MiHomecare Limited

MiHomecare - Huntingdon

Inspection report

Ground Floor Windsor House
The Anderson Centre
Ermine Business Park
Huntingdon
Cambs
PE29 6XY
Tel: 03331 2176501
Website: www.mihomecare.com

Date of inspection visit: 10 and 12 August 2015
Date of publication: 09/09/2015

Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

This announced inspection took place on the 10 and 12 August 2015. The previous inspection was completed on 30 May 2014. At the inspection in May 2014 the provider was meeting the standards that we assessed.

MiHomecare - Huntingdon is a domiciliary care service that provides personal care to people who live in the town of Huntingdon and the surrounding towns and villages. At the time of this inspection the service provided personal care to approximately 68 people.

The service did not have a registered manager in post. The previous registered manager left in December 2014. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the scheme. 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 scheme is run.

Summary of findings

The provider had an effective recruitment process in place. This was to ensure only those staff deemed suitable to work with people were offered employment at the service.

Staff were able to tell us about protecting people from harm and the reporting process. Staff were knowledgeable about the organisations they could contact if required such as the local authority. Staff had not received any training updates for safeguarding or medicines administration. Staff's competency to safely administer medicines had not been regularly assessed. Risk assessments were not always in place. This put people at risk of receiving unsafe or inappropriate care.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found that people who used the service had their capacity to make day-to-day decisions formally assessed. At the time of our inspection people's capacity to make decisions were supported by relatives and staff where it was in the person's best interests.

People's needs were assessed using a combination of the local authority's single assessment process (SAP) and the care staff's assessment of people's needs. Staff supported people in the way people preferred. However, the information and guidance in people's care plans was limited and did not always explain what staff support was required. This meant that staff, especially where agency staff were used, did not always have sufficient detail and guidance in providing people's care.

People's privacy and dignity was provided in a consistent way and this was with compassion and patience.

Most staff had not received regular support, supervision or appraisals which meant that people were at risk of being supported by staff whose skills to meet their needs had not been effectively assessed.

People were supported to access the provider's complaints procedure and advocacy services if this was required. Trends in people's complaints had been identified and were being responded to.

The provider had arrangements and systems in place to assess and manage the quality of care it provided.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take in 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 always safe.

Risks to people's safety were not always identified or recorded. Staff had not had safeguarding or medicines administration refresher training. Staff's competency to administer medicines safely had not been regularly assessed.

Staff were aware of and understood what protecting people from harm meant. Staff were confident in reporting any poor standards of care if required.

An effective recruitment process helped ensure that staff were only offered employment with the service after all the essential checks had been satisfactorily completed.

Requires improvement

Is the service effective?
The service was not always effective.

The majority of staff training and refresher training had not been updated. Staff support, supervision and appraisals had not always been completed regularly.

People were supported to access health care professionals where required.

People were able to choose what and when they preferred to eat and had sufficient quantities of food and drinks available.

Requires improvement

Is the service caring?
The service was caring.

Staff knew how to meet people's needs.

People were supported with care that was compassionate and in consideration of their needs.

People's care was provided in privacy and with dignity.

Good

Is the service responsive?
The service was responsive.

People were supported to actively take part in their hobbies and interests to prevent the risk of social isolation.

Trends in complaints had been identified and action was in progress to address these issues. People were supported to access the provider's complaints procedure.

Good

Is the service well-led?
The service was well led.

Good

Summary of findings

The provider had quality assurance procedures and processes in place to monitor the safety and effectiveness of people's care.

The views of people and staff were actively sought as a way of identifying where there was potential to improve the running and provision of the service.

The provider was aware of the day to day culture in the service and action was planned to make improvements.

MiHomecare - Huntingdon

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 registered manager is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the scheme, and to provide a rating for the scheme under the Care Act 2014.

This announced inspection took place on 10 and 12 August 2015 and was completed by one inspector. 48 hours' notice of the inspection was given because we wanted to make sure the manager and staff were available. We needed to be sure that they would be in.

