MiHomecare Limited

Mihomecare - Shepherds Bush

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this inspection on 12 and 13 May 2016. The first day of the inspection was unannounced. This was our first visit to MiHomecare Shepherds Bush since the service registered at its new location in January 2016. MiHomecare Shepherds Bush is registered to provide personal care to people living in their own homes in the London boroughs of Hammersmith and Fulham and Kensington and Chelsea. At the time of our inspection 472 people were being supported by the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service is growing in terms of hours provided and staff recruitment is ongoing. The registered manager and the referring agencies are aware that systems, policies and procedures need to be established and embedded into practice to ensure the continuous delivery of safe and appropriate support to people living in their own homes.

The service received the majority of its referrals from health and social care professionals working in the local community. This information was used to inform and develop care plans in consultation with people and their family members (where appropriate). This ensured people's support needs could be identified and risk assessments completed before staff began working with people. Not all care plans had been signed and dated by relevant parties to demonstrate that people were in agreement.

Where staff were responsible for prompting people's medicines, staff had completed training in medicines administration. However, effective systems were not yet established to ensure the administration of medicines was always recorded in a safe and consistent way and monitored for potential errors or omissions.

Staff had a good understanding of safeguarding procedures and what steps they would take if someone was at risk of abuse or harm. Despite this, the provider was not always notifying the Care Quality Commission (CQC) of serious safeguarding incidents which should have been reported to us in line with the provider's registration requirements.

People felt able to make a complaint if they needed to and knew how to do so. Staff were aware of their responsibilities regarding reporting any complaints, accidents and/or incidents and systems were in place to record these.

People's risk assessments covered a range of issues including personal care, falls prevention and mobility. For example; information included details about how people mobilised and whether they required walking aids, the support of another person or were independent. However, not all risk assessments had been

completed in full, dated or signed by relevant parties.

CQC monitors the use of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff we spoke with understood what the MCA is designed to do and were able to describe how they supported people to make decisions. The registered manager was aware of the principles of the MCA and how this might affect the care they provided to people. People had their capacity assessed and they were asked (where appropriate) to provide their consent to the support being provided.

People and their family members were able to tell us about the care and support they received. Some people were living with illness associated with advancing age or other long-term health related conditions. Some people lived reasonably independent lives but required support to maintain their independence.

When required, staff supported people to make appointments and attend health appointments. There were protocols in place to respond to any medical emergencies or significant changes in a person's health and well-being. People's health was monitored and when it was necessary, health care professionals were involved to ensure people remained as healthy as possible.

Most of the people we spoke with expressed positive views about the care staff. People felt safe and were supported by staff who knew how to keep them safe. People were treated with dignity and respect and provided with care that was responsive to their changing needs.

Staff were aware of people's specific dietary needs and preferences and people received the level of support they required to have enough to eat and drink.

There were arrangements in place to assess and monitor the quality and effectiveness of the service. The provider sought feedback from people using the service and staff on a regular basis; this included surveys, staff team meetings and spot checks carried out by field care supervisors.

People using the service and staff were supported by a registered manager who was committed to providing a high quality service that met people's needs. The provider had robust policies and procedures in place for the recruitment of new staff. Staff had clear roles and responsibilities and the knowledge and skills to care for people effectively.

We identified a breach of the regulations in regards to notifications and made one recommendation in relation to medicines management. You can see the action we have told the provider to take at the back of the full version of the report.

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

Aspects of MiHomecare Shepherds Bush were not always safe.

People were not always protected against risks associated with unsafe care practices and procedures in relation to medicines management.

People's risk assessments covered a range of issues including personal care, mobility and falls prevention. However, assessments were not always completed in full, signed and dated by the relevant parties.

Care workers were confident about what they would do if they had any concerns or suspected someone was at risk of abuse.

Is the service effective?

Good

MiHomecare Shepherds Bush was effective.

Staff had received training and were aware of their responsibilities in relation to the Mental Capacity Act 2005. Where appropriate, people gave consent to the care they received.

People's health was monitored and medical support was sought when required.

People received the level of support they required to have enough to eat and drink.

Is the service caring?

Good

MiHomecare Shepherds Bush was caring.

