked to carry out any task they were not confident to do and could obtain additional training as required. Staff refreshed their mandatory training annually and refresher training was mostly up to date. For those staff who required

refresher training this had been booked. In addition to mandatory training, other topics related to the people they cared for, such as dementia and end of life care was available. Staff had the opportunity to gain recognised qualifications such as National Vocational Qualifications in Health and Social Care.

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 to 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 had received training in relation to the MCA and were able to talk in detail about it. People's rights to make their own decisions were promoted and staff were aware of their responsibilities. One staff member gave an example of how they had recognised a capacity issue and dealt with it appropriately. Staff sought people's permission before helping them. They told us they explained what they were going to do and waited for the person to agree before doing anything. They were able to give examples of how they dealt appropriately with situations when a person refused care. People and their relatives confirmed staff asked for consent prior to care being given. People had generally signed to indicate their consent in the care plan. This included sharing of information and agreement to the plan.

People were supported with their nutrition when this was part of their assessed need. Staff told us they assisted people to choose what they wanted to eat and drink before preparing it. Where people were unable to get snacks and drinks for themselves, staff left these close by so people could help themselves once they had left. People's nutrition was monitored when necessary and staff were able to explain how they completed food charts if necessary.

People's health support needs were detailed in their individual care plans. Staff sought medical advice from health professionals when necessary. One person told us care staff had called for medical assistance on a number of occasions when they had been unwell and another said, "my carer reacts very quickly if there's a problem." They went on to describe how the care worker had contacted a health professional after noticing a change in the person's well-being."

Is the service caring?

Our findings

People and their relatives told us staff were caring. One person said, "They are wonderful, they are always joking and having a laugh." Another person told us, "I have a regular carer, she's as good as gold, I trust her implicitly." A relative spoke about the positive relationship the staff have with their family member, "[There is] a core of regular carers who interact very well with [name]."

During a previous inspection people had told us they did not always receive care from a regular and consistent team of care workers who knew them well. Improvements had been made and most people told us they had a regular team of staff who visited them and knew their needs well. However, there were still some examples of people not having regular care workers, mostly at weekends and in the evenings. The manager and regional manager were working hard to address this by targeted recruitment and additional training for those staff with the responsibility of scheduling visits.

Staff knew people well and were able to describe how they cared for them. They gave examples which included getting to know people, ensuring people's preferences were respected and treating people as individuals. People and relatives also commented on how well staff knew them and cared for them. Examples included, "[name] does everything well, knows me well and it's all just second nature to [name]," "They are really lovely, perfectly good and do everything I need them to" and "[Name] is very nice, I couldn't ask for anyone better."

People told us they were shown respect by care staff. Care plans detailed how staff were to ensure people's privacy, choices and dignity. Staff fully understood the importance of this and gave examples of how they carried this out. This included, putting people at their ease when providing personal care and pulling curtains and/or closing doors. They also spoke about maintaining confidentiality. Relatives confirmed staff were respectful to their family members, one said, "[They are] always polite and respectful and always preserve his dignity." One person also told us, "[They] respect that I can voice my own opinion."

Staff supported people to maintain their independence. One staff member said, "I like to help them do things for themselves, dignity and independence is important to people." A person who uses the service described how they were supported to take part in an activity to promote their independence and said, "It's made a real difference to my life."

People's diverse needs and how to meet them were contained in people's individual care plans. Staff told us this included cultural and spiritual needs were they had been identified. People said they had been involved in planning and reviewing their care. Care plans included an area for people to sign to confirm they had been involved in care planning, however this had not always been completed.

People's records and other confidential information were kept securely locked in filing cabinets in the service's office. Information held on the computer system was password protected. This helped to ensure unauthorised personnel could not gain access to people's private information. Staff described how they respected people's confidentiality and were clear on what information can be passed on and to whom.

Is the service responsive?

Our findings

At our previous inspection on 26 February and 4 March 2015 the provider was not meeting the requirements of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receiving and acting on complaints. The registered person did not have an effective system in place for identifying, receiving, handling and responding appropriately to complaints and comments. The provider sent us an action plan on 19 June 2015 stating they had made improvements to meet the requirement. At this inspection the provider had met the requirement of the regulation.

The complaints log was reviewed. Eight complaints had been received since the last inspection. All had been dealt with promptly and investigated fully. Actions taken to deal with the complaints had been appropriate. People told us they knew how to raise concerns or make a complaint. They said they had a copy of the complaints policy to refer to in their care file. People felt listened to if they contacted the service to raise a concern and in most cases felt that action had been taken to change things whenever the service was able to. One person told us, "[Name] in the office deserves a mention, she always tries to help," while another said, "[They are] helpful in the office, I talk to [name] she always knows what to do." A third person commented that things had got better and any worries they had were dealt with quickly. They said, "[name] has her finger on the pulse and knows what's going on."