A provider information return (PIR) had been requested but the timescales to submit this to the CQC had not yet expired. 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. Before the inspection we looked at records we hold about the service such as notifications. A notification is information about important events which the provider is required by law to tell us about.

During our inspection we observed how staff interacted with people. We spoke with three people in their homes and eight people and four relatives by telephone. We spoke with the provider's operations director, the regional manager and a visiting manager. We also spoke with two staff who were normally based in the service's office as well as five care staff. We contacted commissioners of the service who pay for people's care for their views.

We looked at eight people's care and medicine administration records. We looked at records in relation to the management of the service such as quality monitoring and accident and incident records. We also looked at staff recruitment documents, supervision and appraisal processes, training records and complaints records.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us they were safe. One person said, "They (staff) have to help me and I feel safe knowing they are going to turn up." Most people commented that their care staff were usually on time and were informed about known delays. One person said, "They are on time nine times out of ten." However, another person said, "I never know which staff are coming to see me and they aren't always on time." They told us sometimes staff were up to an hour early or late. Another person told us, "Over the weekend they (staff) came at 11.45am rather than 12.30pm so my dinner wasn't ready in the oven." Another person said, "I had a missed call five weeks ago and contacted the office but no one has called me back."

We found and staff confirmed that training was not provided on subjects included safeguarding people and medicines administration. We saw that in some instances staff had not received any training or updates since their induction to the service in May 2014. All staff we spoke with confirmed this was the case. Staff's training for medicines administration had not been updated. Staff had not had their competency to safely administer medicines regularly assessed. This meant that people were at risk of not being safely supported with their medicines administration.

Environmental risk assessments were in place to ensure that care could be safely provided in people's homes. However, we found that not all other risks had been identified or managed safely. There was no recorded guidance for staff to follow to manage people with their behaviours which could challenge. There was also a lack of detail on the responses staff needed to take. In addition, there was no recorded details for staff to be aware of what the likely triggers could be or what calming measures worked for the person. Where people used mobility equipment to access the community there was no risk assessment in place on how staff needed to manage the risks to these people. This put people at risk of receiving unsafe or inappropriate care.

This was a breach of Regulation 12 (1) (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our observations of staff administering people's medicines showed that they followed relevant guidance and good practice. One person said, "They (staff) get my medicines out for me and make sure I take them properly. Records of medicines administration we looked at were completed accurately. We found that disposal of medicines followed good practice. Checks were completed to ensure people were only administered medicines they had been prescribed. The regional manager was provided with access to the Medicines and Healthcare Products Regulatory Agency guidance (MHRA) on, and alerts regarding, the recall of people's medicines. This updated information was then passed on to staff where required. Staff were able to tell us how they safely administered medicines including when people required a medicines that had to be administered under specific conditions such as the time of day they had their medicines.

Although staff had not had any updates to their safeguarding training they were able to tell us about the different types of harm and abuse they needed to be aware of. They were able to describe the process for reporting any potential, or actual, abuse and who their concerns could be escalated to. Staff were aware of the provider's whistle-blowing policy and procedure. One care staff said, "I have a card I carry and I can use a confidential phone line to discuss concerns if I had any." They told us they would feel confident in raising any concerns as they would be protected from recrimination. Another care staff said, "I would have no hesitation in reporting any concerns about poor care."

We were told by the regional manager that accident and incident trends such as missed medications were recorded. This allowed specific areas of concern to be identified and acted upon. These were prioritised according to the impact on people. We saw that, as a result of this, action had been taken and was in progress to prevent further incidents. This was by actions including improved call allocation and monitoring.

We found that staff recruited to the service had their suitability to work with people assessed. This included checks on their previous employment, recent photographic identity, satisfactory criminal records checks, and fitness and ability to do their job safely. Staff told us about their recruitment and the documents they had to supply such as their qualifications. This meant that the service only employed staff after all the required and essential recruitment checks had been satisfactorily completed.

We saw, and people confirmed, that there was a sufficient number of staff employed by the service to ensure the

Requires improvement

Is the service safe?

safety of the people receiving personal care. One person said, “The care staff are really good. They keep my kitchen tidy and safe for me.” Another person said, “Staff have the time to tidy up as well as providing my care.” The regional manager and staff confirmed that the recruitment and additional staff brought into the office had improved the response to people’s care needs.