People were cared for by staff who had developed positive and caring relationships with them.

People told us they could make decisions about their own care and how they were supported.

People were complimentary about care staff and the level of care they received.

Is the service responsive?

Requires Improvement

Aspects of MiHomecare Shepherds Bush were not always responsive.

People using the service, their family members and care staff raised concerns about poor communication between office staff and themselves.

People's care needs were reviewed either through meetings in people's homes or via telephone discussions with people and their relatives and where appropriate, health and social care professionals.

Care visits were electronically monitored by an external company who contacted the main office when staff were running late or where visits appeared to have been missed.

Is the service well-led?

Requires Improvement

Aspects of MiHomecare Shepherds Bush were not well-led.

The provider was not always notifying us of serious incidents and/or safeguarding concerns in line with their registration requirements.

The service had a registered manager who was supported in her role by care co-ordinators based in the office and field care supervisors who worked out in the community covering a specific area or patch.

Field care supervisors undertook a combination of announced and unannounced spot checks where staff were observed delivering care and provided with feedback.

Staff meetings were held on a regular basis which gave opportunities for staff to raise any concerns about people using the service.

Mihomecare - Shepherds Bush

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 12 and 13 May 2016. The first day of our inspection was unannounced. We let the registered manager know that we would be returning the following day to complete our inspection.

Before the inspection we reviewed the information we held about the service. We considered information which had been shared with us by the local authority and reviewed safeguarding alerts which had been made. We looked at information we hold about the service including correspondence from the provider and complaints from members of the public.

We carried out this inspection at the provider's office in Shepherds Bush. We spoke to the registered manager, a care manager, a field care supervisor, two administration staff and one member of care staff. We reviewed the care records of 17 people using the service. We looked at seven staff recruitment files, supervision and training records, and spoke with the registered manager about the systems in place for monitoring the quality of care people received. We looked at a variety of the provider's policies such as those relating to safeguarding, medicines, complaints and quality assurance.

Following our visit we made phone calls to 27 people using the service and their relatives. We spoke with a further seven members of care staff by phone. We contacted two members of the local authority safeguarding team to get their views on the service. We used this feedback to help us inform our report.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and trusted the staff who cared for them. People told us, "Of course I feel safe", "I feel safe with [staff]", and "absolutely, I feel safe." Despite people's positive comments, we found that people were not always protected against risks associated with unsafe care practices and procedures.

Staff received training in managing medicines as part of their induction and the provider had a medicines policy which outlined appropriate procedures when assisting or supporting people to take their medicines. We looked at people's daily notes and saw that staff were not always recording what level of assistance they had provided in relation to medicines administration and where they had, there were no details as to which medicines had been prompted or administered and at what dosage and no information as to whether people had actually been observed taking their medicines. Neither did we find medicine administration records (MAR) being used (where appropriate) to document that people had taken their medicines as prescribed. At the time of the inspection, we raised this matter with the registered manager as an area that needed to be addressed.

We recommend the provider take into account 'The handling of medicines in social care' by The Royal Pharmaceutical Society of Great Britain.

Risk assessments were in place and these identified both personal and environmental risks. For example, where some people were at risk of falls, there were assessments in place to reduce the risk. Information included details about how people mobilised and whether they required walking aids, the support of another person or were independent. Environmental risk assessments identified any aspect of the person's home which may present a hazard to them or staff, for example areas which may be cluttered or present a trip hazard. Staff were aware of risks to individuals and what actions they took to mitigate these risks. However, risk assessments were not always dated, completed in full or signed by relevant parties.

The provider had policies and procedures in place for safeguarding adults which were available and accessible to members of staff. Staff completed safeguarding training as part of their induction and this training was refreshed on a regular basis. We saw records that confirmed this and spoke with staff who were able to explain how they would identify abuse and were aware of the correct reporting procedures. One member of staff told us, "Safeguarding relates to a process or procedures whereby service users are protected and cared for against any inadequacies in the care provision, abuse or neglect. We have a duty of care to report to the appropriate authorities, social services, CQC and the police."