Most people told us there had been an improvement in communication with the service when there was a change to their visit. For example one person said, "The office has got better at communication – they let me know if the time has changed or someone else is coming." Another person said, "They phone if they're going to be late." However, not everyone felt that communication had improved and two relatives said they did not always know when to expect the care workers to arrive. They said this made it difficult to plan their day.

People had individual care plans developed from an assessment carried out prior to them using the service. Care plans were detailed and contained information about people's individual wishes, likes and preferences about how they were supported. They gave guidance to staff with regard to supporting people in all aspects of the care the service was responsible for. They also helped to ensure people remained in control of their lives. Reviews of people's care plans were undertaken annually as a minimum or whenever people's needs changed. People told us they were involved in the reviews and had the opportunity to discuss their care and request changes. One person said their care plan had been reviewed and, "They made sure I was happy and everything was up to date." Other methods of gathering people's feedback included telephone monitoring and face to face meetings.

Staff told us how they responded to people's changing needs. They said they wrote any concerns in the daily notes and informed the office immediately. They told us the office would then inform the next carer due to visit the person and take action if a review of care was needed. Daily notes were generally of good quality. They described people's health and well-being as well as the tasks completed. Daily records were audited by senior staff between one and six monthly. The regularity of this auditing had improved and was generally monthly. Any issues were noted and addressed with individual members of staff.

Some people told us they were supported to access activities in the community as part of their agreed care plan. One person explained how this had improved the quality of their life and increased their independence. A relative told us the care staff not only provided very good care for their family member but also, "They're like friends, [they are] good to me and listen to me, I really feel I can talk to them." They said that if it wasn't for the care staff they would not be able to continue to look after their family member at home and commented, "They always respond if I ask for anything."

Is the service well-led?

Our findings

At our previous inspection on 26 February and 4 March 2015 the provider was not meeting the requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance. The registered person did not use systems to monitor the quality of the service effectively. Issues and concerns identified had not been addressed by the registered person. The provider sent us an action plan on 19 June 2015 stating they would make improvements to meet the requirement by 30 September 2015. At this inspection the provider had met the requirement of the regulation.

Quality assurance included three monthly telephone surveys, annual reviews and a variety of audits such as medicine records and daily notes. A quality and performance manager employed by the provider completed a six monthly audit of the service. Any shortfalls identified by this audit were fed into the on-going development plan and reviewed by the regional manager. This allowed appropriate improvement action to be taken. The regional manager conducted a monthly visit to the service and any issues regarding quality were discussed with the manager and an action plan developed. Improvements had been made as a result of the quality assurance systems. These included more efficient use of the computerised systems to maintain records and improve scheduling of visits, developing a support programme for new staff and providing additional training for field care supervisors and care co-ordinators.

At the time of the inspection the service did not have a registered manager, the previous one having deregistered in May 2015. Since that time the service had been managed on a day to day basis by a succession of temporary managers. A new branch manager had been appointed in December 2015 but was not yet registered with the Care Quality Commission (CQC). They told us they were awaiting their clearances from the Disclosure and Barring Service (DBS) so that they could apply to register with CQC.

Staff told us the management team listened to them and took action as necessary. However, they told us that prior to the new manager's appointment things had been, "chaotic." They said they felt confused as to who to approach with problems and concerns. They told us senior managers were not introduced or identified to them. Staff spoke about the short notice they were given to changes in their rota and the chaotic conditions in the office causing low morale amongst the care team. One member of staff said, "things are improving a lot and it's a lot more calm." They described the current culture as, "open and informative" and were hoping that the new scheduling system would cause less short notice changes to their rotas. Staff also told us they get a lot more information now and feel they know what is going on. One told us, "it's more organised now in the office" and another commented, "they're always at the end of the phone if I need them."

Due to the diversity of the locations staff worked in they did not always feel they worked as a team. Some staff felt that more staff meetings would help address this issue. The new manager had planned dates for staff meetings and told us they would be held on a regular basis. Staff were positive about the way the service was developing. They told us they now felt they were listened to when they raised issues and were confident action would be taken. They spoke positively about the new manager introducing themselves to people who use the service and going out to meet people. They felt this gave people confidence in the

manager. However, at the time of the inspection we could not be assured these improvements would be sustained as the manager was new to the post.