One person told us, “There are lots of different staff who help me but as long as there is someone there for me I don’t mind.” Staff told us that if they were going to be delayed they let the office staff know if at all possible. If staff required assistance with unplanned events they could use the ‘on call’ system to request additional staff. People were safely supported with their care needs.

Requires improvement

Is the service effective?

Our findings

People told us, and we found, that they were supported by experienced care staff who knew them and their care needs well. One person said, "The staff know me ever so well and over the past few months we have got to know each other." Another person said, "I haven't needed a doctor for many years but I am sure that the staff would get me one if needed."

Staff told us about their induction and said that it enabled them to do their jobs effectively with support from more experienced staff and field care supervisors. One member of staff said, "My induction covered several subjects including medicines administration and infection control." However, another care staff said, "The training since induction has been non-existent." Another care staff said, "I had a spot check over 12 months ago but there has not been any since." Another care staff said, "The previous manager never seemed to have time for us and despite (me) asking for a supervision. I have not had one in ages." We found two staff supervision records from December 2014. However, most staff had not had any regular support, supervision or appraisals. The regional manager confirmed that the previous manager had not documented people's supervisions. All staff we spoke with confirmed that supervision had not happened for a long time. For most staff this was over 12 months. This put people at risk of being supported by staff without the necessary skills to fulfil their role.

Staff were knowledgeable about the subjects they had been trained in during induction. Subjects covered included medicines administration, moving and handling, nutrition, dementia care and the Mental Capacity Act 2005 (MCA). However, all staff confirmed to us and training plans and records we viewed showed us that most staff had not always been provided with regular training updates for those subjects deemed mandatory by the provider. Staff had received training during their induction but no further training had been provided. This meant that staff were not supported as well as they should have been.

This was a breach of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff were knowledgeable about their needs and how to meet these. We saw and found that staff were matched, as far as possible, to the people they cared for. Examples included staff with a long term understanding of the person's needs supporting that person. One person said, "I like [name of care staff] they come to see me regularly." They know all my needs now." Staff were introduced to people they cared for during their induction. This was so that people were aware of the staff visiting their homes. Any person new to the care provider was met by a team leader and information gathered was used to assist staff in providing the person's care in the way the person preferred. We saw and found that staff understood people's needs well. This was by ensuring that the care provided was only with the person's agreement. This could be verbally, in writing or by implied consent.

We found that the regional manager, care and supervisory office staff had an understanding of the MCA. This was for lawfully depriving people of their liberty and when this could be required. They were aware of what action to take if a person's capacity to make specific decisions had changed such as a change in the person's health. People were provided with care if and when it was in their best interests. Staff knew when to respect people's choices. This showed us that staff knew what protection the MCA offered people and also to staff.

People were able to choose their preferred meal options. One person said, "I usually have what is prepared but if I change my mind they (staff) prepare me something else." We saw that people were supported to ensure they ate and drank sufficient quantities. This included what foods people liked and any food allergies they had. One person told us, "I am having mashed swede, potato and scrambled egg for my dinner." They ate all their meal and described it as "lovely" Staff were observed informing the person what their lunch was and that it was hot. During our visits to people in their homes people told us that they were supported to eat at a relaxed pace in the place of their choosing.

People told us, and we saw, that they were supported to access health care professionals including community nurses or a GP when needed. One person said, "If I need a GP they (staff) call one for me." The regional manager and staff confirmed when referrals to health care professionals had been made. For example to the occupational therapist. Records we viewed confirmed that where health referrals

Requires improvement

Is the service effective?

had been made the reason for this had been explained and also that the person's family had been informed. This also happened if a person was admitted to, or was discharged from, hospital.

Good

Is the service caring?

Our findings

People we spoke with were generally very satisfied with their care and the quality of it. Comments we received included, "It is nice to talk with a younger person (care staff) and we have such laughs." A relative told us, "They (staff) have a job to do. They get on with it, do it well and in a very caring way."