Staff personnel files were ordered and demonstrated an effective recruitment process. The recruitment files we looked at contained relevant checks, which included checks if applicants were eligible to work in the UK, proof of identity, two verified references and Disclosure and Barring Service (DBS) checks. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions.

There were enough staff who had been safely recruited to meet people's needs. We were told that the service was expanding and as a result, recruitment was an ongoing process. The registered manager told us

about the balance they tried to maintain between accepting new people referred to their service and ensuring there were enough suitably qualified and experienced staff to meet their needs. Staff were employed on flexible contracts and received the London living wage which helped the service to recruit and retain staff members. A senior staff member responsible for recruitment told us, "We look for staff who are compassionate and understand what care really means." Staff demonstrated a good understanding of the provider's purpose, aims and core values.

Good

Is the service effective?

Our findings

People using the service were able to build positive relationships with staff, and receive their personal care and support from staff they were familiar and comfortable with. People told us that care workers generally arrived on time and people's comments indicated there were sufficient allocated staff and time to provide people with individual care that met people's needs and wishes. People told us, "They are on time, stay for the full time and are not late at all", and "I have the same carers all the time, she is one of the best and I don't want anyone else."

Records confirmed staff completed the provider's required training which included medicines management, health and safety, equality and diversity, infection control, safeguarding, food hygiene and safe moving and handling. Senior staff told us that an induction programme was in place for new staff and that they recognised and worked to the Care Certificate based on expected standards for care workers by Skills for Care. Staff confirmed that they undertook training that was required and this was both classroom based and through e-learning. Staff told us they completed an induction that included shadowing more experienced staff who provided support and guidance and were required to successfully complete a three month probation period during which they received supervision in line with the provider's policies and procedures. Staff were also visited by field care supervisors who carried out spot checks which involved observing staff during the course of their duties and providing constructive feedback.

People told us their needs were assessed and met by the service and they were happy with their regular care staff. Care plans included care needs assessments, which had been carried out before the person's package of care was commenced. Records included contact details for people's GPs and other relevant health and social care professionals involved in their care. Therefore, staff had a reasonable level of information about people's health and social care needs and some understanding of the support they required, from their very first point of contact. Care plans contained information and guidance for staff on how best to monitor people's health and promote their independence. Senior staff were aware that not all care plans had been signed and dated by relevant parties and told us they were working towards full completion and sign off by the end of the month.

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 people lack the 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. The application procedures for this in domiciliary care services are to be made to the Court of Protection. We checked whether the service was working within the principles of the MCA.

A senior member of staff told us, "The MCA plays a very important part in care delivery. There are five main principles; decision making, best interests, giving people choices, not being restrictive in approach and assessments of people's capacity." Where people had the capacity to make their own decisions, not all care

plans had been signed to show people were in agreement with the information recorded. In cases where people lacked the capacity to make decisions about their own care, plans were developed in people's best interests in conjunction with healthcare professionals and family members (where appropriate). Staff we spoke with understood consent and capacity issues and were aware of what to do and who to report to if the people they were caring for became unable to make decisions for themselves.

Staff supported people with food shopping and meal preparation. Staff were required to prepare or heat up simple meals or serve food prepared by family members. People we spoke with told us their meals were well prepared and they were offered choices wherever possible. One person told us, "[My care worker] warms up my ready meal and makes me a salad." Other people told us, "[Care staff] give me my breakfast and a cup of tea, it's fine", and "I'm very happy, they make me a sandwich for lunch and a hot meal for dinner."

People using the service told us, "Staff do care and they are well trained", and "[Staff] do a good job." Relatives told us "[Staff] are well trained and we feel confident with them" and "Staff know what to do and they take time to chat." Staff had a programme of training and supervision, so people were supported by staff who were trained to deliver care safely and to an appropriate standard. A training matrix showed the training all staff were required to undertake to meet the needs of people they supported such as safeguarding, mental health legislation, equality, diversity and human rights. Staff told us they had access to further training and a high number of staff had completed vocational training courses in health and social care. Any gaps in staff member's training and development needs were addressed during staff supervision sessions.

Good

Is the service caring?

Our findings

People's comments about care staff included, "[Staff] are lovely and very supportive", "kind", "very nice to talk to and very caring." Relatives told us, "[Staff] are very good", "very respectful", "lovely and friendly."

Staff told us they enjoyed their work and comments included, "I love it, I love making a difference, having a chat and a cup of tea with [people]", and "The best bit about the job is changing someone's life. You have to really want to be a carer to do this work." This member of staff told us how they had organised a birthday party for one of the people they cared for and invited family members because they felt it was important for this person to celebrate their life.

We looked at the care records of 17 people and found evidence that people and their family members had been involved in the development of their care plans. This demonstrated people were encouraged to express their views about how their care and support was delivered. The plans contained information about people's medical history, family information, emergency contact details, current needs as well as their wishes and preferences. We saw evidence to demonstrate people's care plans were reviewed with them and updated when required. This ensured the information staff had about people's needs reflected the support and care they required. People told us they had received copies of their care plans and a service user guide which provided people with useful contact numbers for the service.

People we spoke with told us they could make decisions about their own care and how they were supported. People were able to specify whether they preferred a male or female member of staff. Where possible, care staff were matched with people who were able to speak their first language if this was not English. One person using the service told us, "[Staff] talk nicely and say good morning and do what I want." Other people said, "I feel respected", "the care is kind", "they don't shout at me and they don't demand."

People told us their dignity and privacy was respected. People said, "They shut the door when changing me", and "Yes, they always ask if I'm comfortable and readjust my pad if needed." Staff were able to explain and give examples of how they would maintain people's dignity, privacy and independence. One member of staff told us, "I ask people if they would like personal care, I take them to the bathroom, assist with undressing or they do this for themselves if they are able to. I wait outside but am right there if they need help. I make sure people are covered with a towel and doors and curtains are closed."

People told us that they usually had the same care staff and knew them well. One person told us, "I've been with my carer for a long time; she knows what to do and gets on with it. She knows where everything is. She is adorable and great. I'm very satisfied with my carer." Some staff had completed training in dementia care and demonstrated a good understanding of the needs of people living with dementia and other complex health care needs. Relatives told us that staff were "very caring."

Requires Improvement

Is the service responsive?

Our findings

People using the service and their relatives told us they knew how to make a complaint if they were unhappy about anything. The provider had systems in place for recording complaints which included recording the nature of the complaint and the action taken. The majority of people we spoke with told us they had no complaints or concerns and knew who to speak to if they did. People said, "I have no complaints or concerns", and ""It's a good service and I have no complaints." One person told us they had complained about a care worker and that this matter had been dealt with immediately. However, a common theme emerging from our conversations with people using the service and care staff was that communication between themselves and office staff required improvement. We were told, "I rang the office to complain but nothing was done", "The office can be rude and I have given up complaining", "I haven't been listened to" and "There's a problem in the office, their communication is slack."

A number of safeguarding investigations had been initiated as a result of missed visits during the service's initial set up phase. We discussed this matter with the registered manager who told us that the situation had improved significantly due to the advance notification of staff rotas, tighter monitoring, supervision and disciplinary action. We were told that compliance levels for staff logging in and out was now standing at over 85% and that a level of 90% was a contract requirement from service commissioners and something that was reported on fortnightly.

All staff were provided with a mobile hand set which was used to log in and out of people's homes via a simple scanning mechanism attached to people's care plan folders. People we spoke with confirmed that care staff logged in and out each time they visited. Visits were monitored by an external company who contacted the main office when staff were running late or where visits appeared to have been missed. This triggered a call to staff who were able to explain their whereabouts and/or the reason why they had been unable to log in and out. Some staff told us that extra visits were added to their rotas without their knowledge and this sometimes meant they arrived at visits late or had to leave early. Staff told us they were given five minutes to travel form one home to another which also meant they were sometimes late for visits.

There were procedures in place when staff were unable to access the homes of people they were providing care for. This included, contacting the office to report a 'no response' and contacting the police if necessary. We are aware of one incident where this procedure was not followed resulting in a police investigation. Following the incident the provider took action and followed its internal disciplinary procedures. This incident was discussed with staff and clear policies and procedure are now in place to ensure a similar incident does not happen again. In the event of a medical emergency staff had been trained to call 999 and stay with people until an ambulance arrived, offer reassurance and keep the person warm and safe. Staff we spoke with were clear about how to manage a 'no response' incident and able to explain to us what action they would take if and when people's needs changed or their health deteriorated. We saw clear evidence in people's care records that staff had called 999 when they felt people were unwell or required further support and referrals to healthcare professionals.