People's care plans contained information on people's preferences such as the hobbies they liked to take part in, the places they preferred to spend the majority of their day and their preferred name. However, we found the level of detail recorded on how each person needed to be supported was limited. For example, 'needs full support'. There was no further recorded detail of what this meant. There was also no recorded times in any of the care plans we looked at of when their care was to be provided. In addition, another person's care plan stated "likes a cooked breakfast or cereal" but there were no recorded details of what this was or could be. This posed a risk of people being provided with care they weren't aware of or care that was inappropriate.

We found that staff were knowledgeable about people's preferences. For example, where the person liked to sit or relax during the day. All people we spoke with, and our visits to people in their homes, confirmed that care staff were polite, compassionate and respectful. Examples included, asking the person how they were, introducing themselves to the person after knocking on their door and waiting until the person acknowledged their presence. One person said, "I am an active person but all staff care for me in the same way, "wonderfully."

One person said, "I am looked after exceptionally well." And, "I have some lovely staff who look after me and make sure I have everything I need." People were consistently offered choice based on what was important to them. For example, with their safe mobility in and around their homes as well as reminding people to wear their emergency contact equipment 'lifeline'. We saw that staff reminded people to use their walking equipment or they ensured that it was within easy reach. We observed that staff gave people time to complete their chosen activities as well as offering respectful support and encouragement. In addition, care staff showed an interest in what people said and engaged in polite conversation whilst still being able to have a laugh. One person said, "Life's too short not to have a laugh (with staff)."

Care staff gave some examples of what respecting people's privacy and dignified care was. Examples including allowing people privacy to complete their personal hygiene, covering people up as much as possible when completing moving and handling tasks and also locking bathroom doors if the person preferred. A relative told us, "The one thing that they (staff) do well is respecting my [family member's] dignity. They always close the door and keep a towel at hand." Another person said, "I have a (wash in bed) and they do this with the as much dignity as possible."

We saw in records viewed that people's life histories were used to form the basis upon which their care plans were based. For example, the person's work experience and what their hobbies and interests were. Staff were attentive to people's requests for assistance and supported people using appropriate language, referring to people by their preferred name and talking politely and respectfully with people.

We saw that most people had confirmed their agreement to the provision and level of care that was to be delivered. This was by signing their care plan. Where relatives were involved in making decisions for people this was also recorded. If the person was not able, or chose not, to sign their care plan this was recorded. The regional manager told us that advocacy service were available and could be offered. This was from organisations including Age UK.

Good

Is the service responsive?

Our findings

In addition to the Single Assessment Process (SAP) provided by the local authority, care staff and managers completed a full assessment of the person's care needs before the provision of any care was offered. As well as people's contribution to their care, advanced decisions and directives were used to aid the development of care plans on the subjects that really mattered to the person.

The provider recorded people's life histories, relatives and other significant people. Any new information was recorded in care plans to inform staff and to help them gain an individual understanding of what was really important to each person.

The provider had identified that people's care plans were not as individualised or detailed as they could have been. The new care plans we were shown were laid out in a way which put the person more at the centre of their care. This was to help ensure that the care plans reflected how people liked to receive care and support. This information was then to be used to help staff identify what people liked to do including their hobbies and interests. For example, going to a day centre, meeting families and friends or watching TV. One person said, "I liked fishing when I was younger and I like to watch programmes about this."

Staff told us that people's care plans were updated at least every six months or more frequently if ever the need arose. For example, if a person had been discharged from hospital with new equipment such as a specialist bed. This was generally completed by staff based in the office but important information was recorded in daily notes straight away. This allowed staff to respond to the person's needs based upon the most up-to-date care information.

People were provided with information about how to raise a concern. This was in a service user guide (SUG). The SUG included details about the provider's contact details and head office as well the Local Government Ombudsman. This was for people to access if they ever felt that their concerns had not been dealt with to their satisfaction. Responses to most people's complaints and concerns were acted upon within the timescales determined by the provider.