When people were referred to the service we found assessments had been undertaken to identify people's

support needs prior to the service commencing. Where possible, people were supported and encouraged to express their views and wishes about the care and support they required. Where people were not able to make these decisions for themselves, family members (if appropriate) and/or health and social care professionals contributed to the development of care and support plans. The initial assessment process ensured that people's individual care and support needs could be met by the service before a package of care was organised and care staff allocated.

People we spoke with told us they thought staff knew them well and knew how to support them if their needs changed. People told us, "I have a care plan and it's reviewed annually", and "someone comes from the office to review [my care plan]". Staff told us care plans were easy to use and contained relevant and sufficient information to know what the care needs were for each person and how to meet them. However, we were told by some care staff that care plans were not always in place in people's homes because information was not uploaded in a timely manner. This may have meant that staff arriving for visits did not always know what care people required.

We saw that people were able to express when, how and by whom they wanted their support provided. For example some people had been specific about the gender of staff they wanted to support them. We also saw people had expressed their choices and preferences about their visit times and the level of support they required and how these would be met. People's objectives and desires had been identified as part of the plan of care. For example people had requested support to promote their independence or maintain their mobility. People we spoke with said the service had responded to their requests for support and they were satisfied with the service they received.

People's care and support needs were updated and reviewed in line with the provider's policies and procedures. Reviews took place either through meetings in people's homes or via telephone discussions with people and their relatives and where appropriate, health and social care professionals.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager who was supported in her role by care co-ordinators based in the office and field care supervisors who worked out in the community covering a specific area or patch. Staff attended the office regularly and we observed the atmosphere was calm and that people approached the registered manager in a relaxed manner.

Leadership was visible and the registered manager understood her role and responsibilities. Despite this understanding, we have not always received notifications of serious incidents and safeguarding concerns in accordance with the provider's registration requirements. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The registered manager has told us that in future she will ensure CQC is notified of concerns and/or incidents in a timely manner.

Staff told us the registered manager was approachable and supportive. Staff comments about the registered manager included, "She's awesome and easy to get on with", and "She takes anything you say on board." People told us they knew who to speak to if they had any concerns; this included the registered manager, office staff, call alarm personnel, family members and social workers.

The registered manager told us field care supervisors who worked out in the community were responsible for monitoring care staff and the care and support they provided to people using the service. The care supervisors undertook a combination of announced and unannounced spot checks where staff were observed delivering care and provided with feedback. A field supervisor told us people who were new to the service had their care reviewed within the first six weeks and all packages of care were then reviewed every six months. We saw evidence that care needs were reviewed in line with the provider's policies either through home visits or telephone calls.

Staff told us, "morale was good" within the team, they enjoyed their jobs and "treat each other with respect". Staff meetings were held on a regular basis which gave opportunities for staff to raise any concerns about people using the service, feedback ideas and make suggestions about the running of the service. The registered manager told us meeting minutes were available to all staff members. This meant that staff who were unable to attend always had access to information and updates.

The provider had systems in place to monitor the quality of the service provided. Daily notes were audited to check that correct information was recorded in a timely manner and also with the use of appropriate language. Quality audits were completed for the service to ensure quality was maintained and improvements made to the quality of care people received. For example environment checks and checks to make sure people were happy with the service provided. Monitoring records we looked at showed that on the whole people were satisfied with the care they were receiving.

Staff told us they were aware of the reporting procedures in the event of an accident or incident. No accidents or incidents had been recorded in the paper file. We were told by the operations support manager that serious incidents were recorded on their electronic data base. We requested and received this

information following our inspection. We saw that appropriate action was taken in response to incidents and accidents.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider must notify the Care Quality Commission of any important event that affects people's welfare, health and safety so that where action is needed, action can be taken. Regulation 18 (1), (2) (e).