The provider had voluntarily decided not to take on any further people to provide care for until they were confident that all people's needs could safely be met. We saw that improvement plans were in place for the service. This had been as a result of the identification in complaint trends as well as the current workload being experienced by some staff. One person told us, "The time sheets used to be (inaccurate) or delivered late but they have been much better just recently." As well as additional staff, new processes were being implemented to improve how the service responded more promptly and effectively to concerns raised by people. For example, by managing people's care calls more effectively. This was also to ensure that people who required support with their medicines were supported at the right times.

The regional manager told us that they attended regional manager forums where good practice was shared as well as any trends with concerns affecting more than one service. Subjects covered included missed or late calls and the reasons for these. However, we found that the provider was not always aware of the accurate number of these incidents unless the location manager informed them. This limited the provider's overview of the safety of the service it provided.

Good

Is the service well-led?

Our findings

The service did not currently have a registered manager in post. The regional manager told us that they were actively recruiting into the post. This was confirmed on the provider's web site. The regional manager was aware of the general staff culture and had taken action to address this matter. Improvements in valuing staff, such as improving communications, were in progress as the staff team had reported that they had not always felt valued. One care staff said, "When I came into the office last week I couldn't believe the difference it was so much calmer and more organised." Another office base staff confirmed that the provision of additional staff resource had helped considerably in meeting people's requests and expectations.

Most people we spoke with felt that the service was well run. One person said, "They contacted me last week to see if everything was in order and if there was anything I was not happy with." A relative said, "I haven't had any issues but if there was ever anything that my [family member] was not satisfied with they (the care provider) would soon know about it. Another person said, "I have been with MiHomecare for a few years and I generally get the same care staff."

We found that the regional manager as well as the provider's quality auditor had quality assurance survey and audit programmes in place. These had identified several areas for improvement in January 2015 and June 2015. This had identified areas of risk to people who received a service. Actions from these audits were now in place. This included actions for staffing levels, improving the response to people's concerns and addressing the quality of people's care plans.

Further improvements were planned to increase the quality of call monitoring for when staff arrived at people's homes. The regional manager and the provider's operations' director told us that this would improve the reliability and response by the service if staff failed to make a call for whatever reason.

We saw and staff told us that they supported people to maintain links with the local community which included going to a day centre, going out or completing on-line shopping. One relative told us, "I take [family member] out once a week and I have other organisations I can contact if I need any more help." Where staff identified a person as being at risk of social isolation they could be sign posted to the Community Navigator. This organisation helps isolated people to stay independent and maintain social contact with friends and the community. People we spoke with confirmed that this facility had been offered.

Staff confirmed that the support they had received over the past 12 months had been very limited. The regional manager was aware of this situation and confirmed that plans were now in place to support staff. They told us that staff supervisions and appraisals for those staff needing this were planned to be completed, as far as possible by the end of October 2105. Staff confirmed that training deemed mandatory by the provider had not been reliably completed. This had also been confirmed in the provider's June 2015 audit. Staff told us, "We used to have a monthly newsletter for training reminders and this was really helpful especially as we don't go to the office frequently. We saw that two staff had completed their refresher training and other staff had dates for this. This showed us that staff training and refresher training was in progress. This was confirmed in the records we viewed.

People's views were sought in a variety of ways including by telephone monitoring and visits to people in their homes. There was also an opportunity during care plan reviews to seek people's general views and comments about what the service did well for people and any areas requiring some attention.

We found from our review of records we hold about the service that the service had notified the CQC of events they are, by law, required to tell us about. This included incidents involving, missed or late calls to people. We also saw that action had been taken in response to these identified issues.

All staff told us they liked working at the service and that it was the dedication of the core staff team that kept them going. Staff were aware of the values of the service about ensuring that people always came first. One staff said, "All the staff team get on well. I wouldn't do this job if I didn't care (about people)." A relative told us, "They (staff) do what my [family member] wants them to do and they do it well."

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Staff had not received regular training. Staff had not had their competency to safely administer medications assessed. Not all risk assessments were in place. Regulation 12 (1) (2) (a) (b) (g)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Staff were not supported with regular supervision, support or annual appraisal. Regulation 18 (1) (2) (a)